Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: FLORIDA

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation
42 CFR 431.15
AT-79-29

4.1 Methods of Administration

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

Revisions: HCFA-AT-80-38 (BPP)
May 22, 1980

State Florida

Citation	4.2 Hearings for Applicants and Recipients
42 CFR 431.202 AT-79-29 AT-80-34	The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

Revision: HCFA-AT-87-9 (BERC) AUGUST 1987 OMB No.: 0938-0193

State/Territory: FLORIDA

Citation	4.3 Safeguarding Information on Applicants and Recipients
42 CFR 431.301 AT-79-29	Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967	All other requirements of 42 CFR Part 431, Subpart F are met.

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: FLORIDA

Citation
42 CFR 431.800(c)
50 FR 21839
1903(u)(1)(D) of the Act,
P.L. 99-509
(Section 9407)

4.4 Medicaid Quality Control

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

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

/X/ Yes.

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

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: Florida

Citation	4.5 Medicaid Agency Fraud Detection and Investigation Program
42 CFR 455.12 AT-78-90 48 FR 3742 52 FR 48817	The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

New: HCFA-PM-99-3
June 1999

State: FLORIDA

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

4.5a Medicaid Agency Fraud Detection and Investigation Program

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

Revision:

State Florida

PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5b Medicaid Recovery Audit Contractor Program

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

	_____The State will make payments to the RAC(s) on a contingent Basis for collecting overpayments.
Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act	The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee): ____ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register. ____ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RAC as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate. ____ The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.
Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act	_____The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):
Section 1902 (a)(42)(B)(ii)(III) of the Act	_____The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).
Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act	_____ The State assures that the amounts expended by the State to Carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.
Section 1902(a)(42)(B)(ii)(IV(bb) of the Act	_____The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.
Section 1902 (a)(42)(B)(ii)(IV)(cc) of the Act	_____Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Florida

Citation
42 CFR 431.16
AT-79-29

4.6 Reports

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

Revisions: HCFA-AT-80-38 (BPP)
May 22, 1980

State Florida

Citation
42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

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

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Florida

Citation		
42 CFR 431.18 (b) AT-79-29	4.8	Availability of Agency Program Manuals Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

Revisions: HCFA-AT-80-38 (BPP)
May 22, 1980

State Florida

Citation
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

New: HCFA-PM-99-3
JUNE 1999

State: Florida

Citation	
42 CFR 431.51 AT 78-90 46 FR 48524 48 FR 23212 1902(a)(23) P.L. 100-93 (section 8(f)) P.L. 100-203 (Section 4113)	4.10 Free Choice of Providers (a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy person, or organization that is qualified to perform the services, including of the Act an organization that provides these services or arranges for their availability on a prepayment basis. Providers who elect not to provide services based on a history of bad debt, including copayments, shall give recipients advance notice and a reasonable opportunity for payment. Recipients retain the ability to seek services from other enrolled providers. (b) Paragraph (a) does not apply to services furnished to an individual – (1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or (2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or (3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,
Section 1902(a)(23) Of the Social Security Act P.L. 105-33	(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, or
Section 1932(a)(1) Section 1905(t)	(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c). (c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or, managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905 (a)(4)(c).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Florida

Citation
42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

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

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

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Florida

Citation		
42 CFR 431.610 AT-78-90 AT-89-34	4.11(d)	The Health Facility Regulation, Agency for Health Care Administration which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Florida

Citation
42 CFR 431.105(b)
AT-78-90

4.12 Consultation to Medical Facilities

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

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

☐ Yes, as listed below:

☒ Not applicable. Similar services are not provided to other types of medical facilities.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: FLORIDA

Citation 4.13 Required Provider Agreement

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

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

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

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

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

/ / Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

Revision: HCFA-PM-91-9 (MB) OMB No.:
October 1991

State/Territory: FLORIDA

Citation
1902(a)(58)
1902(w)(2)(A) 4.13 (e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

P&I
HCFH 1-28-92

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

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

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

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

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

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

statutory or recognized by the courts) concerning advance directives; and

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

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

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

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

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

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

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

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

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

State/Territory: Florida

Citation		
42 CFR, 431.50; 42 CFR, 456.2; 50 FR, 15312 1902 (a)(30) and 1902(d) of the Act, P.L. 99-509 (Section 9312)	4.14 (a)	Utilization/Quality Control A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR, Part 456 are met:

____ Directly

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

(1) Meets the requirements of 42 CFR, 434.6(a)

(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) Identifies the services and providers subject to the designee's review;

(4) Ensures that the designee's review activities are not inconsistent with the QIO review of Medicare services; and

(5) Includes a description of the extent to which the designee determinations are considered conclusive for payment purposes.

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: FLORIDA

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

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

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

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

/ / All hospitals (other than mental hospitals).

/ / Those specified in the waiver.

/X/ No waivers have been granted.

NOTE: The functions of Section 1154 of Public Law 97-248 are performed on a statewide basis by contract with a utilization and quality control review organization that has entered into a contract with the Secretary in accordance with the provisions of Section 1862(g).

Revision: HCFA-PM-85-7 (BERC) OMB NO.: 0938-0193
JULY 1985

State/Territory: Florida

Citation
42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

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

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

/ / All mental hospitals.

/ / Those specified in the waiver.

/X/ No waivers have been granted.

/ / Not applicable. Inpatient services in mental hospitals are not provided under this plan.

Citation
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

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

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

/ / All skilled nursing facilities.

/ / Those specified in the waiver.

/X/ No waivers have been granted.

State: Florida

Citation
42 CFR, 456.2
50 FR, 15312

4.14 ☒ (e) The Medicaid agency meets the requirements of CFR 456, Subpart F, for control of the utilization of intermediate care facilities for individuals with disabilities.
Utilization review in facilities is provided through:

☐ Facility-based review.

☐ Direct review by personnel of the medical assistance unit of the State agency.

☐ Personnel under contract to the medical assistance unit of the State agency.

☐ Quality Improvement Organization

☐ Another method as described in ATTACHMENT 4.14-A.

☒ Two or more of the above methods. Attachment 4.14-B describes the circumstances under which each method is used.

☐ Not applicable. Intermediate care facility services are not provided under this plan.

50a

1932(c)(2)
and 1902(d) of the
ACT, P.L. 99-509
(section 9431)

_X_ A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E each managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: FLORIDA

Citation 4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

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

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

____ ICFs/MR;

____ Inpatient psychiatric facilities for recipients under age 21; and

____ Mental Hospitals.

42 CFR Part 456 Subpart A and 1902(a)(30) of the Act

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

____ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.

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

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

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Florida

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

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

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

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

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

Citation
42 CFR 433.36(c)
1902(a)(18) and
1917(a) and (b) of
the Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

____ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

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

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

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

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

____ The State imposes liens on both real and personal property of an individual after the individual's death.

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Florida

(b) Adjustments or Recoveries

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

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

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

____ Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

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

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

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

All services paid by the Florida Medicaid program.

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Florida

4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Florida

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

53 c

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

(c) Adjustments or Recoveries: Limitations

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

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

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

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

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

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).

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

(3) Defines the following terms:

- estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
- individual's home,
- equity interest in the home,
- residing in the home for at least 1 or 2 years,
- on a continuous basis,
- discharge from the medical institution and return home, and
- lawfully residing.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

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

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

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

Revision: HCFA-AT-91-4(BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: Florida

Citation 42 CFR 447.51 through 447.58

4.18 Recipient Cost Sharing and Similar Charges

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

1916(a) and (b) of the Act

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

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

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

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

[ ] Age 19

[ ] Age 20

[X] Age 21

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

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Cost Sharing

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Florida

Citation 4.18(b)(2) (Continued)

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women. women.

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

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

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

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

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

42 CFR 438.108
42 CFR 447.60

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

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

1916 of the Act, P.L. 99-272, (Section 9505)

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

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: FLORIDA

Citation 4.18(b) (Continued)

42 CFR 447.51 through 447.48

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

/_/ Not applicable. No such charges are imposed.

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

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

/_/ 18 or older

/_/ 19 or older

/_/ 20 or older

/X/ 21 or older

/_/ Charges apply to services furnished to the following reasonable categories or individuals listed below who are 18 years of age or older but under age 21.

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: FLORIDA

Citation
42 CFR 447.51
through 447.58

4.18(b)(3) (Continued)

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

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

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

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

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

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

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

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

/X/ Not applicable. There is no maximum.

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: FLORIDA

Citation			
1916(c) of the Act	4.18(b)(4)	/_/	A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902(a)(52) and 1925(b) of the Act	4.18(b)(5)	/_/	For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
1916(d) of the Act	4.18(b)(6)	/_/	A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: FLORIDA

Citation

42 CFR 447.51 through 447.58

4.18(c) /X/ Individuals are covered as medically needy under the plan.

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

447.51 through 447.58

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

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

/ / Age 19

/ / Age 20

/X/ Age 21

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

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: FLORIDA

Citation

4.18 (c)(2) (Continued)

42 CFR 447.51 through 447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

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

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

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

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

1916 of the Act, P.L. 99-272 (Section 9505)

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

447.51 through 447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

/X/ Not applicable. No such charges are imposed.

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: FLORIDA

Citation 4.18(c)(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

/ / Not applicable. No such charges are imposed.

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

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

/ / 18 or older

/ / 19 or older

/ / 20 or older

/X/ 21 or older

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

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: FLORIDA

Citation 4.18(c)(3) (Continued)

447.51 through

447.58

(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

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

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

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

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

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

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

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

/X/ Not applicable. There is no maximum.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: FLORIDA

Citation 4.19 Payment for Services

42 CFR 447.252
1902(a)(13)
and 1923 of
the Act

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

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

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

/X/ Inappropriate level of care days are not covered.

Revision: HCFA-PM-93- 6 (MB) OMB No.: 0938-
August 1993

State/Territory: FLORIDA

Citation		
42 CFR 447.201 42 CFR 447.302 52 FR 28648 1902(a)(13)(E) 1903(a)(1) and (n), 1920, and 1926 of the Act	4.19(b)	In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements: (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys). (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan. ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.
1902(a)(10) and 1902(a)(30) of the Act		SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Florida

Citation		
42 CFR 447.40 AT-78-90	4.19(c)	Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

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

☐ No.

Revision: HCFA - Region VI
November 1990

State/Territory: FLORIDA

Citation
42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141
Section 1902(a)(13)(A) of Act (Section 4211 (h)(2)(A) of P.L. 100-203).

4.19 (d)

(1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for nursing facility services and intermediate care facility services for the mentally retarded.

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

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

[X] At the average rate per patient day paid to NFs for routine services furnished during the previous calendar year.

[ ] At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

[ ] Not applicable. The agency does not provide payment for NF services to a swing-bed hospital.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Florida

Citation		
42 CFR 447.45 (c) AT-79-50	4.19 (e)	The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims. ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-019
MARCH 1987

State/Territory: FLORIDA

Citation		
42 CFR 447.15 AT-78-90 AT-80-34 48 FR 5730	4.19 (f)	The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Florida

Citation		
42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19(g)	The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State Florida

Citation		
42 CFR 447.201 42 CFR 447.203 AT-78-90	4.19(h)	The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Florida

Citation		
42 CFR 447.201 42 CFR 447.204 AT-78-90	4.19(i)	The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State: FLORIDA

Citation

42 CFR 447.201 and 447.205	4.19(j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act	(k)	The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: FLORIDA

Citation		
1903(i)(14) of the Act	4.19(1)	The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physican to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

Revision: HCFA-PM-1994 (MB)

State/Territory: FLORIDA

Citation		
	4.19(m)	Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program
1928(c)(2)(C)(ii) of the Act	(i)	A provider may impose a fee for the administration of a qualified pediatric vaccine as stated in 1928(c)(20)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows:
	(ii)	The State:
		_____ sets a payment rate at the level of the regional maximum established by the Secretary.
		__X__ sets a payment rate below the level of the regional maximum established by the Secretary. (If this is checked, fill in information below)
		The State pays the following rate for the administration of a vaccine:
		$10.00 for physicians $8.00 for physician's assistants and advanced registered nurse practitioners $5.00 for CPHUs and FQHCs
1926 of of the Act	(iii)	Medicaid beneficiary access to immunizations is assured through the following methodology:
		As of 10/1/94, Medicaid no longer reimburses for the vaccine - only for the administration of the vaccine. Therefore, physicians and other practitioners may be reimbursed only if they participate in the Vaccine for Children program. The recruitment and participation of providers are conducted by the Florida Immunization Program of the State Health Office.
		Other:

TN No. 95-02
Supersedes
TN No. 94-18

Approval Date 6-14-95

Effective Date 4/1/95

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Florida

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

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

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

☐ Yes, for ☐ physicians' services

☐ dentists' services

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

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

Revision: HCFA-AT-81-34 (BPP) 10-81

State Florida

Citation	4.21 Prohibition Against Reassignment of Provider Claims
42 CFR 447.10(c) AT-78-90 46 FR 42699	Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

TN # 81-17
Supersedes
TN #

Approval Date 1/18/82 Effective Date 7/1/81

Revision: HCFA-PM-90- 2 (BPD) JANUARY 1990 OMB No.: 0938-0193

State/Territory: FLORIDA

Citation

433.137(a)
50 FR 46652
55 FR 1423

4.22 Third Party Liability

(a) The Medicaid agency meets all requirements of 42 CFR 433.138 and 433.139.

433.137(b)
52 FR 1423

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

433.138(f)
52 FR 5967

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

433.138(g)(1)(ii) and (2)(ii)
52 FR 5967

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

433.138(g)(3)(i) and (iii)
52 FR 5967

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

433.138(g)(4)(i) through (iii)
52 FR 5967

(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

Revision: HCFA-PM-90-2 (BPD) OMB No.: 0938-0193
JANUARY 1990

State/Territory: FLORIDA

Citation		
433.139(b)(3)(ii)(A) 55 FR 1423	/ /	(c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
433.139(b)(3)(ii)(A) 55 FR 1423		Providers may bill the agency when services covered under a plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency. Claims are paid and billed to the appropriate insurance carrier for reimbursement by the third party.
		(d) ATTACHMENT 4.22-B specifies the following:
433.139(b)(3)(ii)(C) 55 FR 1423		(1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).
433.139(f)(2) 50 FR 46652		(2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
433.139(f)(3) 50 FR 46652		(3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
42 CFR 447.20 55 FR 1423		(e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

OMB NO: 0938-0193

Revision: HCFA-PM-86-3 (BERC)
March 1986

State/Territory: Florida

Citation	4.22 (continued)	
42 CFR 433.151(a) 50 FR 46652	(f)	The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with at least one of the following: (Check as appropriate.) X State title IV-D agency. The requirements of 42 CFR 433.152(b) are met. See attached Page 70a. __ Other appropriate State agency(s)— _____ _____ __ Other appropriate agency(s) of another State— _____ _____ __ Courts and law enforcement officials.
42 CFR 433.151(b) 50 FR 46652	(g)	The Medicaid agency meets the requirements of 42 CFR and 433.153 and 433.154 for making incentive payments and for distributing third party collections.
1906 of the Act	(h)	The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following. _____ The Secretary's method as provided in the State Medicaid Manual, Section 3910. XX ____ The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

Memorandum of Understanding Between the Offices of
Child Support Enforcement
Financial Management
Economic Services
Children, Youth and Families
Deputy Assistant Secretary for Medicaid
Pursuant to Section 1912 of the Social Security Act

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

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

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

Amendment 87-19
Effective 4/1/87
Supersedes 86-16

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

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

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

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

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

8. That the Office of Child Support Enforcement will maintain an accounting system and supporting fiscal records adequate to assure that claims for payment of the application fee from the Office of the Deputy Assistant Secretary for Medicaid are in accordance with applicable federal requirements in 45 CFR Part 74.

9. That the Offices of Economic Services and Deputy Assistant Secretary for Medicaid shall coordinate the above efforts and reflect compliance with Section 1912 in the Medicaid State Plan or any other relevant document.

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

Signature 10/9/86 Date
Office of Child Support Enforcement

Signature 10/20/86 Date
Office of Financial Management

Signature 9/5/86 Date
Economic Services Program Office

Signature 9/22/86 Date
Children, Youth and Families Program Office

Signature 9/5/86 Date
Deputy Assistant Secretary for Medicaid

Revision: HCFA-AT-84-2 (BERC)
01-84

State/Territory: Florida

Citation	4.23	Use of Contracts
42 CFR 434.4 48 FR 54013		The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.
		/_/ Not applicable. The State has no such contracts.
42 CFR Part 438		The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Consistent with 45 CFR Part 74, risk contracts are procured through an open, competitive procurement process, or through an open application process to allow contracting with all qualified providers. The risk contract is with (check all that apply):
		_X_ a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2
		_X_ a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2
		_X_ a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.
		___ Not applicable.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Florida

Citation	4.24 Standards for Payments for Skilled Nursing and Intermediate Care Facility Services.
42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34	With respect to skilled nursing and intermediate care facilities, all applicable requirements of 42 CFR Part 442, Subparts B and C are met. ☐ Not applicable to intermediate care facilities; such services are not provided under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Florida

Citation		
42 CFR 431.702 AT-78-90	4.25	Program for Licensing Administrators of Nursing Homes The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

TN # 74-1
Supersedes
TN #

Approval Date 9/12/74 Effective Date NA

State/Territory FLORIDA

Citation: 4.26 Drug Utilization Review Program

1927(g)
42 CFR 456.700

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

1927(g)(1)(a)

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

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

1927(g)(1)(a)
42 CFR 456.705(b) and 456.709(b)

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

- Potential and actual adverse drug reactions
- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug-Drug Interactions
- *Drug-allergy interactions
- Clinical abuse/misuse

1927(g)(1)(B)
42 CFR 456.703 (d) and (f)

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

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

* Our DUR program will not target individual drug allergies, as that information cannot be maintained in the recipient information file. However, as part of the Pharmacy Practice Act requiring prescription/patient profiles, all pharmacists will be expected to capture drug allergy information before filling any prescriptions.

State/Territory FLORIDA

Citation:

1927(g)(1)(D)
42 CFR 456.703(b)

D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in:

X Prospective DUR
X Retrospective DUR

1927(g)(2)(A)
42 CFR 456.705(b)

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

1927(g)(2)(A)(i)
42 CFR 456.705(b),
(1)-(7))

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

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

1927(g)(2)(A)(ii)
42 CFR 456.705
(c) and(d)

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

1927(g)(2)(B)
42 CFR 456.709(a)

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

- Patterns of fraud and abuse
- Gross overuse
- Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

State/Territory FLORIDA

Citation:

1927(g)(2)(C)
42 CFR 456.709(b)

F.2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

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

1927(g)(2)(D)
42 CFR 456.711

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

1927(g)(3)(A)
42 CFR 456.716(a)

G.I. The DUR program has established a State DUR Board either:

X Directly, or
_ Under contract with a private organization

1927(g)(3)(B)
42 CFR 456.716
(A) and (B)

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

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

1927(g)(3)(C)
42 CFR 456.716(d)

3. The activities of the DUR Board include:

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

State/Territory: FLORIDA

Citation:

1927(g)(3)(C)
42 CFR 456.711
(a)-(d)

G.4. The interventions include in appropriate instances:

- Information Dissemination
- Written, oral, and electronic reminders
- Face-to-face discussion
- Intensified monitoring/review of prescriber/dispensers

1927(g)(3)(D)
42 CFR 456.711~~1~~2
(A)-(B)

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

1927(h)(1)
42 CFR 456.722

X I.1. The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line:

- real time eligibility verification
- claim data capture
- adjudication of claims
- assistance to pharmacists, etc. applying for and receiving payment.

1927(g)(2)(A)(i)
42 CFR 456.705(b)

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

1927(j)(2)
42 CFR 456.703(c)

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

State/Territory: FLORIDA

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act Provisions

Citation:

1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)

K. The State shall perform the following reviews and actions for opioid claim limitations:

1. Prospective Point of Sale (POS) safety edits for opioid duplicate and early fills and exceeding State defined quantity and dosage limits. A prior authorization shall be required for an override.
2. Prospective POS safety edit for exceeding State defined Morphine Milligram Equivalents (MME) limits. An override by the pharmacist or a prior authorization by the physician may be required.
3. Retrospective reviews on opioid prescriptions exceeding the above limits on an ongoing periodic basis.
4. Prospective POS safety edits for members receiving concurrent opioids and benzodiazepines and for those receiving concurrent opioids and antipsychotics. An override by the pharmacist or a prior authorization by the physician may be required.
5. Retrospective reviews of concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis.

L. The State shall manage and monitor antipsychotic medications used by children in the following manner:

1. Prospective POS safety edits for children younger than the State specified age receiving antipsychotics. A prior authorization shall be required for an override.
2. Prospective POS safety edits for children less than 18 years of age receiving high dosages of antipsychotics. A prior authorization shall be required for an override.
3. Retrospective reviews shall be performed to evaluate the appropriateness of prescribing for children of all ages receiving antipsychotics, including children in foster care based on indications and clinical guidelines. Education shall be provided to practitioners prescribing these medications as deemed appropriate.

M. The State shall identify and respond to potential fraud and abuse using the following methods:

1. Potential fraud and/or abuse shall be identified via automatic claims review and referrals. Potential cases shall be reviewed by the State for possible referral to Medicaid Program Integrity, law enforcement, or the Medicaid fraud control unit.
2. Retrospective reviews shall be performed on opioid claims and discussed with the State DUR Board on an ongoing periodic basis. Education shall be provided to practitioners prescribing these medications.

Revisions: HCFA-AT-80-38 (BPP)
May 22, 1980

State Florida

Citation		
42 CFR 431.115(c) AT-78-90 AT-79-74	4.27	Disclosure of Survey Information and Provider or Contractor Evaluation The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: FLORIDA

Citation	4.28 Appeals Process
42 CFR 431.152; AT-79-18 52 FR 22444; Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)).	(a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154. (b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

New: HCFA-PM-99-3
JUNE 1999

State: Florida

Citation

1902(a)(4)(C) of the Social Security Act P.L. 105-33	4.29 Conflict of Interest Provisions The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the Prohibition against acts, with respect to any activity Under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.
1902(a)(4)(D) of the Social Security Act P.L. 105-33 1932(d)(3) 42 CFR 438.58	The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: FLORIDA

Citation
42 CFR 1002.203
AT-79-54
48 FR 3742
51 FR 34772

4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

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

/X/ The agency, under the authority of State law, imposes broader sanctions.

Excluded Entities/Prohibited Affiliations

Revision: HCFA-AT-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: Florida

Citation		
	(b)	The Medicaid agency meets the requirements of –
1902(p) of the Act		(1) Section 1902(p) of the Act by excluding from participation—
		(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).
42 CFR 438.808		(B) An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that –
		(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
		(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.
1932(d)(1) 42 CFR 438.610		(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438,610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIPH, or PAHP is not in compliance the State will comply with the requirements of 42 CFR 438.610(c)

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193
4.30 Continued

State/Territory: FLORIDA

Citation	
1902(a)(39) of the Act P.L. 100-93 (sec. 8(5))	(2) Section 1902(a)(39) of the Act by-- (A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and (B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.
	(c) The Medicaid agency meets the requirements of--
1902(a)(41) of the Act P.L. 96-272, (sec. 308(c))	(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and
1902(a)(49) of the Act P.L. 100-93 (sec. 5(a)(4))	(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: FLORIDA

Citation

455.103
44 FR 41644
1902(a)(38)
of the Act
P.L. 100-93
(sec. 8(f))

4.31 Disclosure of Information by Providers and Fiscal Agents

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

435.940
through 435.960
52 FR 5967

54 FR 8738

4.32 Income and Eligibility Verification System

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

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

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: FLORIDA

Citation
1902(a)(48) of the Act, P.L. 99-570 (Section 11005) P.L 100-93 (sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

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

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

TN No. 88-4
Supersedes
TN No. 87-21

Approval Date 4/5/88 Effective Date 1/1/88

HCFA ID: 1010P/0012P

☆ U.S. GOVERNMENT PRINTING OFFICE. 1987— 201-818/60437

State: FLORIDA

Citation	Groups Covered
1137 of the Act	4.34 Systematic Alien Verification for Entitlements
P.L.99-603 (sec.121)	The State Medicaid Agency has established procedures for the verification of alien status through the Immigration and Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1998.

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

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

_____ Total waiver

_____ Alternative system

_____ Partial implementation

Revision: HCFA PM-90-2 (BPD)
JANUARY 1990

OMB No.: 0938-0191

State/Territory: Florida

Citation

4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation

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

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

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

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

(1) Denial of payment for new admissions.

(2) Civil money penalty.

(3) Appointment of temporary management.

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

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

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

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

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

/X/ (1) Public recognition.

/X/ (2) Incentive payments.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: FLORIDA

Citation

4.35 Enforcement of Compliance for Nursing Facilities

42 CFR §488.402(f)

(a) Notification of Enforcement Remedies

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

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

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

42 CFR §488.434

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

42 CFR §488.402(f)(2)

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

42 CFR §488.456(c)(d)

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

(b) Factors to be Considered in Selecting Remedies

42 CFR §488.488.404(b)(1)

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

___ The State considers additional factors. Attachment 4.35-A describes the State's other factors.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: FLORIDA

Citation

c) Application of Remedies

42 CFR §488.410

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

42 CFR §488.417(b) §1919(h)(2)(C) of the Act.

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

42 CFR §488.414 §1919(h)(2)(D) of the Act.

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

42 CFR §488.408 1919(h)(2)(A) of the Act.

(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.

42 CFR §488.412(a)

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

(d) Available Remedies

42 CFR §488.406(b) §1919(h)(2)(A) of the Act.

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

- X (1) Termination
- ___ (2) Temporary Management
- ___ (3) Denial of Payment for New Admissions
- X (4) Civil Money Penalties
- X (5) Transfer of Residents; Transfer of Residents with Closure of Facility
- X (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: FLORIDA

Citation

42 CFR
§488.406(b)
§1919(h)(2)(B)(ii)
of the Act.

(ii) X The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

___ (1) Temporary Management
X (2) Denial of Payment for New Admissions
___ (3) Civil Money Penalties
___ (4) Transfer of Residents; Transfer of Residents with Closure of Facility
___ (5) State Monitoring.

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

42 CFR
§488.303(b)
1910(h)(2)(F)
of the Act.

(e) X State Incentive Programs

X (1) Public Recognition
X (2) Incentive Payments

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: FLORIDA

Citation	4.36	Required Coordination Between the Medicaid and WIC Programs
1902(a)(11)(C) and 1902(a)(53) of the Act		The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

Revision: HCFA-PM-91- 10 (BPD)
DECEMBER 1991

State/Territory: FLORIDA

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	4.38		Nurse Aide Training and Competency Evaluation for Nursing Facilities
		(a)	The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.
	X	(b)	The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).
	X	(c)	The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.
		(d)	The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.
	X	(e)	The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.
	X	(f)	The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

State/Territory: FLORIDA

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

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

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

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

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

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

(l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

State/Territory: FLORIDA

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(m)	The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
		(n)	The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
		(o)	The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
		(p)	The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).
	X	(q)	The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.
		(r)	The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

State/Territory: FLORIDA

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(s)	When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.
		(t)	The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
		(u)	The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
		(v)	The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
		(w)	Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.
	X	(x)	The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).
		(y)	The State has a standard for successful completion of competency evaluation programs.

State/Territory: FLORIDA

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(z)	The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
	X	(aa)	The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
		(bb)	The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
	___	(cc)	The State includes home health aides on the registry.
	___	(dd)	The State contracts the operation of the registry to a non State entity.
	X	(ee)	ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
	___	(ff)	ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: FLORIDA

Citation
Secs.
1902(a)(28)(D)(i)
and 1919(e)(7) of
the Act;
P.L. 100-203
(Sec. 4211(c));
P.L. 101-508
(Sec. 4801(b)).

4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities

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

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

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

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

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

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: FLORIDA

4.39 (Continued)

____ (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

Revision: HCFA-PM-92-3 (HSQB)
APRIL 1992

OMB No.:

State/Territory: FLORIDA

Citation		4.40 Survey & Certification Process
Sections 1919(g)(1) thru (2) and 1919(g)(4) thru (5) of the Act P.L. 100-203 (Sec. 4212(a))	(a)	The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.
1919(g)(1) (B) of the Act	(b)	The State conducts periodic education programs for staff and residents (and their representatives). **Attachment 4.40-A** describes the survey and certification educational program.
1919(g)(1) (C) of the Act	(c)	The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. **Attachment 4.40-B** describes the State's process.
1919(g)(1) (C) of the Act	(d)	The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency? _____
1919(g)(1) (C) of the Act	(e)	The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.
1919(g)(1) (C) of the Act	(f)	The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

State/Territory: FLORIDA

1919(g)(2)(A)(i) of the Act	(g)	The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. Attachment 4.40-C describes the State's procedures.
1919(g)(2)(A)(ii) of the Act	(h)	The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
1919(g)(2)(A)(iii)(I) of the Act	(i)	The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
1919(g)(2)(A)(iii)(II) of the Act	(j)	The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
1919(g)(2)(B) of the Act	(k)	The State conducts extended surveys immediately or, if not practicable, not later that 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
1919(g)(2)(C) of the Act	(l)	The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

Revision: HCFA-PM-92-3 (HSQB) OMB No:
APRIL 1992

State/Territory: FLORIDA

1919(g)(2)(D) of the Act	(m)	The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. Attachment 4.40-D describes the State's programs.
1919(g)(2)(E)(i) of the Act	(n)	The State uses a multidisciplinary team of professionals including a registered professional nurse.
1919(g)(2)(E)(ii) of the Act	(o)	The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
1919(g)(2)(E)(iii) of the Act	(p)	The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
1919(g)(4) of the Act	(q)	The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. Attachment 4.40-E describes the State's complaint procedures.
1919(g)(5)(A) of the Act	(r)	The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
1919(g)(5)(B) of the Act	(s)	The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
1919(g)(5)(C) of the Act	(t)	If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
1919(g)(5)(D) of the Act	(u)	The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

Revision: HCFA-PM-92- 2 (HSQB)
MARCH 1992

State/Territory: FLORIDA

Citation	4.41 Resident Assessment for Nursing Facilities	
Sections 1919(b)(3) and 1919 (e)(5) of the Act	(a)	The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.
1919(e)(5) (A) of the Act	(b)	The State is using:
	____	the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or
1919(e)(5) (B) of the Act	X	a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

Citation 1902(a)(68) of the Act, P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries.

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

(1) Definitions.

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

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

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

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

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

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

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

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

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

State/Territory: Florida

Citation	
1902(a)(69)of the Act, P.L. 109-171(section 6034)	4.43 Cooperation with Medicaid Integrity Program Efforts. The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

DRAFT – Medicaid State Plan Preprint – DRAFT

State/ Territory: Florida

PROPOSED SECTION 4 – GENERAL PROGRAM ADMINISTRATION

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

Citation

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

__X__ The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

National Governors Association
ENCLOSURE A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Florida

4.46 Provider Screening and Enrollment

Citation	
1902(a)(77) 1902(a)(39) 1902(kk); 111-148 and 111-152 42 CFR 455 Subpart E	The State Medicaid agency gives the following assurances: PROVIDER SCREENING __X__ Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS __X__ Assures enrolled providers will be screened in accordance with 42 CFR 455.400, et seq. __X__ Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider. 4/1/12 - In 2011, Florida adopted legislation to expand its Medicaid managed care delivery system statewide. CMS is currently reviewing waivers and renewal requests submitted to facilitate this expansion. If Florida is granted approval by CMS, approximately 85% of the Florida Medicaid population will be enrolled in risk based managed care. Note that Medicaid providers who serve Medicaid recipients via managed care organizations are registered as Medicaid providers.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES __X__ Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT __X__ Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT __X__ Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.
42 CFR 455.420	REACTIVATION OF PROVIDER ENROLLMENT __X__ Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460. 4/1/12 – Florida Medicaid does not does not allow providers who were previously terminated to re-enroll in the program unless terminated voluntarily. Additionally, per **1866(j)(2)(C)(ii) of the Act,** Florida Medicaid has been granted a hardship waiver by CMS for collection of application fees from ICF/DD and SIPP providers (the only provider types in Florida that could not be Medicare providers).

SPA TN: 2012-008
Effective Date: April 1, 2012
Supersedes: NEW
Approval Date: 06-27-12

42 CFR 455.422 APPEAL RIGHTS

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

SITE VISITS

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

CRIMINAL BACKGROUND CHECKS

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

FEDERAL DATABASE CHECKS

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

NATIONAL PROVIDER IDENTIFIER

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

SCREENING LEVELS FOR MEDICAID PROVIDERS

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

APPLICATION FEE

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

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

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW

42 CFR 455.470 PROVIDERS OR SUPPLIERS

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

Medicaid Administration

State Name: Florida

OMB Control Number: 0938-1148

Transmittal Number: 17 - 00 - 0001

State Plan Administration
Designation and Authority

A1

42 CFR 431.10

Designation and Authority

State Name: Florida

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency: Agency for Health Care Administration

Type of Agency:

- ○ Title IV-A Agency
- ○ Health
- ○ Human Resources
- ◉ Other

Type of Agency: State Medicaid Agency

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

Section 409.902(1), Florida Statutes

The single state agency supervises the administration of the state plan by local political subdivisions.

○ Yes ◉ No

☑ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

An attachment is submitted.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

○ Yes ◉ No

Medicaid Administration

☒ Waivers of the single state agency requirement have been granted under authority of the Intergovernmental Cooperation Act of 1968.

The waivers are still in effect.

◉ Yes ○ No

Enter the following information for each waiver:

Remove

Date waiver granted (MM/DD/YY): 01/24/17

The type of responsibility delegated is (check all that apply):

☒ Determining eligibility

☒ Conducting fair hearings

☐ Other

Name of state agency to which responsibility is delegated:

Department of Children and Families (DCF) (IV-A Agency)

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

On or after March 1, 2017, DCF's Office of Appeal Hearings, a subcomponent of the DCF Office of the Inspector General, will retain delegated responsibility for, and will continue to administer and conduct, the following Medicaid fair hearings:

(1) All fair hearings arising from Florida Medicaid financial eligibility determinations made by DCF.
(2) All fair hearings arising from eligibility determinations and service denials, reductions, terminations or suspensions pertaining to the iBudget Waiver administered by the Florida Agency for Persons with Disabilities.
(3) All fair hearings arising from the Pre-Admission Screening and Resident Review, as mandated by the Section 1917(e)(7) of the Social Security Act and Title 42, Code of Federal Regulations (CFR), Sections 483.100 through 483.138, Subpart C.
(4) All fair hearings resulting from resident transfers or discharges as those terms are defined in Section 400.0255, Florida Statutes.

The DCF is the state's Title IV-A agency. The DCF implements policy for determining Florida Medicaid eligibility for all MAGI and non-MAGI eligibility categories other than those determined by the Social Security Administration. The Economic Self-Sufficiency Program/ACCESS Florida program division within the DCF is responsible for determining eligibility for all Florida Medicaid populations (MAGI and non-MAGI groups) other than those determined by the Social Security Administration.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

The AHCA retains oversight of the Florida Medicaid State Plan and waiver authorities, and monitors the appeals process, including the quality and accuracy of the final decisions made by the DCF Office of Appeal Hearings. Once implemented on March 1, 2017, AHCA will monitor the quality and accuracy of fair hearings officers' final decisions.

The AHCA will ensure that every applicant and recipient is informed, in writing, of the fair hearing process, how to contact the AHCA or DCF, and how to obtain information about fair hearings.

The AHCA ensures compliance with all federal and state laws, regulations and policies.

The AHCA and DCF have a cooperative interagency agreement. The AHCA and DCF communicate regularly to ensure compliance with all state and federal regulations pertaining to eligibility determinations for Florida Medicaid services.

Add

☐ The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

☐ The Medicaid agency

☒ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

☐ The Medicaid agency

☒ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☒ The Federal agency administering the SSI program

Indicate which agency determines eligibility for any groups whose eligibility is not determined by the Federal agency:

☐ Medicaid agency

☒ Title IV-A agency

☐ An Exchange

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

☒ Medicaid agency

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☐ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

○ Yes ◉ No

State Plan Administration
Organization and Administration **A2**

42 CFR 431.10
42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

AGENCY FOR HEALTH CARE ADMINISTRATION
STATEMENT OF AGENCY ORGANIZATION AND OPERATION
GENERAL DESCRIPTION
The Agency for Health Care Administration (AHCA) is the chief health policy and planning entity for the state. The AHCA is responsible for health facilities licensure, inspection, and regulatory enforcement; investigation of consumer complaints related to health care facilities and managed care plans; the Certificate of Need program; operating the Florida Center for Health Information and Policy Analysis; administering the Florida Medicaid program; administering the Title XXI program; certifying health maintenance organizations and prepaid health clinics; and other duties prescribed by statute or agreement.

The head of AHCA is the Secretary, who is appointed by the Governor, subject to confirmation by the Senate.

ORGANIZATIONAL STRUCTURE
The AHCA is divided into various Divisions and Offices as follows:

Division of Health Quality Assurance
The Division of Health Quality Assurance is responsible for:
• State licensure, federal certification, criminal background checks for owners, operators and certain health care provider staff.
• Routine and complaint inspections, plans and construction reviews for certain facilities.
• Providing consumer and public information regarding health care facilities, including licensure and inspection information to the public, and public records requests.
• Financial reviews and analysis for licensure and regulatory assessments, commercial managed care regulation, including: network verification licensure, complaint investigations, and subscriber grievance review.

Division of Operations
The Division of Operations is the AHCA's business support unit.
It is responsible for:
• Financial, personnel, and support related functions.
• Third party liability activities including: casualty recovery, estate recovery, and Medicare and other third party payer recoveries.

Chief of Staff
The Chief of Staff's office is responsible for:
• Coordinating Florida Medicaid and health care regulation policy with other state agencies, the Florida Legislature, and the federal government.
• Overseeing communications, legislative affairs, and information technology.
• Serving as the liaison to the Florida Washington Office.

General Counsel
The General Counsel functions as the chief legal advisor to the Secretary in his/her official capacity, including:
• Providing counsel to the AHCA staff regarding legal issues that arise in the day-to-day operation of the AHCA;
• Representing the AHCA in lawsuits in which the AHCA or its employees are named in their official capacity;
• Functioning as the Chief Ethics Officer for the Agency;
• Serving as the AHCA's liaison to the general counsels of other state agencies and the Governor's Office of General Counsel;
• Providing oversight and supervision of the AHCA's Fair Hearings Office. The AHCA Fair Hearings Office is within the General Counsel's Office.

Pursuant to Section 409.285(2), Florida Statutes, Medicaid fair hearings related to Florida Medicaid service denials, reductions, terminations or suspensions for services rendered through the Florida Medicaid State Plan, or the waiver programs directly administered by the Agency for Health Care Administration (AHCA), filed on or after March 1, 2017, will be conducted by the AHCA Office of Fair Hearings.

The AHCA retains oversight for the Florida Medicaid State Plan and waiver authorities, and the development and issuance of policies, rules and regulations on program matters, including oversight of rules and processes associated with the conduct of Medicaid fair hearings by DCF Office of Appeal Hearings.

Inspector General
The Inspector General ensures that the AHCA's programs and services comply with all applicable laws, policies and procedures. This office includes the Bureau of Medicaid Program Integrity, which is responsible for ensuring that Medicaid provider fraud and abuse is mitigated, and for recovering over-payments and imposing sanctions.
The Inspector General's office is also responsible for:
• Investigations to detect and prevent fraud, waste, misconduct, mismanagement and other abuses within the AHCA.
• Conducting reviews, audits, management consulting engagements and control self-assessments.
• Assisting Florida Medicaid recipients in exercising their rights under the Health Insurance Portability and Accountability Act (HIPAA).

Division of Medicaid
The Division of Medicaid directs all Florida Medicaid program planning and development activities. It plans, develops, organizes and monitors program planning, service and reimbursement policies. The Division of Medicaid includes the following three offices' sub-divisions: Medicaid Policy and Quality, Medicaid Finance and Analytics, and Medicaid Operations.
The Medicaid Division:
• Develops and maintains the Florida Medicaid State Plan.
• Develops and maintains federal and state authority for the Florida Medicaid program waivers, managed care, and provider contracts, inter-agency agreements and state rules.
• Oversees Medicaid provider and consumer relations.
• Establishes and enforces quality standards.
• Provides data analysis, rate setting for health plans, prepares the Florida Medicaid annual budget, calculates cost effectiveness and budget neutrality.
• Administers the Florida Medicaid fiscal agent contract, coordinates eligibility information transfers, the enrollment broker contract and activities including assisting recipients and providers with the health plan enrollment process, assisting Florida Medicaid providers in claims resolution.
• Monitoring all activities of the Florida Medicaid fiscal agent for compliance with the contract agreement and all federal mandates, state rules, and regulations.

Upload an organizational chart of the Medicaid agency.

An attachment is submitted.

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

The AHCA is the state Medicaid agency. All health, human service and public assistance agencies, including the AHCA, are under the purview of the Governor. The Governor appoints, and the Senate confirms, the head of each of these agencies.

The following outlines the AHCA's involvement with the state's health, human service, and public assistance agencies, and other state organizational entities:

The Agency for Persons with Disabilities operates the Florida Medicaid i-Budget home and community-based services waiver, and is responsible for level of care determinations and utilization reviews for individuals with intellectual disabilities in intermediate care facilities.

The Department of Children and Families (DCF) is the state's Title IV-A agency. The DCF implements policy for determining Medicaid eligibility for all MAGI and non-MAGI eligibility categories other than those determined by the Social Security Administration. The DCF is the single state authority on substance abuse and mental health, and is the state's child welfare agency.

The Department of Elder Affairs (DOEA) conducts level of care assessments for the Institutional Care Program and the majority of the Florida Medicaid 1915(c) home and community-based services waiver programs. It is the operating agency for the Program of All-inclusive Care for the Elderly. The DOEA conducts monitoring functions for the Statewide Medicaid Managed Care Long-term Care program.

The Department of Health (DOH) provides medical care to children with chronic, disabling conditions, or potentially disabling conditions through the Children's Medical Services plan; assists with planning and implementing preventive health care programs and primary care programs. The DOH operates two Medicaid home and community-based services waiver programs, and it licenses healthcare practitioners.

The Department of Legal Affairs, lead by the Attorney General, investigates and prosecutes Florida Medicaid provider and recipient fraud.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Remove

Type of entity that determines eligibility:

- (•) Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ( ) An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ( ) The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

The DCF is the state's Title IV-A agency. The following describes the DCF Florida Medicaid eligibility program division and staff responsibilities:

The Economic Self-Sufficiency Program/ACCESS Florida program division within DCF (as described in A1, page 2)

Economic Self-Sufficiency Specialist:
Processes applications and re-determinations for the purpose of determining eligibility for Florida Medicaid. This process includes collecting and updating required eligibility information on applicants, recipients, and their household members, for the purpose of establishing eligibility for the Economic Self-Sufficiency Public Assistance program.

Interview Clerk:
Primarily reviews applications for the basic demographic information on applications and reconciles any discrepancies on all household members through the FLORIDA computer system. This may require assisting the applicant in the completion of the Florida Medicaid application.

Remove

Type of entity that determines eligibility:

- ( ) Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ( ) An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

(•) The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Pursuant to a 1634 agreement, the Social Security Administration determines Medicaid eligibility for Supplemental Security Income recipients.

Add

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Remove

Type of entity that conducts fair hearings:

( ) An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

( ) An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

( ) Yes (•) No

The types of the local subdivisions that administer the state plan under the supervision of the Medicaid agency are:

( ) Counties

( ) Parishes

( ) Other

Are all of the local subdivisions indicated above used to administer the state plan?

( ) Yes ( ) No

State Plan Administration Assurances — A3

42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

[✓] The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.

[✓] All requirements of 42 CFR 431.10 are met.

☑ There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.

☑ The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

☑ There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

☐ There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).

☐ When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

☑ The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

PRA Disclosure Statement

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