# Overview of the Florida Medicaid Assistive Care Services Program

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# How Do I Ask Questions ?

- While we will answer as many questions as possible ***after*** the presentation, responses to all questions will be posted at**:**

  http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/index.shtml.

# Training Objectives

- Provide an overview of Florida Medicaid Assistive Care Services (ACS) policies
- Participants will gain an understanding of the distinction between ACS and the Assisted Living for the Elderly waiver
- Together we can better assist providers to avoid duplication of services

# Assistive Care Services Description

Eligible recipients must reside in ACS enrolled:

- Qualified assisted living facility (ALF)
- Adult family care home (AFCH), or
- Residential treatment facility (RTF)

Services should include scheduled and unscheduled care by the facility on a 24-hour per day basis when needed by the recipient.

# Assistive Care Services Description

The Medicaid Assistive Care Services State Plan Program provides care to:

- **Eligible** Medicaid recipients
- Individuals who require an **integrated** set of services
- Individuals who require services on a **24-hour per day** basis

# Medicaid State Plan

- *The Title XIX (Medicaid) programs are state administered programs funded by both the federal government and state governments*
- *All states administer their programs under federally approved state plans*
- *Federal Medicaid laws mandate certain benefits for certain populations*
- *Services must be available statewide in the same amount, duration, and scope*

# Purpose of Assistive Care Services

- The purpose of the Medicaid Assistive Care Service Program is to promote and maintain the health of eligible recipients;
- Minimize the effects of illness and disabilities in order to **delay** or **prevent** institutionalization; and
- Allow the individual to continue to reside in the community.

# Who Can Receive Assistive Care Services?

In addition to being Medicaid eligible, individuals receiving ACS must meet all of the following criteria:

- Be 18 years old or older;
- Have a health assessment, arranged by the facility, that indicates the **medical necessity** of Assistive Care Services; and
- The health assessment must be completed by a **physician** or Physician Assistant, Advanced Registered Nurse Practitioner or Registered Nurse acting within the scope of practice under state law.

# Who Can Receive Assistive Care Services?

The recipient must be determined to need at least:

- Two out of the four service components provided under the ACS program based on the health assessment; and
- Reside in a Medicaid-enrolled ALF, RTF, or AFCH.

# Who Cannot Receive Assistive Care Services ?

Medicaid recipients residing in institutions such as:

- Nursing facilities
- State mental hospitals
- Institutions of mental disease
- Intermediate care facilities for the developmentally disabled

# Functional & Health Criteria

ACS eligible Medicaid recipients must have, at a minimum, the following functional capabilities:

- Be ambulatory with or without assistance;
- Do not exhibit chronic inappropriate behavior that disrupts the facility's operations or is harmful to self or others;
- Capable of taking medication with assistance;
- Do not have any stage 3 or 4 pressure sores; and
- Do not require 24-hour nursing care.

# Covered Services

Assistive Care Services provides:

1. Health support;
2. Assistance with activities of daily living (ADLs);
3. Assistance with instrumental activities of daily living (IADLs); and
4. Assistance with self-administration of medication.

# Health Support Component

- Observing the recipient's whereabouts and well-being on a **daily basis;**
- Reminding the recipient of any important tasks; and
- Recording and reporting any significant changes in the recipient's appearance, behavior, or state of health to the recipient's health care provider, designated representative, or case manager.

# Assistance with ADLs Component

- Providing individual assistance with one or more of the following types of activities: ambulating, transferring, bathing, dressing, eating, grooming, and toileting.

- If the health assessment indicates a need for ADL assistance, the ACS provider must provide assistance with at least one ADL daily.

# *Assistance -Instrumental ADLs Component*

Providing individual assistance with one or more of the following types of activities:

- Shopping for personal items
- Making telephone calls, or
- Managing money

# *Assistance with Self-Administration of Medication Component*

Assistance with, or supervision of, self-administration of medication at least daily in accordance with licensure requirements applicable to the facility type.

# Start Date for ACS

Assistive Care Services for an eligible recipient may be provided and billed *from the first day of the need for services as long as the plan of care is being developed and is completed as required.*

# Initial Health Assessment for ACS

- If the recipient's need and eligibility for ACS began with the recipient's *admission* to the ALF, AFCH or RTF, the initial assessment requirement is the same as the initial assessment for the facility type.

- If the need and eligibility for ACS begins *after* admission to the ALF, AFCH or RTF, the assessment will follow the same procedure used for the re-assessment and must be completed prior to billing for ACS.

# Initial Health Assessment Requirement for ACS

| ALF | AFCH | RTF |
| --- | --- | --- |
| 58A-5.0181, Florida Administrative Code | 58A-14.0061, Florida Administrative Code | 65E-4.016(9), Florida Administrative Code |

# Initial Assessment Documentation

The following forms are mandatory as of July 20, 2010.

1. *Certification of Medical Necessity for Medicaid Assistive Care Services* (AHCA-Med Serv Form 035, July 2009), signed by a physician, physician assistant, ARNP, or registered nurse.
2. *Resident Service Plan for Assistive Care Services* (AHCA-Med Serv Form 036, July 2009).
3. *Resident Service Log* (AHCA-Med Serv Form 037, July 2009).

Documentation of completed, up-to-date forms must be available in the recipient's case file at the facility, available to surveyors and monitoring staff.

**CERTIFICATION OF MEDICAL NECESSITY**
**FOR MEDICAID ASSISTIVE CARE SERVICES**

## Form for Assisted Living Facility, Residential Treatment Facility and Adult Family Care Home Residents

Resident Name _____ DOB _____

This is to certify that this recipient is in need of an integrated set of assistive care services on a 24-hour basis, including at least two of the following four service components on a daily basis (check as applicable):

____ Assistance with activities of daily living, which is defined as individual assistance with ambulating, transferring, bathing, dressing, eating, grooming, and/or toileting.

____ Assistance with instrumental activities of daily living, which is defined as individual assistance with shopping for personal items, making telephone calls, managing money, etc.

____ Health support, which is defined as observing the resident's whereabouts and well-being; reminding the resident of any important tasks; and recording and reporting any significant changes in appearance, behavior, or state of health to the health care provider, designated representative, or case manager.

____ Assistance with self-administration of medication, which is defined as assistance with or supervision of self-administration of medication as permitted by law.

HEALTH CARE PROVIDER

Facility Name: _____

License Number: _____

Administrators' Signature: _____

Date Signed: _____

CERTIFICATION OF MEDICAL NECESSITY:

Physician/Physician Assistant/
Advanced Registered Nurse Practitioner/
Registered Nurse: _____

## RESIDENT SERVICE PLAN FOR ASSISTIVE CARE SERVICES

| | |
|---|---|
| FACILITY: | DATE: |
| RESIDENT NAME: | MEDICAID #: |
| Beginning Date of Service Plan _____ | Ending Date of Service Plan_____ |

### ASSISTANCE WITH ACTIVITIES OF DAILY LIVING (ADLs)

| ACTIVITY | SERVICE NEED | |
|---|---|---|
| **AMBULATION** | ☐ Independent<br>☐ Provide Assistance<br>☐ Assist with Ambulatory Device<br>☐ Wheelchair ☐ Walker ☐ Cane | |
| Expected Outcome of Service: _____ | | |
| Comments: _____ | | |
| **BATHING** | ☐ Independent<br>☐ Provide Supervision<br>☐ Provide Assistance<br>☐ Provide Total Help | ☐ Tub<br>☐ Shower<br>☐ Morning<br>☐ Evening |
| Expected Outcome of Service: _____ | | |
| Comments: _____ | | |

**DRESSING**

| Choose attire | Put on shoes | Dress/ Undress | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Independent |
| ☐ | ☐ | ☐ | Provide Supervision |
| ☐ | ☐ | ☐ | Provide Assistance |
| ☐ | ☐ | ☐ | Provide Total Help |

Expected Outcome of Service: _____

Comments: _____

| | | |
|---|---|---|
| **TOILETING** | ☐ Independent<br>☐ Supervision/Prompting<br>☐ Provide Assistance<br>☐ Incontinent:<br>☐ Bladder ☐ Bowel | ☐ Adult Brief<br>☐ Catheter Care<br>☐ Ostomy Assistance |
| Expected Outcome of Service: _____ | | |
| Comments: _____ | | |
| **EATING** | ☐ Independent<br>☐ Provide Supervision<br>☐ Provide Assistance<br>☐ Provide Total Help | ☐ Hand Guidance<br>☐ Cutting Food<br>☐ Opening Packages |

Special diet: ☐ Regular ☐ Diabetic ☐ No added salt ☐ Low fat/Low cholesterol Other _____

Expected Outcome: _____

Comments: _____

## RESIDENT SERVICE LOG

**Form for Medicaid Assistive Care Services**

**FACILITY NAME** _____ **MONTH & YEAR** _____

| Resident Name | Medicaid # | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | Days |
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| TOTALS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

AHCA-Med Serv Form 037, July 2009
June 2010

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# Annual Assessment

- Recipients receiving Assistive Care Services must have an assessment annually by a physician, PA, ARNP, or RN.
  - Sooner if a significant change in the recipient's condition occurs.
  - An assessment triggered by a significant change must be completed no more than fifteen days after the significant change.
- An annual assessment must be completed no more than one year plus fifteen days after the last assessment.

# *Annual Assessment Update Certification*

Recipients receiving an ACS update must also have:

1. An updated ***Certification of Medical Necessity*** for Medicaid Assistive Care Services (AHCA-Med Serv Form 035, July 2009)
2. An updated ***Resident Service Plan for Assistive Care Services*** (AHCA-Med Serv Form 036, July 2009)

# Resident Service Plan

Every ACS recipient must have a service plan completed by the ACS service provider.

The *Resident Service Plan for Assistive Care Services* (AHCA-Med Serv Form 036, July 2009) must be used for each recipient receiving ACS.

- The form must be included in the recipient's case file at the facility.
- The facility is responsible for ensuring the service plan is developed and implemented.

# Service Plan Principles

- ✓ Individuality - Addresses individual needs and preferences;
- ✓ Accountability - specifies who is responsible for providing service;
- ✓ Outcome orientation - identifies outcome of service;
- ✓ Completeness - addresses all needs in the health assessment;
- ✓ Input - resident must be consulted and agree with the plan; and
- ✓ Staffing - guides staffing and facilities.

# Service Plan
# Required Components

The service plan for ACS recipients must:

- Follow the service components outlined in Appendix C of the *Assistive Care Services Coverage and Limitations Handbook*.
- Be agreed to by the recipient or guardian/representative. The representative may not be an owner or employee of the facility.
- Signed by the recipient, guardian or designated representative and the facility representative.

# Facility Service Plan Approval

## Approval requires facility signatures:

- For an ALF, the facility administrator or person designated in writing by the administrator must sign.
- For an AFCH, the provider who is the licensee must sign the service plan.
- For a RTF, the administrator or person designated in writing by the administrator must sign.

# *Service Plan Approval Date*

The service plan is considered complete as of the last date signed by either party.

# Service Documentation

- The ALF, RTF or AFCH must document that the recipient received services in the facility on each day for which ACS is billed.
- The service documentation must be made on the *Resident Service Log* and kept in the client's case file.

# ACS Recipient Documentation

The following forms and documents will be kept in the recipient's case file:

- Copies of all eligibility documents;
- Health Assessment Forms (AHCA Form 1823 or AHCA Form 3110-1023 (AFCH-1110), including updated reassessment forms;
- Certification of Medical Necessity for Medicaid Assistive Care Services (AHCA-Med Serv Form 035);

# ACS Recipient Documentation (con't)

- The Resident Service Plan for Assistive Care Services (AHCA-Med Serv Form 036); and
- The Resident Service Log (AHCA-Med Serv Form 037).

  This documentation must be maintained at the facility for five years and made available, upon request, to the Agency for Health Care Administration monitoring or surveying staff or its designated representative.

# ACS Record Documentation Requirements

- ✓ Legible
- ✓ Written in blue or black ink
- ✓ No erasures or “whiteout” are permitted
- ✓ In case of an error, the ALF administrator or designee, AFCH provider or RTF administrator or designee must line through the error, initial and date it, then make the correct entry.

# ACS Electronic Records

- ✓ ACS documentation may be in electronic format.
- ✓ The original, signed (if applicable) documents must be kept in the recipient's case file in the facility in chronological order for audit, monitoring and quality assurance purposes.
- ✓ If electronic format is used, back up files must be kept.

# Leave of Absence and Discharge

- Recipients may leave the facility for more than 24 hours for health or personal reasons.
- During such periods of absence, ACS are not being provided and should not be billed.
- If the ALF, AFCH, or RTF representative initiates discharge of an ACS recipient, this must be done in accordance with licensure requirements applicable to the facility type.

# *Assisted Living for the Elderly & Optional State Supplementation*

Assisted Living for the Elderly (ALE) waiver recipients who receive Optional State Supplementation (OSS) may also receive Assistive Care Services, provided the waiver and ACS component services are not duplicative and that the services are listed on the ALE plan of care.

# *Optional State Supplementation (OSS)*

- Administered by the Department of Children and Families.
- A cash assistance program that helps low income recipients with room and board payments in adult living facilities.

# Assisted Living for the Elderly (ALE) Waiver

- A home and community-based services program.
- Provides extra support services to eligible Medicaid recipients living in assisted living facilities (ALFs) licensed for extended congregate care (ECC) or limited nursing services (LNS).

# Assisted Living for the Elderly Waiver

The program provides:

- Case management services;
- Assisted living services, and;
- Incontinent supplies, if needed.
- ALE waiver services are provided based on a written plan of care.

# Who Can Receive ALE Services?

- ALE waiver recipients must demonstrate functional deterioration that would result in placement in a nursing facility were it not for the provision of ALE waiver services.
- Eligible Medicaid recipients 60 to 64 years of age and determined disabled per Social Security Administration criteria and individuals 65 years old and older;

# Who Can Receive ALE Services? (con't)

- Florida residents that meet nursing facility level of care criteria for Intermediate I or Intermediate II as referenced at 59G-4.180, F.A.C;
- Individuals deemed appropriate for ALF placement by the facility administrator;
- Individuals moving out of a nursing facility or other institutional program;
- An ALF resident in need of additional services in order to remain in the ALF;

# Who Can Receive ALE Services? (con't)

- Individuals who have been living at home and have been determined to be at risk of nursing facility placement and have chosen to move into an ALF;
- Individuals who meet one or more functional criteria as described in the ALE Waiver Services Coverage and Limitations Handbook;
- Have a case manager employed by a waiver enrolled case management agency.

# Functional Criteria Requirements

Recipients must meet at least one of the following criteria:

- Require assistance with four or more ADLs or three ADLs plus supervision or administration of medication;
- Require total help with one or more ADLs;
- Have a diagnosis of Alzheimer's disease or another type of dementia and require assistance with two or more ADLs;

# Functional Criteria Requirements (con't)

- Have a diagnosed degenerative or chronic medical condition requiring nursing services that cannot be provided in a standard ALF but are available in an ALF licensed for limited nursing or extended congregate care; or
- Be a Medicaid-eligible recipient who meets ALF criteria, awaiting discharge from a nursing facility placement and who cannot return to a private residence because of a need for supervision, personal care, periodic nursing services, or a combination of the three.

# Level of Care Requirements

- All applicants for ALE waiver services must be assessed to meet the nursing home level of care for Intermediate I or Intermediate II as stated in 59G-4.180, F.A.C.
- Level of care reviews are performed by the Comprehensive Assessment and Review for Long Term Care Services (CARES) Program in the Department of Elder Affairs.

# ALE Waiver Covered Services

- All ALE waiver recipients must receive:
  - Case management; and
  - Assisted living services
- The receipt of incontinence supplies is based on need
- Services are based on the recipient's needs documented in an approved plan of care
- ALE waiver services are provided by qualified, Medicaid-enrolled, waiver providers

# Case Management

- Case management is a service that provides the ALE waiver recipient with a case manager who will:
  - Identify;
  - Organize;
  - Coordinate; and
  - Monitor services needed by the recipient.
- The case manager also assists the recipient to access needed services.

# Assisted Living Services Components

If the recipient is assessed to need certain service components, the facility will provide:

- Attendant call system;
- Attendant care;
- Behavior management;
- Chore services;
- Companion services;
- Homemaker services;
- Intermittent nursing;

# *Assisted Living Services Components (con't)*

- Medication administration;
- Occupational therapy;
- Personal care;
- Physical therapy;
- Specialized medical equipment and supplies;
- Speech therapy; and
- Therapeutic social and recreational services.

# ACS and the ALE Waiver

ACS is a Medicaid state plan service that allows ALE waiver providers to provide extra services to their waiver recipients receiving Optional State Supplementation (OSS).

If ACS is provided it may be billed along with the ALE Waiver Reimbursement.

ACS is not an ALE waiver service.

# Optional State Supplementation

OSS is a cash assistance program for low-income individuals.

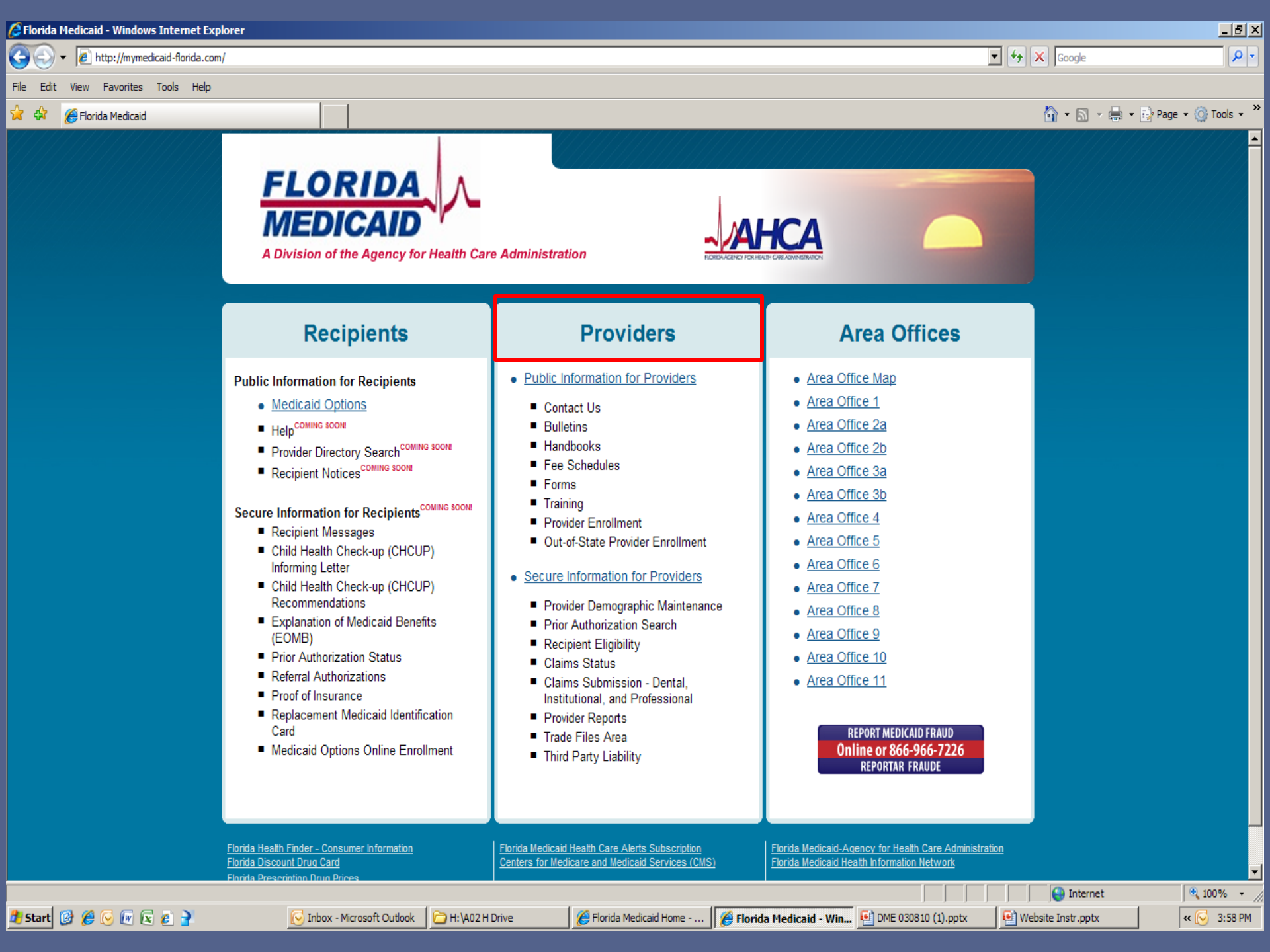
Its purpose is to supplement a person's income to help pay for room and board costs of an assisted living facility, mental health residential treatment facility or adult family care home.

# *Online Information*

All Medicaid handbooks, fee schedules, forms, provider notices, and other important Medicaid information are available on the Medicaid fiscal agent's Web Portal at:

**http://mymedicaid-florida.com/**

Click on "Public Information for Providers", then on "Provider Support", and then click on "Provider Handbooks, Fee Schedules, Forms, or Provider Notices."


Florida Medicaid - Windows Internet Explorer
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File Edit View Favorites Tools Help
Florida Medicaid
FLORIDA MEDICAID
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AHCA
Recipients
Public Information for Recipients
Medicaid Options
Help COMING SOON!
Provider Directory Search COMING SOON!
Recipient Notices COMING SOON!
Secure Information for Recipients COMING SOON!
Recipient Messages
Child Health Check-up (CHCUP) Informing Letter
Child Health Check-up (CHCUP) Recommendations
Explanation of Medicaid Benefits (EOMB)
Prior Authorization Status
Referral Authorizations
Proof of Insurance
Replacement Medicaid Identification Card
Medicaid Options Online Enrollment
Providers
Public Information for Providers
Contact Us
Bulletins
Handbooks
Fee Schedules
Forms
Training
Provider Enrollment
Out-of-State Provider Enrollment
Secure Information for Providers
Provider Demographic Maintenance
Prior Authorization Search
Recipient Eligibility
Claims Status
Claims Submission - Dental, Institutional, and Professional
Provider Reports
Trade Files Area
Third Party Liability
Area Offices
Area Office Map
Area Office 1
Area Office 2a
Area Office 2b
Area Office 3a
Area Office 3b
Area Office 4
Area Office 5
Area Office 6
Area Office 7
Area Office 8
Area Office 9
Area Office 10
Area Office 11
REPORT MEDICAID FRAUD
Online or 866-966-7226
REPORTAR FRAUDE
Florida Health Finder - Consumer Information
Florida Discount Drug Card
Florida Prescription Drug Prices
Florida Medicaid Health Care Alerts Subscription
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Florida Medicaid-Agency for Health Care Administration
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FLORIDA MEDICAID

A Division of the Agency for Health Care Administration

AHCA

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

## Providers

- Home
- Area Offices
- Contact Us
- Provider Support
- Enrollment
- EDI
- Managed Care
- Pharmacy
- TPL

REPORT MEDICAID FRAUD
Online or 866-966-7226
REPORTAR FRAUDE

## Provider Home

### Web Portal Alert

**Known Issues List**
Please review the Known Issues and Informational Items List (Updated 3/26/2010) for details related to the MMIS.

**Web Portal Claims with Attachments**
We are currently experiencing intermittent issues affecting the system's identification that an attachment was sent for a Web Portal submitted claim. In some cases, claims improperly deny for no paper attachment received within 21 days, when in fact an attachment was submitted. Please be advised that we are working diligently to resolve this issue as quickly as possible, and we apologize for any inconvenience this may cause.

If your claim is impacted by this issue because it was initially submitted electronically, we ask that providers resubmit the claim hard-copy (paper) with the attachment. Providers will be notified when this issue has been resolved. We apologize for this temporary inconvenience.

**Eligibility Verification**
REMINDER: When performing an eligibility verification on the secure Web Portal, the response may include references that state "limited to family planning benefit." That statement is referring to the Family Planning Waiver benefit. As a reminder, in cases where a recipient has eligibility in multiple

## Contact Us

- Provider Relations Phone Number: 800-289-7799
- Field Services: Option 7
- Provider Enrollment: Option 4
- Support Services Contact Center: Option 7
- EDI: 866-586-0961

## Quick Links

- Centers for Medicare and Medicaid Services
- Florida Discount

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

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## Local Navigation



About Florida Medicaid | Administration and Funding | Beneficiary Information | Eligibility for Medicaid Services | Florida Medicaid Health Care Alerts | Medicaid Headquarters | Medicaid Fiscal Agent | Other Resources | Recent Medicaid Presentations | Summary of Services | Third Party Liability

# Florida Medicaid Health Care Alerts

The Florida Medicaid program has an e-mail alert system to supplement the present method of receiving Provider Alerts information and to notify registered providers or interested parties of "late-breaking" health care information. An e-mail will be delivered to your mailbox when Medicaid policy clarifications or other health care information is available that is appropriate for your selected provider type.

To subscribe to the automated alert system, complete the online form below. A confirmation e-mail will be sent to your mailbox to avoid fraudulent subscription requests. ***Subscribers must return the confirmation e-mail to complete their subscription.***

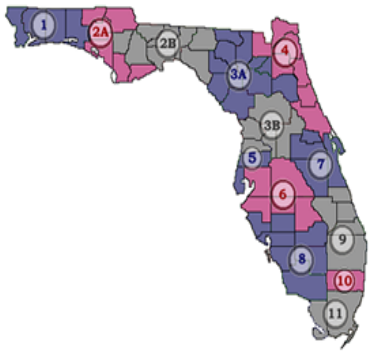
*Email

First Name

Last Name

*Area

- ☐ All Areas
- ☐ Area 1
- ☐ Area 2
- ☐ Area 3
- ☐ Area 4
- ☐ Area 5



# Medicaid Health Care Alerts

- Florida Medicaid now has an e-mail alert system for providers to receive Provider Alerts information.
- Registered providers or interested parties are notified of "late-breaking" health care information and Medicaid policy clarifications.
- For information or to sign up go to: www.ahca.myflorida.com/Medicaid/alerts/alerts.shtml

From: State of Florida Agency for Health Care Administration [medicaid_alert@ahca.myflorida.com]
To: Sacipa,Yolanda
Cc:
Subject: Out-of-State Authorization - Revised
Sent: Thu 3/11/2010 6:37 PM

**Example of a Provider Alert**

help protect your privacy, Outlook prevented automatic d

*Better Health Care for All Floridians*

# FLORIDA MEDICAID

*A Division of the Agency for Health Care Administration*

## Health Care Alerts & Provider Alerts Messages
## March 2010

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### General Providers/All Providers

#### Out-of-State Authorization - Revised

MediPass providers - Per the Agreement for Participation in MediPass and the Medicaid Provider General Handbook, you are reminded that should a recipient require services that cannot be provided in Florida, the PCP may refer the recipient for out-of-state care. **Prior-authorization for out-of-state services requires a unique authorization granted by the Medicaid Services/Medicaid Prior-Authorization Unit within the Agency for Health Care Administration (AHCA). Do not provide your MediPass authorization number to providers for out-of-state services, as these providers will not be paid without the AHCA issued unique authorization number.**

**Should you need to refer a MediPass patient for out-of-state care, you should:**

1. Complete the out-of-state request packet which should include the following:
   a. Completed prior-authorization form (PA01), available in the Medicaid Provider General Handbook, filled out by the recipient's Florida Medicaid primary care or specialist physician (cover page).
   b. Documentation that justifies the need for the service, such as medical history, lab reports, etc.
   c. Documentation from the requesting physician indicating the requested service(s) is/are not available in the state of Florida.
   d. Contact information for the requesting primary care or specialist physician.
   e. Name and address of the out-of-state facility.
   f. Name and telephone number of the out-of-state facility's contact.

# QUESTIONS ?

While we will answer as many questions as possible responses to all questions will be posted at:

http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/index.shtml