Four Levels of Care in the Florida Medicaid Hospice Benefit

**Routine Home Care:** provided in the home (where “home” may be a nursing home, assisted living facility, group home, or homeless shelter) by the interdisciplinary team. Visits are determined by plan of care and goals of patient/family. The plan of care is reassessed every 14 days.

- **Reimbursement:** is currently $114 per day in Leon and Gadsden and $117 per day in other rural counties and includes team services, medications related to hospice diagnosis, medical equipment and supplies.

**Continuous Care:** provided in the home (where “home” may be a nursing home, assisted living facility, group home, or homeless shelter) by the continuous care team only during a period of crises as necessary to maintain the terminally ill individual at such home. The hospice must provide a minimum of 8 hours of care during any 24-hour period.

- **Reimbursement:** is currently $666.97 per day in Leon and Gadsden and $685.21 per day in other rural counties.

**Respite Care:** When a patient’s caregiver needs respite, this is provided to a patient in a hospice inpatient unit, hospital, or nursing home/skilled nursing facility (SNF) which has 24/7 R.N. services and with which the hospice has a contract.

- **Reimbursement:** is currently $119.90 per day. (We normally pass on the full amount to the contracted health care facility.)

**Inpatient Care:** provided in hospice inpatient unit, hospital, or nursing home/SNF for patients needing pain or symptom control which can not be feasibly handled in other settings or may be needed by a family whose home support has broken down. Examples are medication adjustment, observation, stabilizing treatment, or family unwilling to provide needed care at home.

- **Reimbursement:** is currently $510.69 per day. (Hospices can and do negotiate a rate with hospitals, SNF’s and nursing homes.)

**Types of Federal Medicaid Waivers**

**Description of Waivers:** Every state that operates a Medicaid program must have a State Plan. Services provided through the State Plan must be statewide and all recipients must receive the same services. When a state wants to make a change to their Medicaid Plan, a waiver must be submitted to CMS to allow the State to not follow Federal rules and laws. There are two kinds of waivers:
1915b – this allows a state to try a unique program in a certain area or to a select group of recipients. It must be cost neutral which the state must be able to demonstrate and runs for 2 years with 2-year renewals.

1115 – has to do with eligibility and must be unique (managed care may be an example). These waivers run for 5 years and must be cost neutral.

Cost effectiveness/neutrality is reviewed by CMS as well as OMB (they can really slow down the process). They scrutinize the 1115’s much more than others.

[NEED TO LIST THE VARIOUS TYPES OF FLORIDA LTC WAIVERS HERE – AS SOON AS I FIND THAT LIST..... THEN INDICATE WHAT WE KNOW ABOUT HOW THAT AFFECTS HOSPICE CARE AND REIMBURSEMENT FOR SAME]

[2004 statute PENDING review of 2005 legislation – Please do NOT rely on this]

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician’s opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of
services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency is authorized to seek federal waivers necessary to implement this policy.

(33) The agency shall, by rule, develop a process whereby a Medicaid managed care plan enrollee who wishes to enter hospice care may be disenrolled from the managed care plan within 24 hours after contacting the agency regarding such request. The agency rule shall include a methodology for the agency to recoup managed care plan payments on a pro rata basis if payment has been made for the enrollment month when disenrollment occurs.

History.--s. 43, ch. 91-282; s. 3, ch. 94-299; s. 5, ch. 94-317; s. 59, ch. 95-144; s. 6, ch. 96-199; s. 11, ch. 96-223; s. 3, ch. 96-387; s. 7, ch. 96-417; s. 11, ch. 97-82; s. 43, ch. 97-98; s. 202, ch. 97-101; s. 66, ch. 97-237; s. 10, ch. 97-260; s. 15, ch. 97-263; s. 5, ch. 97-290; ss. 29, 30, ch. 98-191; s. 150, ch. 98-403; s. 188, ch. 99-8; ss. 14, 15, 53, ch. 99-228; s. 16, ch. 99-393; ss. 69, 207, ch. 99-397; s. 60, ch. 2000-153; s. 20, ch. 2000-157; s. 61, ch. 2000-158; ss. 19, 26, ch. 2000-163; s. 5, ch. 2000-209; ss. 19, 59, ch. 2000-256; s. 1, ch. 2000-277; s. 98, ch. 2000-349; s. 71, ch. 2000-367; s. 52, ch. 2001-62; s. 9, ch. 2001-104; s. 7, ch. 2001-222; ss. 8, 9, ch. 2001-377; ss. 8, 14, ch. 2002-223; ss. 26, 27, ch. 2002-400; s. 47, ch. 2003-1; s. 450, ch. 2003-261; s. 9, ch. 2003-279; s. 18, ch. 2003-405; s. 55, ch. 2004-5; s. 28, ch. 2004-267; s. 17, ch. 2004-270; s. 5, ch. 2004-344; s. 3, ch. 2004-365; s. 3, ch. 2004-386.

¹Note.--The word "subsection" was substituted for the word "paragraph" by the editors to conform to context.