GATEWAY TO GLOBAL AGING DATA

g2aging.org

Gateway Policy Explorer: Long-Term Care Series

Florida, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2023

Authors
Maya Fransz-Myers
David Knapp

Contributors
MaryBeth Musumeci
Samuel Lau
Jinkook Lee
Drystan Phillips
Kanghong Shao
Michael Upchurch
Maya Wedemeyer

Version: 1.0 (September 2023)

This project is funded by the National Institutes of Health, National Institute of Aging, R01 AG030153.

Please cite as "Gateway to Global Aging Data (2024). *Gateway Policy Explorer: Florida, USA, Long-Term Care In-Kind Benefit Plan Details, 1992-2023*, Version: 1.0 (September 2023), University of Southern California, Los Angeles. https://doi.org/10.25553/gpe.ltc.kb.u12"

Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/app/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Florida, USA

In-Kind Benefits

Plan details 1992-2023 * †

Public long-term care (LTC) benefits in Florida are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Florida, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, semi-residential care, residential care, and some that cover a variety of care. Programs may vary in eligibility criteria.

Since 1992, Florida's Medicaid LTC system has been subject to three major policy reforms: the approval of the Nursing Home Diversion program in 1998, the addition of the optional Medicaid for the Aged or Disabled coverage group in 2006, and the implementation of the Statewide Medicaid Managed Care program in 2013, which changed the LTC delivery system from fee-for-service to capitated managed care for all populations.

Key Dates

First law: 1965

Major changes since 1992: 1998, 2013

Contents

* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-1997

Overview

Long-term care (LTC) benefits in Florida are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Florida is administered at the state level by the Agency for Health Care Administration (AHCA), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Florida are mostly provided through state plan benefit programs (Home Health Services, Institutional Care Program - ICP).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries that have established medical necessity, while the ICP only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while ICP beneficiaries must either require intermediate care services or skilled nursing services before admission.

During this policy period, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2022)

Florida Law for Medicaid

- Fla. Admin. Code Division 59G - Medicaid (Fla. Admin. Code 59A-1.058, 2023)
- Fla. Stat. Title XXX - Social Welfare, Chapter 409 - Social and Economic Assistance (Fla. Stat. § 409.901-409.985, 2023)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Florida Medicaid spending on beneficiaries in fiscal year 1992 was 54.69%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (54.69% in 1992), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Florida Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Florida.

Eligibility for Medicaid in Florida for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple (SSA, 2023). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
  - Citizenship/immigration requirements: The applicant must be a Florida resident and a U.S. Citizen or non-citizen who meets additional eligibility requirements.[3] After 1996, the applicant must be a Florida resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 1992, this was $1,266 for an individual. Eligibility for this track is generally determined as a household of one. Couple limits only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[5]
  - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[6]
    - Asset transfer: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be receiving nursing facility care through the Institutional Care Program (ICP), Florida's nursing home benefit.
- 2b. Federal Poverty Level (FPL) aged and disabled
  - Income requirements: Monthly income may not exceed 100% of the FPL. In 1992, this was $568 for an individual and $766 for a household of two. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[5]
  - Asset requirements: Same asset requirements as eligibility track 1a. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[6]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Medically Needy: Florida provides month-to-month Medicaid coverage for older adults that meet eligibility requirements of other tracks except for excess income and assets. To qualify for medically needy coverage, the individual must be at least age 65, blind, or disabled, and spend down their income on a monthly basis to meet the income limit of $180.00 for an individual and $241.00 for a couple. This track is not included as a main eligibility track because medically needy beneficiaries are not eligible for long-term care services in Florida (NLM, 1988; State Library of Florida, 1993; Fla. Admin. Code 59A-1.058, 2023).

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Institutional Care Program (ICP)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or age 18-64 and physically disabled.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Aged and Disabled Adult (ADA) Program (implemented in 1993)
- Assisted Living for the Elderly Program (implemented in 1995)
- Channeling Program (Broward and Dade counties only)
- Frail Elder Program (Broward and Dade counties only)
- Hospice Care Services

Benefit

Home care benefit

Home Health Services

Home Health provides (FSU, 1991; AHCA, 2005; FL Rules, 2013):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Medicaid reimbursement for home health services is limited to two visits per day by registered nurses, one visit per day by licensed practical nurses, and one visit per day by home health aides (State Library of Florida, 1993).

ICP

The ICP does not provide home care during this policy period.

Semi-residential care

Home Health Services, ICP

These programs do not provide semi-residential care during this policy period.

Residential care

Home Health Services

Home Health does not provide residential care during this policy period.

ICP

The ICP covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (FSU, 1991; AHCA, 2005; AHCA, 2012). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment

- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Florida Medicaid provides additional benefits related to LTC (FSU, 1991):

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Florida Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the two largest programs are summarized below.

Home Health Services

Medicaid covers home health services that are medically necessary when the applicant is certified as homebound. This means that either leaving the home is medically unwise or the Medicaid recipient is unable to leave home without the assistance of another person (HRS, 1989; State Library of Florida, 1998; AHCA, 2005; FL Rules, 2013).

ICP

To qualify for placement in a nursing facility, the applicant or recipient must require intermediate care services or skilled nursing services including 24-hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and services provided in a hospital (Fla. Admin. Code 59G-4.180, 1995; Fla. Admin. Code 59G-4.290, 1995; Fla. Admin. Code 65A-1.711, 2006; Fla. Admin. Code 65A-1.711, 2008).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the two largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (KFF, 2002).

Home Health Services

Services must be ordered by a physician and accompany a written plan of care. The physician must certify the applicant's homebound status and review the written plan of care every 60 days (HRS, 1989; 42 CFR 440.70, 1998; AHCA, 2012; FL Rules, 2013).

ICP

Unknown

Author's note: Information pending requested materials.[7]

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services

There is no age requirement.

ICP

Individuals must be at least age 65, blind, or disabled.

Care needs assessment

Definition of dependence

Definitions of dependence vary by health benefit program. The details of the two largest programs are summarized below.

Home Health Services

Services are provided when medically necessary and when the applicant is certified as homebound, meaning either leaving the home is medically unwise or the Medicaid recipient is unable to leave home without the assistance of another person (HRS, 1989; State Library of Florida, 1993; State Library of Florida, 1998; AHCA, 2005). Medically necessary home health services means that the services are required and reasonable to the treatment of a documented illness, injury, or condition (HRS, 1989; Fla. Stat. 409.9131, 2006; FL Rules, 2013).

ICP

To qualify for placement in a nursing facility, the applicant or recipient must require intermediate care services or skilled nursing services (State Library of Florida, 1993). However, state documents detailing eligibility for services at this time do not define these care levels, but they are defined in future policy periods, starting in 1998.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the two largest programs are summarized below.

Home Health Services

Individuals must have a written physician's order from the treating or attending physician that describes all of the following (42 CFR 484.18, 1998; ACHA, 2012; FL Rules, 2013):

- Recipient's acute or chronic medical condition or diagnosis that causes a recipient to need home health care.
- Documentation regarding the medical necessity for the service(s) to be provided at home.
- Home health services needed.
- Frequency and duration of the needed services.
- Minimum skill level (nurse, home health aide) of staff who can provide the services.

Following the physician's order, a plan of care will be created. Once the physician approves and signs the plan of care, services will be authorized.

ICP

Nursing facility services must be ordered by and provided under the direction of a licensed physician (FSU, 1991). Before admission to the program, all beneficiaries are evaluated by the Comprehensive Assessment and Review for Long-Term Care Services (CARES) unit at the Florida Department of Elder Affairs. The CARES assessment is an on-site assessment that evaluates the individual's cognitive, emotional, social, and health status (including ability to perform ADLs) to determine their needs (OASM, 1989). Following the assessment, a physician and interdisciplinary staff recommended placement and determine service needs (State Library of Florida, 1993).

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 1 for more information on the PASRR, and Box 2 for the MDS.

Evaluators

Evaluators vary by LTC health benefit program. The details of the two largest programs are summarized below.

Home Health Services

A licensed physician must order home health services, develop the plan of care, and periodically review the plan of care (FSU, 1991; AHCA, 2012; FL Rules, 2013).

ICP

Nursing facility services must be ordered by a licensed physician (FSU, 1991; Fla. Stat. 409.905, 1998. The CARES assessment must be administered by a registered nurse and social worker (OASM, 1989; AHCA, 2002; Lambert, 2004, p. 23).

Benefit limitations

Can you mix LTC benefits?

All Florida Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

In 1993, Florida implemented a Medicaid Estate Recovery program as required by federal law. Medicaid estate recovery allows the Medicaid agency to file a claim against the estate of a Medicaid recipient after their death. Estate recovery applies to those Medicaid recipients who have received services at any time on or after August 31, 1993, and who were 55 years of age or older at the time of provision of the service.

Home Health Services

There are no mentions of copayments for this service in the Florida Medicaid Summary of Services for this time.

ICP

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 1992, the PNA was $35 per month (HRS, 1992).

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 1998-2012

Policy change in 1998

In 1998, Florida implemented the Nursing Home Diversion (NHD) program, designed to provide people aged 65 an alternative to nursing home care. The program offers integrated acute and long-term care (LTC) services to people eligible for Medicare and Medicaid (known as dual eligibles). The LTC services are provided through a managed care service model (Medicaid.gov, 2011). The program requires a nursing facility level of care (NFLOC) to be met, along with additional dependence criteria detailed in the *Minimum Level of Dependence* section of this policy period (1998-2005).

The program began operating only in the Orlando area in 1998, but eventually expanded to almost all Florida counties. For context on enrollment growth over time, in 2006, the program operated in 25 counties and served over 7,000 Floridians (OPPAGA, 2006). By 2013, the program operated in 66 out of 67 counties and served about 25,000 individuals before being discontinued.

Other reforms during this period:

- (2002) Florida reduced the income limit for individuals eligible under eligibility track 2b (FPL aged and disabled) from 100% of the FPL to 88% of the FPL (Fla. Stat. 409.904, 2002). Asset limits remained the same during this time.
- (2006) Florida implemented new Medicaid eligibility requirements for eligibility track 2b (FPL aged and disabled) adults under the authority of the federally approved MEDS-AD program (Medicaid.gov, 2018). This population was previously covered under an optional categorically needy coverage group but was removed from the Florida Medicaid plan in 2005 by state legislation. However, this 2005 legislation allowed Florida to continue covering this population through a federally approved program. This became the MEDS-AD program that was officially implemented in 2006. Although operating under a new authority, MEDS-AD beneficiaries are subject to the same delivery systems that are used under the state plan, and individuals receive all the same Medicaid state plan benefits if eligible.
- (2006) The federal Deficit Reduction Act of 2005 implemented a home equity limit of $500,000 for Medicaid applicants. Prior to 2006, in determining an applicant's assets, the value of an individual's home was usually exempt. Under the new law, a person with more than $500,000 in home equity is ineligible for nursing facility care under Medicaid. Homes occupied by a spouse or a disabled or minor child are exempt (NYT, 2006).

Overview

Long-term care (LTC) benefits in Florida are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Florida is administered at the state level by the Agency for Health Care Administration (AHCA), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Florida are mostly provided through state plan benefit programs (Home Health Services, Institutional Care Program - ICP), or through federally approved home-and community-based services (HCBS) LTC programs (Nursing Home Diversion - NHD).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries that have established medical necessity, while the ICP only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the NHD program are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC). Those applying for the NHD program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a prioritized waiting list.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while ICP and NHD beneficiaries must either require intermediate care services or skilled nursing services before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2022)

Florida Law for Medicaid

- Fla. Admin. Code Division 59G - Medicaid (Fla. Admin. Code 59A-1.058, 2023)
- Fla. Stat. Title XXX - Social Welfare, Chapter 409 - Social and Economic Assistance (Fla. Stat. § 409.901-409.985, 2023)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Florida Medicaid spending on beneficiaries in fiscal year 1998 was 55.65%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (55.65% in 1998), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Florida Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Florida.

Eligibility for Medicaid in Florida for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients (Fla. Stat. 409.903, 1998)
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1998, the monthly federal benefit amount was $494 for an individual and $741 for a couple (SSA, 2023). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
    - Home equity limit: There was no home equity limit in 1998. From 2006, the equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services (KFF, 2006). From 2011, this figure increases annually with inflation.[8]
  - Citizenship/immigration requirements: The applicant must be a Florida resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules (Fla. Stat. 409.904, 1998)
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 1998, this was $1,482 for an individual. Eligibility for this track is generally determined as a household of one. Couple limits only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[9]
  - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[10]
    - Asset transfer & Home equity limit: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be receiving nursing facility care through the Institutional Care Program (ICP), Florida's nursing home benefit, or HCBS through the Nursing Home Diversion (NHD) program.
- 2b. Federal Poverty Level (FPL) aged and disabled (Fla. Stat. 409.904, 1998)
  - Income requirements: Monthly income may not exceed 100% of the FPL. In 1998, this was $671 for an individual and $904 for a household of two. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[9] As of 2002, this was reduced to 88% of the FPL, which was $683 for an individual and $916 for a household of two (Fla. Admin. Code 65A-1.716, 2006).
  - Asset requirements: Same asset requirements as eligibility track 1a. As of 2006, resources may not exceed $5,000 for an individual and $6,000 for a household of two (Fla. Admin. Code 65A-1.716, 2006). Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[10]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4] As of 2006, the applicant must also be ineligible for Medicare or eligible for Medicare and receiving HCBS, hospice, or institutional care services (DOEA, 2005).

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Medically Needy: Florida provides month-to-month Medicaid coverage for older adults that meet eligibility requirements of other tracks except for excess income and assets. To qualify for medically needy coverage, the individual must be at least age 65, blind, or disabled, and spend down their income on a monthly basis to meet the income limit of $180.00 for an individual and $241.00 for a couple. This track is not included as a main eligibility track because medically needy beneficiaries are not eligible for long-term care services in Florida (NLM, 1988; State Library of Florida, 1993; Fla. Admin. Code 59A-1.058, 2023).
- Medicaid Cancer Treatment Program (implemented in 2001): Optional coverage is provided for individuals with breast and cervical cancer. Coverage is limited only for the duration of the individual's treatment (Fla. Stat. 381.93, 2001).

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Institutional Care Program (ICP)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or age 18-64 and physically disabled.

Nursing Home Diversion (NHD)

NHD participants must meet the following criteria beyond minimum level of dependence requirements (AHCA, 2002):

- At least age 65
- Eligible for Medicare and Medicaid (i.e., dually eligible)
- Live in the pilot project areas of Orange, Osceola, Seminole, Brevard, Palm Beach, Martin, Okeechobee, Saint Lucie, and Indian River counties

If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available.

Author's Note: Additional information on NHD program requirements is pending requested materials.[7]

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Aged and Disabled Adult (ADA) Program
- Assisted Living for the Elderly Program
- Assistive Care Services
- Channeling Program
- Frail Elder Program
- Hospice Care Services

Benefit

Home care benefit

Home Health Services

Home Health provides (FSU, 1991; AHCA, 2005; FL Rules, 2013):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Medicaid reimbursement for home health services is limited to four visits per day by registered nurses, licensed practical nurses, and home health aides, and a total of 60 visits by all three provides per lifetime. Exceptions to the 60-visit limit may be requested through a Medicaid contracted peer review agency (State Library of Florida, 1998; AHCA, 2005).

ICP

The ICP does not provide home care during this policy period.

NHD

NHD provides the following services in addition to those offered under the state plan, unless otherwise noted (AHCA, 2002; Fla. Admin. Code 59G-13.080, 2005; OPPAGA, 2006):

- Adult companion services: Activities necessary to assist the recipient in performing household or personal tasks and providing social stimulation to relieve the negative effects of loneliness and isolation
- Chore services: Maintenance of the home in a clean, sanitary and safe environment
- Personal care services[11]
  - Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Semi-residential care

Home Health Services, ICP

These programs do not provide semi-residential care during this policy period.

NHD

NHD provides Adult Day Health Care (AHCA, 2002). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (Fla. Admin. Code 59G-13.080, 2005; OPPAGA, 2006).

Residential care

Home Health Services, NHD

These programs do not provide residential care during this policy period.

Author's Note: Additional information on NHD program services is pending requested materials.[7]

ICP

The ICP covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (FSU, 1991; AHCA, 2005; AHCA, 2012). Services may include the following:

- Physician services

- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Florida Medicaid provides additional benefits related to LTC (FSU, 1991):

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services (AHCA, 2005)
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy (AHCA, 2005)

NHD

NHD provides the following services in addition to those offered under the state plan, unless otherwise noted (Fla. Admin. Code 59G-13.080, 2005; OPPAGA, 2006):

- Case Management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Environmental accessibility and adaptation: Physical adaptations made to the home to allow the enrollee to function with greater independence in the home and without which the enrollee would require institutionalization, including the installation of ramps and grab-bars, widening of doorways, or modification of bathroom facilities
- Escort services: Assistance in gaining access to services, such as providing language interpretation for people who have hearing or speech impairments or who speak a language different from that of the provider
- Family training: Training and counseling services provided to the families of enrollees, including instruction and updates about treatment regimens and use of equipment specified in the plan of care to safely maintain the enrollee at home
- Home-delivered meals: Delivers healthy meals to the beneficiary's home
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite care: Short-term relief provided to an enrollee's caregiver. Respite care is provided in the home/place of residence, Medicaid licensed hospital, nursing facility, or ALF

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Florida Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Medicaid covers home health services that are medically necessary when the applicant is certified as homebound. This means that either leaving the home is medically unwise or the Medicaid recipient is unable to leave home without the assistance of another person (HRS, 1989; State Library of Florida, 1998; AHCA, 2005; FL Rules, 2013).

ICP

To qualify for placement in a nursing facility, the applicant or recipient must require intermediate care services or skilled nursing services including 24-hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and services provided in a hospital (Fla. Admin. Code 59G-4.180, 1995; Fla. Admin. Code 59G-4.290, 1995; Fla. Admin. Code 65A-1.711, 2006; Fla. Admin. Code 65A-1.711, 2008).

NHD

Applicants for the NHD program must meet the following dependence criteria (AHCA, 2002; OPPAGA, 2006):

- Have a nursing facility level of care (NFLOC)
- At risk of nursing home placement if HCBS were not provided
- Meet one or more of the following clinical criteria:
  - Require assistance with five or more ADLs
  - Require assistance with four ADLs as well as require supervision or administration of medication
  - Require total help with two or more ADLs
  - Diagnosed with Alzheimer's disease or another type of dementia and require help with three or more ADLs
  - Diagnosed with a degenerative or chronic condition that requires daily nursing services

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (KFF, 2002).

Home Health Services

Services must be ordered by a physician and accompany a written plan of care. The physician must certify the applicant's homebound status and review the written plan of care every 60 days (HRS, 1989; 42 CFR 440.70, 1998; AHCA, 2012; FL Rules, 2013).

ICP

Each resident admitted to a nursing facility must be reassessed for medical eligibility every 12 months, and the assessment shall be reviewed every 3 months or after a significant change in the resident's physical or mental condition (Fla. Admin. Code 59A-4.109, 1995).

NHD

Participants must be reassessed every 12 months (Medicaid.gov, 2011).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services

There is no age requirement.

ICP

Individuals must be at least age 65, blind, or disabled.

NHD

Individuals must be at least age 65 (OPPAGA, 2006).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Services are provided when medically necessary and when the applicant is certified as homebound, meaning either leaving the home is medically unwise or the Medicaid recipient is unable to leave home without the assistance of another person (HRS, 1989; State Library of Florida, 1993; State Library of Florida, 1998; AHCA, 2005). Medically necessary home health services means that the

services are required and reasonable to the treatment of a documented illness, injury, or condition (HRS, 1989; Fla. Stat. 409.9131, 2006; FL Rules, 2013).

ICP

To qualify for placement in a nursing facility, the applicant or recipient must require intermediate care services or skilled nursing services including 24 hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and services provided in a hospital (Fla. Admin. Code 59G-4.180, 1995; Fla. Admin. Code 59G-4.290, 1995; Fla. Admin. Code 65A-1.711, 2008). See Box 4 for additional information on these levels of care.

NHD

Applicants for the NHD program must meet an NFLOC based on a CARES assessment. The level of care criteria is the same as described above for intermediate care services under the ICP. NHD applicants must require intermediate care services including 24-hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and services provided in a hospital or that meets the criteria of skilled services. Individuals requiring intermediate care services must qualify as intermediate level I or intermediate level II, defined in Box 4. If the program has reached enrollment capacity, the applicant may be placed on a waiting list for program services or directed to another program. Individuals transitioning out of a nursing home and those at imminent risk for nursing home admission are given priority (FL Senate, 2003).

Author's Note: Additional information on NHD waiting lists is pending requested materials.[7]

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Individuals must have a written physician's order from the treating or attending physician that describes all of the following (42 CFR 484.18, 1998; ACHA, 2012; FL Rules, 2013):

- Recipient's acute or chronic medical condition or diagnosis that causes a recipient to need home health care.
- Documentation regarding the medical necessity for the service(s) to be provided at home.
- Home health services needed.
- Frequency and duration of the needed services.
- Minimum skill level (nurse, home health aide) of staff who can provide the services.

Following the physician's order, a plan of care will be created. Once the physician approves and signs the plan of care, services will be authorized.

ICP

Nursing facility services must be ordered by and provided under the direction of a licensed physician (FSU, 1991). Before admission to the program, all beneficiaries are evaluated by the Comprehensive Assessment and Review for Long-Term Care Services (CARES) unit at the Florida Department of Elder Affairs. The CARES 701B assessment evaluates the individual's cognitive, emotional, social, and health status (including ability to perform ADLs) to determine their needs (OASM, 1989). Following the assessment, a physician and interdisciplinary staff recommended placement and determine service needs (State Library of Florida, 1993). To view the full assessment, see (DOEA, 2008).[12] See Box 3 for additional information on sections within the assessment.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 1 for more information on the PASRR, and Box 2 for the MDS.

NHD

NHD applicants undergo the CARES 701B assessment as described above (AHCA, 2002). If the program has reached enrollment capacity, they may be placed on a waiting list for program services or directed to another program. Individuals transitioning out of a nursing home and those at imminent risk for nursing home admission are given priority (FL Senate, 2003).

Author's Note: Additional information on NHD program requirements and waiting lists are pending requested materials.[7]

Evaluators

Evaluators vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician must order home health services, develop the plan of care, and periodically review the plan of care (FSU, 1991; AHCA, 2012; FL Rules, 2013).

ICP

Nursing facility services must be ordered by a licensed physician (FSU, 1991; Fla. Stat. 409.905, 1998. The CARES assessment must be administered by a registered nurse and social worker (OASM, 1989; AHCA, 2002; Lambert, 2004, p. 23).

NHD

The CARES assessment must be administered by a registered nurse and social worker (AHCA, 2002).

Benefit limitations

Can you mix LTC benefits?

All Florida Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, Florida enforces Estate Recovery. The acceptance of Medicaid in Florida creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (AARP, 1996; Fla. Stat. 409.9101, 2006; Fla. Stat. 409.9101, 2013).

Home Health Services

There is a $2.00 copayment per service per day unless the recipient is exempt (State Library of Florida, 1998; AHCA, 2005; FL Rules, 2013).

ICP

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 1998, the PNA was $35 per month (CGA OLR, 1998).

NHD

There are no copayments or similar charges imposed upon participants for program services.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2013-2023

Policy change in 2013

In 2013, Florida implemented the Statewide Medicaid Managed Care (SMMC) program with the aim of transitioning most of the Medicaid population to managed care. There are two components that make up the new managed care system: Managed Medical Assistance (MMA) and Statewide Medicaid Managed Care Long-Term Care (SMMC-LTC). Both provide services through a capitated managed care delivery system, but MMA provides state plan benefits (e.g., Home Health), while SMMC-LTC provides extended home-and community-based services (HCBS) and nursing facility care to individuals that require an institutional level of care. SMMC-LTC changed the way many individuals received LTC, as it replaced other HCBS programs including the Nursing Home Diversion (NHD) program, which was discontinued in 2014.

Additionally, Florida's authority to cover the Medicaid for the Aged or Disabled (MEDS-AD) population expired in 2017, but this population was covered under SMMC with no changes to their eligibility requirements (DOEA, 2021; Medicaid.gov, 2017; CMS, 2022).

Practically, the main change brought by SMMC was the managed care delivery system. Rather than through the traditional fee-for-service (FFS) system, beneficiaries enroll in managed care health plans to receive care. Under the managed care system, health plans authorize services, typically by using medical history and information from the enrollee's physician or other health care providers.

Medicaid recipients who qualify and become enrolled in the SMMC-LTC program will receive a variety of LTC services from their managed care health plan. Eligible beneficiaries must be at least age 65 or disabled, require a nursing facility level of care (NFLOC), and meet specific financial criteria in order to be admitted. However, meeting all eligibility criteria does not guarantee admission. The program limits the number of participants seeking HCBS, and applicants are placed on a waitlist according to level of care (priority rank) until a spot in the program becomes available. Individuals with a high priority rank will be notified of waitlist placement. Individuals with a low priority rank will be notified of ineligibility for waitlist placement and provided information on how to find community resources available to assist them. This process is detailed further in the *Evaluation of Dependence* section of this policy period.

Overview

Long-term care (LTC) benefits in Florida are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Florida is administered at the state level by the Agency for Health Care Administration (AHCA), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Florida are mostly provided through state plan benefit programs (Home Health Services, Institutional Care Program - ICP), or through federally approved home-and community-based services (HCBS) LTC programs (Statewide Medicaid Managed Care Long-Term Care - SMMC-LTC).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries that have established medical necessity, while the ICP only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the SMMC-LTC program are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC). Those applying for the SMMC-LTC program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a prioritized waiting list.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while ICP beneficiaries must either require intermediate care services or skilled nursing services before admission. SMMC-LTC beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2022)

Florida Law for Medicaid

- Fla. Admin. Code Division 59G - Medicaid (Fla. Admin. Code 59A-1.058, 2023)
- Fla. Stat. Title XXX - Social Welfare, Chapter 409 - Social and Economic Assistance (Fla. Stat. § 409.901-409.985, 2023)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Florida Medicaid spending on beneficiaries in fiscal year 2013 was 58.08%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (58.08% in 2013), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Florida Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Florida.

Eligibility for Medicaid in Florida for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients (Fla. Stat. 409.903, 2013)
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2013, the monthly federal benefit amount was $710 for an individual and $1,066 for a couple (SSA, 2013). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[13]
    - Home equity limit: The equity interest in the individual's home may not exceed $536,000, or else they will be ineligible for LTC services (Fla. Admin. Code 65A-1.712, 2013). This figure increases annually with inflation.[8]
  - Citizenship/immigration requirements: The applicant must be a Florida resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023) for additional information.

  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules (Fla. Stat. 409.904, 2013)
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 2013, this was $2,130 for an individual. Eligibility for this track is generally determined as a household of one. Couple limits only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized (or receiving HCBS, as of 2014) and has a spouse residing in the community.[14]
  - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized (or receiving HCBS, as of 2014) and has a spouse residing in the community.[15]
    - Asset transfer & Home equity limit: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be receiving nursing facility care through the Institutional Care Program (ICP), Florida's nursing home benefit, or HCBS through the Statewide Medicaid Managed Care-Long-Term Care (SMMC-LTC) program.
- 2b. Federal Poverty Level (FPL) aged and disabled (Fla. Stat. 409.904, 2013; CMS, 2022)
  - Income requirements: Monthly income may not exceed 88% of the FPL. In 2013, this was $843 for an individual and $1,138 for a household of two (Fla. Admin. Code 65A-1.712, 2013). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized (or receiving HCBS, as of 2014) and has a spouse residing in the community.[14]
  - Asset requirements: Resources may not exceed $5,000 for an individual and $6,000 for a household of two (Fla. Admin. Code 65A-1.716, 2012). Additional asset disregards exist if a person is institutionalized (or receiving HCBS, as of 2014) and has a spouse residing in the community.[15]
    - Asset transfer and Home Equity Limit: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]
    - The applicant must be ineligible for Medicare OR eligible for Medicare and receiving HCBS, hospice, or institutional care services.

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Medically Needy: Florida provides month-to-month Medicaid coverage for older adults that meet eligibility requirements of other tracks except for excess income and assets. To qualify for medically needy coverage, the individual must be at least age 65, blind, or disabled, and spend down their income on a monthly basis to meet the income limit of $180.00 for an individual and $241.00 for a couple. This track is not included as a main eligibility track because medically needy beneficiaries are not eligible for long-term care services in Florida (NLM, 1988; State Library of Florida, 1993; Fla. Admin. Code 59A-1.058, 2023).
- Medicaid Cancer Treatment Program: Optional coverage is provided for individuals with breast and cervical cancer. Coverage is limited only for the duration of the individual's treatment (Fla. Admin. Code 65A-1.711, 2006).
- Hospice Program: Individuals with a terminal illness and written medical prognosis of six months or less to live if the illness runs its normal course may be eligible for hospice care if their income and resources are within the ICP limits (Fla. Admin. Code 65A-1.716, 2006).

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Institutional Care Program (ICP)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or age 18-64 and physically disabled.

SMMC-LTC
Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or 18-64 disabled. If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available.

Other community-based programs
There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Aged and Disabled Adult (ADA) Program —phased out by 2014
- Assisted Living for the Elderly Program —phased out by 2014
- Assistive Care Services
- Program of All-Inclusive Care for the Elderly (PACE)
- Consumer Directed Care Plus (CDC+) Program
- Nursing Home Diversion Program —phased out by 2014
- Traumatic Brain Injury (TBI) and Spinal Cord Injury Program —expired in 2022

Benefit

Home care benefit

Home Health Services
Home Health provides (FSU, 1991; AHCA, 2005; FL Rules, 2013):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Medicaid reimbursement for home health services is limited for non-pregnant adults to three visits per day by registered nurses, licensed practical nurses, and home health aides (AHCA, 2012).

ICP
The ICP does not provide home care during this policy period.

SMMC-LTC
SMMC-LTC provides the following services in addition to those offered under the state plan, unless otherwise noted (UHC Community Plan, 2013):

- Adult companion services: Activities necessary to assist the recipient in performing household or personal tasks and providing social stimulation to relieve the negative effects of loneliness and isolation
- Personal care services[16]
  - Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Home health services (as described above under the state plan)
- Attendant care: Nursing services and medical assistance provided in the home to help manage or recover from a medical condition, illness, or injury
- Medication administration: Help taking medications if they cannot take themselves

Semi-residential care

Home Health Services, ICP
These programs do not provide semi-residential care during this policy period.

SMMC-LTC
SMMC-LTC includes Adult Day Health Care. Recipients receive daytime supervision and personal care assistance in a group setting. It may also include meals if the individual is present during mealtimes (UHC Community Plan, 2013) .

Residential care

Home Health Services

Home Health does not provide residential care during this policy period.

ICP

The ICP covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (FSU, 1991; AHCA, 2005; AHCA, 2012). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

SMMC-LTC

SMMC-LTC provides nursing facility services as detailed above for the ICP.

Other benefits

Florida Medicaid provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services (AHCA, 2005)
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy (AHCA, 2005)

SMMC-LTC

SMMC-LTC provides the following services in addition to those offered under the state plan, unless otherwise noted (UHC Community Plan, 2013):

- Case Management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Family training: Training and counseling services provided to the families of enrollees, including instruction and updates about treatment regimens and use of equipment specified in the plan of care to safely maintain the enrollee at home
- Environmental accessibility and adaptation: Physical adaptations made to the home to allow the enrollee to function with greater independence in the home and without which the enrollee would require institutionalization, including the installation of ramps and grab-bars, widening of doorways, or modification of bathroom facilities
- Home-delivered meals: Delivers healthy meals to the beneficiary's home
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite care: Short-term relief provided to an enrollee's caregiver provided in the home/place of residence, Medicaid licensed hospital, nursing facility, or ALF
- Hospice: Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free —support services are also available for family members and caregivers.
- Nutritional assessment/Risk reduction: Education and support about diets

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Florida Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Medicaid covers home health services that are medically necessary when the applicant is certified as homebound. This means that either leaving the home is medically unwise or the Medicaid recipient is unable to leave home without the assistance of another person (HRS, 1989; State Library of Florida, 1998; AHCA, 2005; FL Rules, 2013).

ICP

To qualify for placement in a nursing facility, the applicant or recipient must require intermediate care services or skilled nursing services including 24-hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and services provided in a hospital (Fla. Admin. Code 59G-4.180, 1995; Fla. Admin. Code 59G-4.290, 1995; Fla. Admin. Code 65A-1.711, 2006; Fla. Admin. Code 65A-1.711, 2008).

SMMC-LTC

To be eligible for the SMMC-LTC program, beneficiaries must meet an NFLOC.

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (KFF, 2002).

Home Health Services

Services must be ordered by a physician and accompany a written plan of care. The physician must certify the applicant's homebound status and review the written plan of care every 60 days (HRS, 1989; 42 CFR 440.70, 1998; AHCA, 2012; FL Rules, 2013).

ICP

Each resident admitted to a nursing facility must be reassessed for medical eligibility every 12 months, and the assessment shall be reviewed every 3 months or after a significant change in the resident's physical or mental condition (Fla. Admin. Code 59A-4.109, 1995).

SMMC-LTC

Participants must be reassessed every 12 months.

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services

There is no age requirement.

ICP

Individuals must be at least age 65, blind, or disabled.

SMMC-LTC

Individuals must be at least age 65, or age 18-64 and disabled (Fla. Stat. 409.979, 2013).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Services are provided when medically necessary and when the applicant is certified as homebound, meaning either leaving the home is medically unwise or the Medicaid recipient is unable to leave home without the assistance of another person (HRS, 1989; State Library of Florida, 1993; State Library of Florida, 1998; AHCA, 2005). Medically necessary home health services means that the services are required and reasonable to the treatment of a documented illness, injury, or condition (HRS, 1989; Fla. Stat. 409.9131, 2006; FL Rules, 2013).

ICP

To qualify for placement in a nursing facility, the applicant or recipient must require intermediate care services or skilled nursing services including 24 hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and services provided in a hospital (Fla. Admin. Code 59G-4.180, 1995; Fla. Admin. Code 59G-4.290, 1995; Fla. Admin. Code 65A-1.711, 2008). See Box 4 for additional information on these levels of care.

SMMC-LTC

There are different definitions of dependence for each step in the evaluation process (screening, physician's order, and comprehensive assessment). Here we detail the dependence levels and definitions for each step.

The initial screening results in a priority score, a numerical value that determines the applicant's placement on the enrollment waitlist. A higher score corresponds to a higher level of need, and typically a higher position on the waitlist. Priority scores are grouped into dependence-based levels or categories (referred to as "ranks") (Fla. Admin. Code 59G-4.193, 2016). See Box 7 for additional information on ranks.

Upon release from the waitlist, applicants must submit a completed and signed Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (Form 5000-3008). The applicant must have their medical provider (Florida licensed physician, Advanced Practice Registered Nurse, or Physician Assistant) complete the form, where they will describe the applicant's need for services and other relevant health information.

Finally, the applicant must be determined medically eligible for the program through the 701B Comprehensive Assessment form. An NFLOC must be achieved in order to be eligible. An applicant meeting an NFLOC can fall into 3 levels, all of which meet the eligibility requirements for the program (Fla. Stat. 409.985, 2013). See Box 8 for definitions of each of the three levels.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Individuals must have a written physician's order from the treating or attending physician that describes all of the following (42 CFR 484.18, 1998; ACHA, 2012; FL Rules, 2013):

- Recipient's acute or chronic medical condition or diagnosis that causes a recipient to need home health care.
- Documentation regarding the medical necessity for the service(s) to be provided at home.
- Home health services needed.
- Frequency and duration of the needed services.
- Minimum skill level (nurse, home health aide) of staff who can provide the services.

Following the physician's order, a plan of care will be created. Once the physician approves and signs the plan of care, services will be authorized.

ICP

Nursing facility services must be ordered by and provided under the direction of a licensed physician (FSU, 1991). Before admission to the program, all beneficiaries are evaluated by the Comprehensive Assessment and Review for Long-Term Care Services (CARES) unit at the Florida Department of Elder Affairs. The CARES 701T assessment, a shortened assessment based off the 701B used in previous years and other programs, evaluates the individual's cognitive, emotional, social, and health status (including ability to perform ADLs) to determine their needs. See Box 5 for a list of assessment sections. The completed assessment will indicate whether the individual requires intermediate care or skilled nursing services that are available in a nursing facility.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 1 for more information on the PASRR, and Box 2 for the MDS.

SMMC-LTC

In order to determine an applicant's level of dependence, the applicant and/or caregiver must first complete a screening with the Aging and Disability Resource Center (AHCA, 2023). The Screener uses the 701S Screening Form.

The screening interview covers basic demographic information as well as their income and assets. The interview mostly asks about the applicant's needs for care, including their ability to perform activities of daily living (ADLs). To view the full screening interview form, see DOEA (2013).

The screening results in a priority score, a numerical value that determines the applicant's placement on the enrollment waitlist. The score is calculated by adding or subtracting specific values based on answers to the screening form. See Box 6 for an example screening question and possible point responses. Depending on the applicant's final priority score, their place on the waitlist will be determined.

Upon release from the waitlist, the applicant will be notified of the requirement to submit a completed and signed Form 5000-3008. This form must be completed and returned to the Department of Elder Affairs (DOEA) within 30 calendar days of notice.

Finally, the DOEA will contact the applicant to determine clinical eligibility for the program. See Box 3 for a list of 701B assessment sections.

Following the assessment, a level of care determination is made. If the individual meets an NFLOC, they will be medically eligible for the SMMC-LTC program.

Evaluators

Evaluators vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician must order home health services, develop the plan of care, and periodically review the plan of care (FSU, 1991; AHCA, 2012; FL Rules, 2013).

ICP

Nursing facility services must be ordered by a licensed physician (FSU, 1991; Fla. Stat. 409.905, 1998. The CARES assessment must be administered by a registered nurse and social worker (OASM, 1989; AHCA, 2002; Lambert, 2004, p. 23).

SMMC-LTC

The CARES assessment must be administered by a registered nurse and social worker (AHCA, 2002).

Benefit limitations

Can you mix LTC benefits?

All Florida Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, Florida enforces Estate Recovery. The acceptance of Medicaid in Florida creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (AARP, 1996; Fla. Stat. 409.9101, 2006; Fla. Stat. 409.9101, 2013).

Home Health Services

There is a $2.00 copayment per service per day unless the recipient is exempt (State Library of Florida, 1998; AHCA, 2005; FL Rules, 2013).

ICP

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 2013, the PNA was $35 per month. In 2014, the PNA was raised to $105/month, and in 2018, it was raised to $130/month where it remains (Edwards Elder Law, 2014; DHC Law, 2018).

SMMC-LTC

There are no copayments or similar charges imposed upon participants for program services (AHCA, 2022).

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Florida Federal Medical Assistance Percentage (FMAP) for Medicaid

Fiscal Year	FMAP
1992	54.69%
1993	55.03
1994	54.78
1995	56.28
1996	55.76
1997	55.79
1998	55.65
1999	55.82
2000	56.52
2001	56.62
2002	56.43
2003	60.31
2004	61.14
2005	58.90
2006	58.89
2007	58.76
2008	56.83
2009	67.64
2010	67.64
2011	62.59
2012	56.04
2013	58.08
2014	58.79
2015	59.72
2016	60.67
2017	61.10
2018	61.79
2019	60.87
2020	66.12
2021	68.16
2022	67.23
2023[1]	65.03

Source: U.S. DHHS (2022)

Notes: FMAPs displayed apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period. [1] The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Table 2: Historical Florida Medicaid Income Limits

Year	SSI (Individual)	SSI (Couple)	300% SSI (Individual)	300% SSI (Couple)	100% FPL (Individual)	100% FPL (Couple)
1992	$422.00	$633.00	$1,266.00	$1899.00	$568.00	$766.00
1993	434.00	652.00	1,302.00	1,956.00	581.00	786.00
1994	446.00	669.00	1,338.00	2,007.00	614.00	820.00
1995	458.00	687.00	1,374.00	2,061.00	623.00	836.00
1996	470.00	705.00	1,410.00	2,115.00	645.00	864.00
1997	484.00	726.00	1,452.00	2,178.00	658.00	885.00
1998	494.00	741.00	1,482.00	2,223.00	671.00	905.00
1999	500.00	751.00	1,500.00	2,253.00	687.00	922.00
2000	513.00	769.00	1,539.00	2,307.00	696.00	938.00
2001	531.00	796.00	1,593.00	2,388.00	716.00	968.00
2002	545.00	817.00	1,635.00	2,451.00	739.00	995.00
2003	552.00	829.00	1,656.00	2,487.00	749.00	1,010.00
2004	564.00	846.00	1,692.00	2,538.00	776.00	1,041.00
2005	579.00	869.00	1,737.00	2,607.00	798.00	1,070.00
2006	603.00	904.00	1,809.00	2,712.00	817.00	1,100.00
2007	623.00	934.00	1,869.00	2,802.00	851.00	1,141.00
2008	637.00	956.00	1,911.00	2,868.00	867.00	1,167.00
2009	674.00	1,011.00	2,022.00	3,033.00	903.00	1,215.00
2010	674.00	1,011.00	2,022.00	3,033.00	903.00	1,215.00
2011	674.00	1,011.00	2,022.00	3,033.00	908.00	1,226.00
2012	698.00	1,048.00	2,094.00	3,144.00	931.00	1,261.00
2013	710.00	1,066.00	2,130.00	3,198.00	958.00	1,293.00
2014	721.00	1,082.00	2,163.00	3,246.00	973.00	1,311.00
2015	733.00	1,100.00	2,199.00	3,300.00	981.00	1,328.00
2016	733.00	1,100.00	2,199.00	3,300.00	990.00	1,335.00
2017	735.00	1,103.00	2,205.00	3,309.00	1,005.00	1,354.00
2018	750.00	1,125.00	2,250.00	3,375.00	1,012.00	1,372.00
2019	771.00	1,157.00	2,313.00	3,471.00	1,041.00	1,410.00
2020	783.00	1,175.00	2,349.00	3,525.00	1,064.00	1,437.00
2021	794.00	1,191.00	2,382.00	3,573.00	1,074.00	1,452.00
2022	841.00	1,261.00	2,523.00	3,783.00	1,133.00	1,526.00
2023	914.00	1,371.00	2,742.00	4,113.00	1,215.00	1,643.00

Source: SSA (2022)

Notes: Supplemental Security Income (SSI) and federal poverty level (FPL) amounts for individuals and couples are monthly.

Box 1: Preadmission Screening and Resident Review (PASRR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR). The purpose of PASRR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level 1 screening), and a final determination. All applicants of Medicaid certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASRR evaluation.

PASRRs were required on an annual basis until 1996, when the annual requirement was removed. Some states continue to conduct PASRRs on an annual basis.

Source: 42 CFR 483.100-138

Box 2: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: UCSF (2023)

Box 3: 701B Comprehensive Assessment Form Sections (2013-2023)

The assessment includes the following sections:

1. Demographic information (e.g., marital status, ethnicity, current location)
2. Memory (e.g., diagnoses of dementia, recollection exercises)
3. General health, sensory, and communication (e.g., ability to climb stairs, diagnoses of hearing issues)
4. ADL assessment of assistance required and assistance currently received
5. IADL assessment of assistance required and assistance currently received
6. Health conditions and therapies (e.g., allergies, anemia, dialysis, ostomy)
7. Mental health (e.g., satisfaction with life, poor appetite, feeling depressed)
8. Residential living environment (e.g., residence issues, pets, living conditions level of risk)
9. Nutrition (e.g., dietary restrictions, fluid intake)
10. Medications and substance use
11. Social resources (e.g., informal caregivers, social connections)
12. Caregiver information, if available (e.g., availability, relationship, residence)

Source: DOEA (2013).

Box 4: Institutional Care Program Level of Care Definitions (1998-2005)

To be classified as an intermediate care or skilled nursing service, the service must be:

1. Ordered by and remain under the supervision of a physician
2. Medically necessary and provided to an applicant or recipient whose health status and medical needs are of sufficient seriousness as to require nursing management, periodic assessment, planning or intervention by licensed nursing or other health professionals
3. Required to be performed under the supervision of licensed nursing or other health professionals
4. Necessary to achieve the medically desired results and to ensure the comfort and safety of the applicant or recipient
5. Required on a daily or intermittent basis
6. Reasonable and necessary to the treatment of a specific documented medical disorder, disease or impairment
7. Consistent with the nature and severity of the individual's condition or the disease state or stage

Intermediate care services fall into two levels of care:

- Intermediate Care Level I: Extensive health-related care and service required by an individual who is incapacitated mentally or physically (e.g., administration of routine or stabilized dosages of oral medication, eye drops, or ointments, routine oral suctioning).
- Intermediate Care Level II: Limited health-related care and services required by an individual who is mildly incapacitated or ill to a degree to require medical supervision (e.g., assistance with ADLs such as eating, dressing, or bathing, assistance with colostomy care, routine measurement and recording of vital signs). Individuals requiring this level of care shall:
    1. Be ambulatory, with or without assistive devices
    2. Demonstrate independence in ADLs
    3. Not require the administration of psychotropic drugs on a daily or intermittent basis or exhibit periods of disruptive or disorganized behavior requiring 24-hour nursing supervision
    4. Require the constant availability of medical and nursing treatment and care on a routine basis

Source: Fla. Admin. Code 65A-1.711 (2008); Fla. Admin. Code 59G-4.180 (1995); Fla. Admin. Code 59G-4.290 (1995)

Box 5: 701T Non-Community Placement Assessment Form Sections (2013-2023)

The 701T assessment includes the following sections (DOEA, 2013):

1. Demographic information (e.g., marital status, ethnicity, current location)
2. Memory (e.g., diagnoses of dementia, recollection exercises)
3. General health (e.g., times fallen, emergency room visits)
4. ADL assessment of assistance required
5. IADL assessment of assistance required
6. Health conditions and therapies (e.g., allergies, anemia, dialysis, ostomy)
7. Mental health (e.g., satisfaction with life, poor appetite, feeling depressed)
8. Nutrition (e.g., dietary restrictions, weight gained or lost)
9. Medications

Source: DOEA (2013)

Box 6: SMMC-LTC Priority Score Example Question (2013-2023)

Question: "How much assistance does the client require to bathe?" Possible answers and corresponding point values are as follows:

- No assistance needed: 0 points
- Uses assistive device: +1 point
- Needs supervision or prompt: +2 points
- Needs assistance, but not total help: +3 points
- Needs total assistance (cannot do at all): +5 points

An example of subtracting points can be demonstrated through the question "When the client needs medical care, how often do they get it?" The possible answers are as follows:

- Always: -2 points
- Most of the time: -1 point
- Rarely, only in an emergency, or never: 0 points

Source: DOEA (2014)

Box 7: SMMC-LTC Priority Score Ranks (2013-2023)

1. Rank 1: 0-15
2. Rank 2: 16-29
3. Rank 3: 30-39.
4. Rank 4: 40-45.
5. Rank 5: Greater than or equal to 46
6. Rank 6: Aging Out Referral - categorical code for an individual who has reached the maximum age for disabled adult care and is referred for screening and prioritization for the LTC program
7. Rank 7: Imminent Risk - when individuals living in their home or community meet all of the following:
    - Unable to perform self-care because of deteriorating mental or physical health condition(s)
    - There is no capable caregiver
    - Placement in a nursing facility is likely within a month, or very likely within three months
8. Rank 8: Adult Protective Services High Risk Referral

Source: Fla. Admin. Code 59G-4.193 (2016)

Box 8: SMMC-LTC Level of Care Definitions (2013-2023)

- Level of Care 1: Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and care required to be performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care professional. The individual also requires services that are sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse because of a mental or physical incapacitation.
- Level of Care 2: Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment. The individual also requires services on a daily or intermittent basis that are to be performed under the supervision of licensed nursing or other health professionals because the individual is incapacitated mentally or physically.
- Level of Care 3: Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment. The individual also requires limited services that are to be performed under the supervision of licensed nursing or other health professionals because the individual is mildly incapacitated mentally or physically.

Source: Fla. Stat. 409.985 (2013)

Sources

This section records key sources consulted when we collected the institutional details reported in this document. Archived versions of these sources are available at the Gateway Policy Explorer website (http://g2aging.org/app/policy-explorer).

AARP (1996). Questions and Answers on Medicaid Estate Recovery for Long-Term Care Under OBRA '93. As of February 9, 2023. [Link]

Agency for Health Care Administration (2002). Florida Medicaid Summary of Services 2002. As of April 19, 2023. [Link]

Agency for Health Care Administration (2005). Florida Medicaid Summary of Services 2005-2006. As of April 19, 2023. [Link]

Agency for Health Care Administration (2012). Attachment 3.1-A - Home Health Services. As of April 11, 2023. [Link]

Agency for Health Care Administration (2012). Florida Medicaid Summary of Services 2012-2013. As of April 19, 2023. [Link]

Agency for Health Care Administration (2017). Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy. As of January 25, 2023. [Link]

Agency for Health Care Administration (2021). 59G-4.193 Statewide Medicaid Managed Care Long-term Care Waiver Program Prioritization and Enrollment. As of January 25, 2023. [Link]

Agency for Health Care Administration (2022). Application for 1915(c) HCBS Waiver: FL.0962.R02.00 - Apr 01, 2022. As of January 30, 2023. [Link]

Agency for Health Care Administration (2023). Become Eligible for Medicaid. As of January 25, 2023. [Link]

Agency for Health Care Administration (2023). CARES. Assessment of Long-Term Care Needs. As of January 25, 2023. [Link]

Agency for Health Care Administration (2023). Find Out About Long-Term Care Services. As of January 25, 2023. [Link]

Agency for Health Care Administration (2023). Florida Medicaid's Covered Services and HCBS Waivers. As of January 25, 2023. [Link]

Agency for Health Care Administration (2023). Statewide Medicaid Managed Care Long-Term Care Program - Screening. As of January 25, 2023. [Link]

Agency for Health Care Administration (2023). Statewide Medicaid Managed Care Long-Term Care Program Waitlist Release. As of January 25, 2023. [Link]

Agency for Health Care Administration (2023). Who Can Receive Long-Term Care Services. As of January 25, 2023. [Link]

ASPE Office of the. Assistant Secretary for Planning and Evaluation (2011). Federal Percentages and Federal Medical Assistance Percentages, FY 1961 - FY 2011. As of January 30, 2023. [Link]

Centers for Medicare and Medicaid Services (2017). Florida MEDS-AD Waiver Amendment Request. As of August 8, 2023. [Link]

Centers for Medicare and Medicaid Services (2021). Implementation Guide: Medicaid State Plan Eligibility Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules. As of September 6, 2023. [Link]

Centers for Medicare and Medicaid Services (2022). Florida Managed Medical Assistance. As of August 8, 2023. [Link]

Code of Federal Regulations (1998). 42 CFR 440.70 Home Health Services. As of April 11, 2023. [Link]

Code of Federal Regulations (1998). 42 CFR 484.18 Condition of participation: Acceptance of patients, plan of care, and medical supervision. As of April 11, 2023. [Link]

Code of Federal Regulations (2012). 42 CFR § 483.100-138. As of August 16, 2023. [Link]

Congress.gov (2005). The Deficit Reduction Act of 2005. As of May 5, 2023. [Link]

Connect General. Assembly Office of Legislative Resarch (1998). OLR Research Report: 1998 PNA For Medicaid Recipients in Nursing Homes in the 50 States and the District of Columbia. As of February 9, 2023. [Link]

Davidow, Davidow, Siegel and Stern, LLP (2006). Medicaid Management: 2006 Figures. As of February 6, 2023. [Link]

Department of Children and Families (2022). SSI-Related Medicaid Fact Sheet. As of January 25, 2023. [Link]

Department of Children and Families (2023). SSI-Related Medicaid Coverage Groups Financial Eligibility Standards: January 2023. As of January 25, 2023. [Link]

Department of Elder Affairs (2005). Preparing for the End of the MEDS-AD Program. As of February 6, 2023. [Link]

Department of Elder Affairs (2008). DOEA. Assessment Instrument Form 701B. As of February 9, 2023. [Link]

Department of Elder Affairs (2013). 701B Comprehensive. Assessment Form. As of January 25, 2023. [Link]

Department of Elder Affairs (2013). 701S Screening Form. As of January 25, 2023. [Link]

Department of Elder Affairs (2013). 701T Non-Community Placement. Assessment. As of January 30, 2023. [Link]

Department of Elder Affairs (2014). Priority Score Calculation. As of January 25, 2023. [Link]

Department of Elder Affairs (2021). Statewide Medicaid Managed Care Long-Term Care Program. As of January 25, 2023. [Link]

Department of Health and Rehabilitative Services (1989). Medicaid Provider Handbook Home Health Services. As of July 10, 2023. [Link]

Department of Health and Rehabilitative Services (1992). Medicaid Handbook Update Nursing Home Services Handbook. As of July 10, 2023. [Link]

DHC Law (2014). Florida Personal Needs Allowance Raise. As of January 27, 2023. [Link]

Edwards Elder Law (2014). Florida Medicaid Increases the Personal Needs Allowance. As of January 27, 2023. [Link]

FL Rules (2013). Florida Medicaid Home Health Services Coverage and Limitations Handbook, March 2013. As of January 31, 2023. [Link]

Florida Administrative Code (1995). 59A-4.109 Resident. Assessment and Care Plan. As of January 30, 2023. [Link]

Florida Administrative Code (1995). 59G-4.180: Intermediate Care Services. As of January 27, 2023. [Link]

Florida Administrative Code (1995). 59G-4.290: Skilled Services. As of January 27, 2023. [Link]

Florida Administrative Code (2005). 59G-13.080 Home and Community-Based Services Waivers. As of February 6, 2023. [Link]

Florida Administrative Code (2006). 65A-1.710 SSI-Related Medicaid Coverage Groups. As of February 6, 2023. [Link]

Florida Administrative Code (2006). 65A-1.711: SSI-related Medicaid Non-Financial Eligibility Criteria. As of February 3, 2023. [Link]

Florida Administrative Code (2006). 65A-1.713 SSI-Related Medicaid Income Eligibility Criteria. As of February 6, 2023. [Link]

Florida Administrative Code (2006). 65A-1.716 Income and Resource Criteria. As of February 6, 2023. [Link]

Florida Administrative Code (2007). 65A-1.712 SSI-Related Medicaid Resource Eligibility Criteria. As of February 6, 2023. [Link]

Florida Administrative Code (2008). 58A-1 Notice of Change. As of February 9, 2023. [Link]

Florida Administrative Code (2008). 65A-1.711: SSI-related Medicaid Non-Financial Eligibility Criteria. As of January 27, 2023. [Link]

Florida Administrative Code (2008). 65A-1.713: SSI-related Medicaid Income Eligibility Criteria. As of January 26, 2023. [Link]

Florida Administrative Code (2012). 65A-1.716 Income and Resource Criteria. As of January 31, 2023. [Link]

Florida Administrative Code (2013). 65A-1.712: SSI-related Medicaid Resource Eligibility Criteria. As of January 26, 2023. [Link]

Florida Administrative Code (2016). 59G-4.193 Statewide Medicaid Managed Care Long-term Care Waiver Program Prioritization and Enrollment. As of January 30, 2023. [Link]

Florida Administrative Code (2023). 59G-1.058 Eligibility. As of May 16, 2023. [Link]

Florida Senate (2003). Model Florida LongTerm Care System/Analyzing Long-Term Care Initiatives in Florida. As of August 14, 2023. [Link]

Florida State University (1991). Title XXX Ch. 409 Social and Economic Assistance. As of April 4, 2023. [Link]

Kaiser Family Foundation (1999). Medicaid Eligibility for the Elderly. As of February 8, 2023. [Link]

Kaiser Family Foundation (2002). The Medicaid Resource Book. As of February 8, 2023. [Link]

Kaiser Family Foundation (2006). Medicaid Long-Term Services Reforms in the Deficit Reduction Act. As of February 6, 2023. [Link]

Kaiser Family Foundation (2023). Federal Medical. Assistance Percentage (FMAP) for Medicaid and Multiplier. As of January 30, 2023. [Link]

Lambert, J. (2004). Long-Term Care in Florida: home and community-based services. As of February 6, 2023. [Link]

LTC Ombudsman (2010). Appendix 1: Nursing Home Personal Needs Allowance by State and Year. As of February 3, 2023. [Link]

Medicaid.gov (2011). Florida Nursing Home Diversion. As of February 1, 2023. [Link]

Medicaid.gov (2017). Florida MEDS-AD Waiver Amendment Request. As of January 31, 2023. [Link]

Medicaid.gov (2018). Florida MEDS-AD Section 1115 Demonstration Fact Sheet. As of February 3, 2023. [Link]

Mitchell, G., Salmon, J., Polivka, L., & Soberon-Ferrer, H. (2004). The Relative Benefits and Cost of Medicaid Home- and Community-Based Services in Florida. As of February 7, 2023. [Link]

National Library of Medicine (1988). Medicaid eligibility for persons in nursing homes. As of February 10, 2023. [Link]

National Library of Medicine (2000). Medicaid Financial Eligibility for Older People: State Variations in Access To Home and Community-Based Waiver and Nursing Home Services. As of February 8, 2023. [Link]

Office of Program Policy Analysis and Government Accountability (OPPAGA) (2006). Service Use for Nursing Home Diversion Waiver Clients Depends on Living Situation. As of February 6, 2023. [Link]

Office of Program Policy Analysis and Government Accountability (OPPAGA) (2006). The Nursing Home Diversion Program Has Successfully Delayed Nursing Home Entry. As of February 3, 2023. [Link]

Office of the. Assistant Secretary for Medicaid (1989). The Florida Medicaid Program - An Overview. As of April 12, 2023. [Link]

Office of the. Assistant Secretary for Planning and Evaluation (1996). The Personal Responsibility and Work Opportunity Reconciliation Act of 1996. As of May 9, 2023. [Link]

Office of the. Assistant Secretary for Planning and Evaluation (ASPE) (1998). 1998 HHS Poverty Guidelines. As of February 8, 2023. [Link]

Office of the. Assistant Secretary for Planning and Evaluation (ASPE) (2003). Using Medicaid to Cover Services for Elderly Persons in Residential Care Settings: State Policy Maker and Stakeholder Views in Six States. As of February 6, 2023. [Link]

Social Security Administration (1998). Noncitizens and the Supplemental Security Income Program. As of March 28, 2023. [Link]

Social Security Administration (2006). Annual Statistical Supplement, 2006. As of February 6, 2023. [Link]

Social Security Administration (2011). State Assistance Programs for SSI Recipients. As of August 22, 2023. [Link]

Social Security Administration (2013). Annual Statistical Supplement, 2013. As of January 26, 2023. [Link]

Social Security Administration (2023). SSI Federal Payment Amounts 1975-2023. As of February 8, 2023. [Link]

Social Security Administration (2023). Supplemental Security Income (SSI) for Noncitizens. As of May 9, 2023. [Link]

Social Security Administration (2023). Title XIX: Grants to States for Medical. Assistance Programs. As of March 16, 2023. [Link]

Social Security Administration (2023). Understanding Supplemental Security Income SSI Eligibility Requirements. As of August 8, 2023. [Link]

State Library of Florida (1993). Florida Medicaid Program Summary of Services. As of April 12, 2023. [Link]

State Library of Florida (1998). Florida Medicaid Program Summary of Services. As of April 12, 2023. [Link]

Statewide Medicaid Managed Care (2023). Health Plans and Program. As of January 25, 2023. [Link]

Tampa Bay Times (1992). Widow should apply for homestead exemption. As of February 10, 2023. [Link]

The Florida Legislature (1998). The 1998 Florida Statues: 409.903 - Mandatory payments for eligible persons. As of February 8, 2023. [Link]

The Florida Legislature (1998). The 1998 Florida Statues: 409.904 - Optional payments for eligible persons. As of February 8, 2023. [Link]

The Florida Legislature (1998). The 1998 Florida Statues: 409.905 - Mandatory Medicaid Services. As of April 4, 2023. [Link]

The Florida Legislature (2001). The 2001 Florida Statutes: 381.93 - Breast and Cervical Cancer Early Detection Program. As of May 5, 2023. [Link]

The Florida Legislature (2002). The 2002 Florida Statues: 409.904 - Optional payments for eligible persons. As of August 8, 2023. [Link]

The Florida Legislature (2006). The 2006 Florida Statues: 409.905 - Mandatory Medicaid services. As of February 3, 2023. [Link]

The Florida Legislature (2006). The 2006 Florida Statues: 409.906 - Optional Medicaid services. As of February 3, 2023. [Link]

The Florida Legislature (2006). The 2006 Florida Statutes: 409.903 - Mandatory payments for eligible persons. As of May 5, 2023. [Link]

The Florida Legislature (2006). The 2006 Florida Statutes: 409.904 - Optional payments for eligible persons. As of May 5, 2023. [Link]

The Florida Legislature (2006). The 2006 Florida Statutes: 409.9081 - Copayments. As of February 3, 2023. [Link]

The Florida Legislature (2006). The 2006 Florida Statutes: 409.9101 - Recovery for payments made on behalf of Medicaid-eligible persons. As of February 3, 2023. [Link]

The Florida Legislature (2006). The 2006 Florida Statutes: 409.9131 - Special provisions relating to the integrity of the Medicaid program. As of April 19, 2023. [Link]

The Florida Legislature (2013). The 2013 Florida Statutes: 409.903 - Mandatory payments for eligible persons. As of May 5, 2023. [Link]

The Florida Legislature (2013). The 2013 Florida Statutes: 409.904 - Optional payments for eligible persons. As of January 31, 2023. [Link]

The Florida Legislature (2013). The 2013 Florida Statutes: 409.9101 - Recovery for payments made on behalf of Medicaid-eligible persons. As of January 30, 2023. [Link]

The Florida Legislature (2013). The 2013 Florida Statutes: 409.979 - Eligibility. As of January 25, 2023. [Link]

The Florida Legislature (2013). The 2013 Florida Statutes: 409.985. As of January 25, 2023. [Link]

The Florida Legislature (2022). Fla. Stat. Title XXX - Social Welfare, Chapter 409 - Social and Economic Assistance. As of August 11, 2023. [Link]

The New York Times (2006). New Medicaid Rules on Home Ownership. As of February 8, 2023. [Link]

U.S. Department of Health and Human Services (2022). State Federal Medical Assistance Percentages. As of August 29, 2023. [Link]

UHC Community Plan (2013). A Snapshot of the Florida Medicaid Long-term Care Program. As of January 25, 2023. [Link]

University of California San Francisco (2023). Minimum Data Set (MDS) Data. As of March 30, 2023. [Link]

Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

701B Comprehensive Assessment Form: Florida's comprehensive assessment that is administered face-to-face to assess all case-managed clients regardless of the program in which they are enrolled.

701S Screening Form: Florida's form administered over the telephone as the initial screening of applicants for long-term care programs. It is also used as an enrollment management tool to re-screen individuals who are on a waiting list and not active in any program.

701T Assessment Form: Florida's shortened assessment instrument for use by CARES staff for individuals residing in a nursing facility with no intent to return to the community or for individuals residing in the community intending to enter the nursing facility.

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Adult Day Health Care (ADHC): A community-based long-term care program that provides comprehensive health care services in a congregate day setting. Services include nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine or daily basis. Services are provided according to the assessed needs of the beneficiary.

Adult Family Care Home (AFCH): Private residences that provide a home-like environment for older adults that require some assistance.

Agency for Health Care Administration (AHCA): Florida's state-level agency that administers the state Medicaid program.

Assisted Living Facility (ALF): Personalized care in a residential setting but not to the level of care received in a nursing facility.

Capitation: A payment arrangement for health care services where an entity (e.g., a managed care organization - MCO) receives a risk adjusted amount of money for each Medicaid beneficiary enrolled in the plan. States typically pay MCOs for managed care services through fixed, periodic payments (capitation payments) for a defined package of benefits.

Community Spouse Resource Allowance (CSRA): Amount of disregarded assets for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care.

Comprehensive Assessment and Review for Long-Term Care Services (CARES): Florida's state unit responsible for determining medical eligibility (level of care) for home-and community-based Medicaid programs and nursing facility services.

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that generally automatically results in Medicaid coverage for individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with low income and assets.

Eligibility Track 2a. Institutional Rules: Optional coverage group under Medicaid that allows for expanded income limits, up to 300 percent of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

Eligibility Track 2b. Federal Poverty Level (FPL) Aged and Disabled: Optional coverage group under Medicaid that allows for expanded income limits, up to 100 percent of the federal poverty level, for individuals that are at least age 65 or disabled.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals

age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent.

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The FPL is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility.

Fee-for-service (FFS): A health care delivery system where providers are paid for each service performed. This was the primary system of providing Medicaid-covered services before managed care systems entered widespread use.

Home and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes and in lieu of nursing home admission.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Medicaid mandatory health benefit program that provides services in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Institutional Care Program (ICP): Florida's health benefit program that covers 365 days of all-inclusive nursing facility services, per year, per recipient if the applicant meets certain financial and medical eligibility criteria.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Intermediate Care Services: Extensive health-related care and service required by an individual who is incapacitated mentally or physically. Examples include administration of routine or stabilized dosages of oral medication, eye drops or ointments or routine administration of intramuscular or subcutaneous medication and observation of the individual's response and side effects.

Managed Care: A health care delivery system organized to manage cost, utilization, and quality. Under Medicaid, managed care provides for the delivery of state plan services and HCBS through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

Managed Medical Assistance (MMA): A plan type under Florida's Statewide Medicaid Managed Care system. MMA provides Medicaid covered medical services like doctor visits, hospital care, prescribed drugs, mental health care, and transportation to these services. Most people on Florida Medicaid will receive their care from a plan that covers MMA services.

Mandatory Categorically Needy: Groups that states are required to cover through Medicaid, which include low-income families, pregnant women, low-income children, and individuals receiving Supplemental Security Income (SSI).

Medicaid for the Aged or Disabled (MEDS-AD) Program: Florida's coverage group for certain aged and disabled individuals with incomes up to 88 percent of the federal poverty level (FPL). Enrollees receive services through the same delivery systems as the state plan.

Medicaid State Plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Minimum Monthly Maintenance Income Allowance (MMMNA): Guaranteed amount of disregarded income protected for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing facility level of care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs, such as the Statewide Medicaid Managed Care Long-Term Care (SMMC-LTC) program.

Nursing Home Diversion (NHD) Program: A Florida program designed to help frail seniors stay at home instead of moving into nursing homes. This program allows participants to select a case manager and a county-approved managed care organization (sometimes called an HMO) that will provide them with all their medical and custodial (non-medical) care services in their homes as well as pays for their Medicare co-insurance and deductibles. This program was discontinued when the Statewide Medicaid Managed Care Long-Term Care (SMMC-LTC) program was implemented in 2013. Note: in government documents, the program is sometimes referred to as the "Long-Term Care Community Diversion Pilot Project."

Optional Categorically Needy: Groups that states may choose to cover through Medicaid, which may include aged and disabled individuals not receiving SSI and some individuals receiving long-term care.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series.

Personal Care Services: Benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Program of All-Inclusive Care for the Elderly (PACE): PACE provides comprehensive medical and social services to some older adults still living in the community. Most of the participants who are in PACE are dually eligible for both Medicare and Medicaid. However, enrollment in PACE programs is typically capped at a relatively low number of participants.

PRUCOL: An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Skilled Nursing Care: Services that must be provided by a registered nurse or licensed practical nurse under the supervision of an RN. Examples include administration of intravenous medication, colostomy and ileostomy care, and complex wound care.

Social Security Administration (SSA): United States government agency that administers public assistance programs covering disability, retirement, and survivors' benefits. The SSA administers Supplemental Security Income (SSI) payments.

State Supplemental Payment (SSP): Monthly cash payments offered by states to low-income individuals in addition to Supplemental Security Income (SSI). States offering optional SSPs may do so to account for higher costs of living or as an additional income disregard for individuals in certain living arrangements (e.g., nursing facility). In Florida, some individuals residing in assisted living facilities and other institutions may receive an SSP. The recipient's gross monthly countable income is subtracted from the sum of the standard residential care rate (depending on type of facility) and the personal needs allowance. The difference, up to a specified amount, is the state optional payment amount.

Statewide Medicaid Managed Care (SMMC) Program: A Florida program implemented in 2013 that established a plans for general Medicaid services (e.g., doctors visits) and a plan type specifically for long-term care services. Most Florida Medicaid recipients receive their care, both general and long-term care, through this program.

Statewide Medicaid Managed Care Long-Term Care (SMMC-LTC) Program: A Florida program established under the Statewide Medicaid Managed Care (SMMC) program in 2013 that provides long-term care services.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. old-age cash assistance program for aged, blind, and disabled persons with limited income and assets.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. Some SSI recipients and non-SSI recipients who meet state eligibility criteria may receive a State Supplementary Payment (SSP). SSP amounts vary by living arrangement. Receipt of this payment will marginally increase the income limit under this track. See Fla. Stat. § 409.212 (2023) and SSA (2011) for more information.
2. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999).
3. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees) (SSA, 1998).
4. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2023) for more information on these requirements.
5. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is guaranteed to receive a protected amount of the institutionalized spouse's income, called the Minimum Monthly Maintenance Needs Allowance (MMMNA). The MMMNA in Florida is equal to 150% of the FPL for a family of two. In 1992, this was $1,149 (NLM, 1988).
6. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $68,700 in 1992 (TBT, 1992). Countable assets/property are real and personal property that are counted to determine eligibility.
7. Our team has submitted a Freedom of Information Act (FOIA) request to the federal Centers for Medicare and Medicaid Services and the Florida Archives office. The requested documents will provide information on the Nursing Home Diversion programin 1998, as well as additional eligibility information for state plan services in multiple chapters. Until then, these sections have missing information.

8. The equity value is derived by subtracting any legal encumbrances (e.g., liens, mortgages) from the fair market value of the home. Exceptions exist if the person's spouse, child, or adult child with a disability is living in the home.

9. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is guaranteed to receive a protected amount of the institutionalized spouse's income, called the Minimum Monthly Maintenance Needs Allowance (MMMNA). The MMMNA in Florida is equal to 150% of the FPL for a family of two. In 1998, this was $1,357 (NLM, 2000). From 2011, Florida extended spousal impoverishment rules to spouses of individuals receiving HCBS through the NHD program. Authors were unable to verify whether Florida extended spousal impoverishment rules to NHD prior to 2011.

10. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $81,960 in 1998 (NLM, 2000). Countable assets/property are real and personal property that are counted to determine eligibility. From 2011, Florida extended spousal impoverishment rules to spouses of individuals receiving HCBS through the NHD program. Authors were unable to verify whether Florida extended spousal impoverishment rules to NHD prior to 2011.

11. Under the NHD program, this standard service is separated into two benefits: homemaker services (assistance with ADLs and IADLs) and personal care services (assistance only with ADLs). For consistency and clarity, we have combined the two benefits under the standardized personal care services benefit used in most states.

12. The Florida Administrative Code (FAC) shows that a new version of the 701B form was introduced to the Department of Elder Affairs (DOEA) in 2008. Prior to 2008, the 701B form in place was last updated in the year 2000. Only the 2008 form is available online, and therefore is used as the sole source for the assessment details in this part. However, a 2008 FAC Notice of Change details the changes to the form that necessitated a new version. The changes were limited to implementing a written explanation of the DOEA's request for the applicant to provide their Social Security Number, and did not alter any section of the medical assessment (Fla. Admin. Code 58A-1.010 Notice of Change, 2008). With this information, we can assume that the relevant sections of the 701B assessment in this policy period are the same as those in the available 2008 form.

13. Transfers made prior to January 1, 2010 are subject to a 36 month look back period, except in the case of a trust treated as a transfer in which case the look back period is 60 months. Transfers made on or after January 1, 2010 are subject to a 60 month look back period (Fla. Admin. Code 65A-1.712, 2013).

14. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is guaranteed to receive a protected amount of the institutionalized spouse's income, called the Minimum Monthly Maintenance Needs Allowance (MMMNA) (Fla. Admin. Code 65A-1.712, 2013). The MMMNA in Florida is equal to 150% of the FPL for a family of two. In 2013, this was $1,938.75 (Fla. Admin. Code 65A-1.716, 2012). From 2014, the ACA required states to extend spousal impoverishment rules to spouses of individuals receiving HCBS. Authors were unable to verify whether Florida extended spousal impoverishment rules to SMMC-LTC and home health recipients prior to 2014.

15. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $115,920 in 2013 (Fla. Admin. Code 65A-1.712, 2013). Countable assets/property are real and personal property that are counted to determine eligibility. From 2014, the ACA required states to extend spousal impoverishment rules to spouses of individuals receiving HCBS. Authors were unable to verify whether Florida extended spousal impoverishment rules to SMMC-LTC and home health recipients prior to 2014.

16. Under the SMMC-LTC program, this standard service is separated into two benefits: homemaker services (assistance with ADLs and IADLs) and personal care services (assistance only with ADLs). For consistency and clarity, we have combined the two benefits under the standardized personal care services benefit used in most states.

Version information

Current Version: 1.0 (September 2023)

Version History

- 1.0 (September 2023): First version.