Medicaid SA Abuse Local Match Certification Program
Answers to Providers' Frequently Asked Questions

Program Overview

Q1: How did this program get started? Is this a completely new initiative? Did Florida have to get a waiver from CMS in order to start this program?

A1: FADAA -- in cooperation with AHCA, DCF, Central Florida Behavioral Health Network and FMHI -- received Robert Wood Johnson funds in 2004-2005, for activities to expand substance abuse services to Medicaid recipients. One of the project's successes was obtaining the 2005 Florida Legislature's approval to add three new service codes to the State Medicaid Plan, services available to counties who agreed to commit their local, public dollars for the required state match.

A federal waiver is not required. There are other Medicaid local match certification programs already operating in many counties for e.g. health clinic services in public schools, Healthy Start pre-natal services, and Targeted Case Management services for at-risk children, using Children's Services Council funds.

Q2: Why did FADAA and DCF endorse this initiative? Why did AHCA support it when they are trying to cut Medicaid?

A2: Based on county preliminary commitments, this initiative will bring as much as $ 24 million new federal dollars to substance abuse treatment in Florida, for services to Medicaid enrolled families. No new state General Revenue dollars will be needed.

Only about $6 million in Medicaid funds now go to community-based substance abuse treatment in Florida each year. The Local Match initiative is seen as a way to expand substance abuse treatment services to the Medicaid families who need such services: families in the child welfare system, returning from juvenile justice commitments, or referred by a local physician serving Medicaid patients.

Many counties commit more public dollars to substance abuse treatment services than are required by Baker Act or federal block grant requirements. If a county assigns some of these dollars to a treatment agency or provider network, specifically for these 3 services to Medicaid recipients, the agency can draw down from federal Medicaid more than double the amount received from the county.

Q3: What are the services and what are the rates of reimbursement?

A3: The three new Medicaid services available in participating counties are: Outpatient detoxification ($90 for 3 hours), Intervention ($60 an hour) and Community Support ($60 an hour.)[1]

Q4: **Is it true that the federal matching funds more than double the monies allocated to the program?**

A4: Yes, that is true based on Florida's current Federal Match rate (58.89%.) The rate is set each year, but Florida's match rate has been close to this percentage for years.

If a county allocates $5,000 in local, public funds, the treatment agency receiving the funds can draw down an additional $7,162 federal matching funds to support a total of $12,162 in services.

Q5: Is this benefit available *only* for Medicaid recipients receiving services in participating counties, and only up to the limits of the match?

A5: Yes. The services will only be available in counties that allocate the match, up to a total budget equal to the county dollars committed plus the federal match. The federal draw down based on local match is available *only* for these 3 services, and *only* when they are delivered to Medicaid enrolled consumers.

Ideally, AHCA expects counties over time to determine the total demand for services, and to allocate the required match so that services are available for all those who request services.

You may bill fee for service Medicaid directly for services to any recipient, regardless of whether they are enrolled in Medipass, an HMO, a Prepaid Mental Health Plan, or a Medicaid reform demonstration plan (Duval, Broward.)

Q6: Can any county participate? Can any agency provide the services?

A6: Any county or city can sign a written agreement with AHCA, submit a "plan" for accountability mechanisms, participate in training, and commit local, public monies to these services for Medicaid recipients.

Only those licensed treatment agencies that a local government designates to AHCA as eligible to bill for the services, may participate. A designated agency must have an active and unique Florida Medicaid Community

[1] AHCA proposed reimbursement

Behavioral Health provider identification number (Type 05) affiliated with any and all physical addresses where the three specified services would be provided. The agency also must comply with the staff qualifications and other restrictions, just like for any service billed to Medicaid.

The new services will not be added to the regular Medicaid Handbook, but there will be a separate manual for providers participating in a local match program.

Q7: Why are the AHCA agreements with local governments rather than with agencies?

A7: AHCA is signing agreements with counties or cities because the local governments are putting up their dollars to support the services, and likely also because the State government prefers to obtain commitments from local governments to accept the fiduciary responsibility associated with the program.

Q8: What else has to be in the local government "plan" submitted to AHCA?

A8: The city or county will work with their designated treatment agency (ies) or provider network to write a brief "plan" which states how procedures will be put in place for the city or county to insure that 1) the match monies are local, public dollars; 2) the services delivered comply with Medicaid definitions and restrictions, and are delivered to Medicaid enrolled clients, and 3) for every dollar in services billed to AHCA (agencies will bill total reimbursement rate, not just the federal match portion), 41 cents in local match are spent on the services.

Q9: Explain how these monies and services will remain fee for service, exempt from Medicaid reform and from capitated contracts.

A9: Federal Medicaid policy allows States to decide how to contract for Medicaid services; in many states, all Medicaid services are reimbursed fee for service. Although the Legislature may decide to put all state General Revenue funds used as Medicaid match into managed care, it is not possible for the State of Florida to mandate that local governments add their dollars to pre-paid contracts.

Services supported by a Local Match Certification program will never be put into managed care, never added to capitated HMO or Prepaid Mental Health Plan contracts. *AHCA states this in the memo that was sent to counties.* The services supported by other Local Match Certification programs have been left out of Medicaid reform contracts, as well.

Medicaid services matched with local, public dollars *will remain* fee for service unless federal Medicaid policy changes, and at that point counties could choose to withdraw their dollars.

Q10: Explain the impact on current clients and programs if counties use existing funds to match.

A10: If counties decline to allocate *new* dollars, they may want to redirect monies they currently give an agency, dollars which are "excess match" - that is, they are not needed as match for block grant or Baker Act services. If an agency is using such local dollars to support services to non-Medicaid populations, it would be necessary to identify other resources to continue those services at the current level.

As an example, if you were operating a $50,000 program with local dollars, which served a non-Medicaid enrolled population, you could redirect $10,000 of those local dollars to the Local Match Certification program. Your current program serving a non-Medicaid population would then have $40,000 in resources, and the new program for Medicaid enrollees would have a total budget of $24,323, after drawing down the federal match. Before participating in the Local Match initiative, the local dollars would have supported $50,000 in services. Under the Local Match initiative, the *same local dollars* would support $64,323 in services.

Q11: But isn't this just supplanting existing services, redirecting the funds to another population?

A11: No, the total dollars committed to substance abuse services in your county will increase under this initiative. Every dollar committed to this program will bring in federal matching monies equal to more than double the local dollars. There may, however, be a change in the proportion of Medicaid and non-Medicaid consumers served. But in some instances, these are the same families who enroll and then dis-enroll from Medicaid based on changes in their income over time.

Q12: But it costs more to provide Medicaid reimbursed services, with the level of staff required, and learning the billing process, and the documentation needed.

A12: That is true, but it really isn't a choice any more for the field, since DCF is going to continue to tighten restrictions on using DCF dollars to provide services to Medicaid enrolled families. Secretary Lucy Hadi is reviewing policy recommendations at this time to phase out DCF financed services to Medicaid recipients, even those services which Medicaid does not cover.

It is very likely that some of your current clients are enrolled in Medicaid for at least some time during the year. Going forward, it will become necessary for agencies to determine Medicaid enrollment at intake, and either bill Medicaid for services provided or refer the client to another provider who is Medicaid enrolled.

The Local Match Initiative takes away some of the fears about building Medicaid services as a larger proportion of your business, because these services will remain fee for service, at reimbursement rates set by the State Medicaid Plan, and will never be "capitated" or added to HMO contracts. There is no upper limit on the amount of federal matching funds that can be drawn down for these services, provided that there are local, public dollars available as match.

Once at agency commits to serving Medicaid families, and establishes the necessary systems and procedures, the per client costs to stay current with regulations will be diminished if spread over a larger caseload. Check the FADAA web site **www.fadaa.org** (click on "Resources" and then "Medicaid") for charts and other training materials to learn how to effectively bill for Medicaid substance abuse services.

Q13: What if we don't see a lot of Medicaid enrolled clients?

A13: It may be necessary to establish linkages with agencies that do have a lot of Medicaid enrolled clients; outreach may be necessary to establish referral linkages.

As an example of target populations for the services: the Community Support services may support co-occurring clients in re-entry status from jails, prisons, juvenile justice facilities and institutions, and also clients completing treatment. The Intervention services may be targeted to children with substance abuse issues in foster care and to families in protective services. Outpatient detox services could be advertised to e.g. hospital Emergency Rooms and local law enforcement, particularly if you are willing to have 24-hour intake.

You may check the FADAA web site www.fadaa.org (click on "Resources" and then "Provider Networks"), for information about setting up an Outpatient Detox service. FADAA expects in future to prepare additional service models and recommendations for outreach methods, as the program rolls out.

Timing:

Q14: When can we start billing for these services?

A14: AHCA expects to authorize billing beginning the first quarter of 2007.

Your county must first sign a written agreement with AHCA[2], send county staff to participate in training, and designate a treatment agency or agencies (or a provider network) to receive the local funds and be authorized to bill for the services. The county will work with the designated agency(ies) or provider network to write a plan stating how the accountability mechanisms AHCA requires will be put in place at the local level. This plan must be submitted to AHCA for approval by staff.

AHCA must also complete a State Plan Amendment and establish budget authority to accept the federal funds. AHCA staff are working on these tasks now.

Q15: How do I know if my county plans to participate? Can a county still participate if they didn't send a preliminary commitment form to AHCA?

A15: Local governments can decide to participate and sign the written agreement with AHCA at any time beginning in the fall of 2006. Also, if a county decided after a period of time to dis-enroll from the program, AHCA would not be able to prohibit that action.

Following are the 29 local governments that submitted preliminary commitment forms to AHCA:

- Alachua
- Charlotte
- Brevard
- Broward
- Citrus
- Clay
- Dade
- Dixie
- Escambia
- Flagler
- Hernando
- Hillsborough
- Jackson
- the City of Jacksonville
- Lake
- Lee
- Leon
- Manatee
- Marion
- Martin
- Orange
- Osceola

[2] See attachment A, City/ County Agreement with AHCA: "Certified Medicaid Match Agreement for the Reimbursement of Specified Substance Abuse Treatment Services for Medicaid Recipients"

- Palm Beach
- Polk
- Pinellas
- Sarasota
- Santa Rosa
- Volusia
- Wakulla.

The Dollars: Local Match, Federal Match

Q16: What local dollars qualify as match under this program?

A16: Allowable match is local public, not private, funds that are not already obligated as match for another funding source. Possible sources are county taxes, Children's Coalition funds, and locally funded Health Trust or Homeless Trust dollars. AHCA is researching whether dollars from county established fees can be counted as local match. Private funds, such as United Way funds, do *not* qualify as match.

Q17: We want to make sure that the county doesn't cut our existing services to finance this initiative, or just because they have given us "excess" match.

A17: The dialogue with county staff will be important, so that the impact of participating in the program is clear. You might want to approach your county staff first to request that they consider budgeting new dollars for this initiative, stressing the ability to more than double any new dollars allocated. You can also explain that **there are no "excess" dollars**, and that it will be necessary to cut services if you cannot identify another funding source to replace dollars now committed to non-Medicaid populations, if the county decides to redirect those dollars to the Local Match initiative.

On the other hand, county staff may point out that there aren't really two distinct populations, but rather that many of our clients go on and off Medicaid over time as their income changes.

Q18: How can an agency determine if they already have dollars which may qualify?

A18: The best way for you and your county staff to make the determination is to work with your agency's auditors to review accounting reports, and identify the extent to which current funding can be redirected and still meet all match requirements. In the final analysis, it is the financial auditors, your C.P.A., who will be able to advise you about available funds and how to create an audit trail which demonstrates that the local funds are adequate in total to match the federal funds your agency bills for through AHCA.

Q19: If a County indicates they will set aside dollars for services covered, do they have to set the dollars aside in specific categories?

A19: No, the local government can establish a total budget for the three services.

Q20: Is there a limit on the federal matching dollars, a budgeted amount which total claims by an agency or county, or the State, cannot exceed?

A20: There is **no** upper limit on the amount of federal matching funds that can be drawn down for these services, now or in the future, provided that there are local, public dollars available as match. AHCA is seeking a somewhat accurate projection of the funds which counties expect to commit to the program, so that they can submit a budget authority memo which estimates the federal funding which the state is expected to receive.

The Services:

Q21: Does our county have to commit to all 3 services?

A21: It is not necessary for every county to commit to all 3 services. On the other hand, as an example, if only Hillsborough and Pinellas plan to offer Outpatient Detox, it will be difficult for AHCA to demonstrate that the service is available statewide, and CMS might begin to question whether there is truly adequate access for Florida Medicaid clients.

Q22: What are the AHCA definitions and restrictions for the services?

A22: See the AHCA definitions for each service, which are attached.[3]

Q23: If I have county match for this population, can I bill an Intervention services for a Bupenorphine client?

A23: Recipients must meet the following criteria to be eligible for Intervention services: 1) meet the ASAM PPC-2R Level 0.5 Dimensions 4, 5, or 6 under Early Intervention, and 2) be at risk for substance abuse or dependence.

Program Operations:

Q24: How will we receive the funding, once the program starts?

[3] See Attachment B: ACHA Service Definitions

A24: Basically, the treatment agency(ies) or provider network which the county designates to provide the services will receive the local match directly from a county or counties, and bill AHCA for the federal match portion only. Reimbursement from CMS through AHCA will occur following the same procedures, rules and timing as traditional fee for service Medicaid.

Q25: Is there an upper limit of the amount of funds we can commit that will be matched with federal dollars?

A25: No, there is no upper limit of the amount of federal financial participation, as long as there is an audit trail that substantiates that local match is there for each dollar received from the feds. AHCA does need to project what amount they expect to draw down for the total services statewide, as part of their budgeting activity, but that is for State accounting and could be exceeded without penalty.

Q26: **If there is no upper limit, how will expenditures be controlled?**

A26: This is the city or county, and not AHCA's, responsibility, once they have signed an agreement with AHCA. The designated treatment agency(ies) will likely be asked by county staff how they intend to insure that they do not bill for more services than they have local match. That will be one of the accountability mechanisms to be explained in the local "plan" sent to AHCA.

ACHA will "pay" (forward to CMS) all claims received from treatment agencies or provider networks *which a city or county has authorized to AHCA* as designated to deliver the services. AHCA will assume that the local match has been authorized. The local government will periodically sign a statement to AHCA that "certifies" that there is match sufficient for the amounts billed. When Medicaid auditors come on site, documentation will be reviewed.

Agencies obviously must establish accounting mechanisms to insure that billings do not go over the budgeted local match, just like for any other funding source.

See the Attachments to this paper for alternative administrative models which communities may use.[4]

Q27: **What if we serve residents of other counties, is that allowed?** If a resident of another county were to present for services, are we required to serve them?

A27: Yes, if you have capacity at that time, you cannot turn away someone because they are a resident of another county. AHCA must demonstrate that

[4] See Attachment C: "Administrative Models"

there is access statewide to these services, even though every county will not offer them.

Q28: **Isn't it unlikely that Medicaid consumers will drive out of town** regularly to obtain outpatient substance abuse treatment?

A28: Yes, experience would say so. But it is AHCA's responsibility to insure there is reasonable access, regardless of whether consumers take advantage of it.

Q29: What documentation will be required for these Medicaid services?

A29: AHCA will require the same type of documentation as for all fee for service Medicaid claims, i.e. linking to a treatment plan, and insuring appropriate staff credentialing, and billing according to established limits.

In addition, AHCA will require documentation that 41 cents of each dollar spent on the services was local, public money.

Q30: Will outcomes be reported to the state data base as on our other Medicaid clients and this will be part of the "n" on the Exhibit D?

A30: We are waiting for clarification from DCF about this; likely they will require the same reporting as for other Medicaid services.

Billing:

Q31: How will the billing process work: what forms, electronic vs. paper, how often?

A32: The process will be just the same as for every other Medicaid substance abuse service that you bill now: same process, same forms, same timing.

Q33: Is it necessary for agencies to submit two claims for each service?

A34: This is unclear at this time – AHCA staff have said they will advocate with federal CMS that they ***not*** require that there be two separate claims for each service delivered.

Instead, AHCA will propose that treatment agencies be allowed to establish through their accounting system an "audit trail" which documents that the required amount of (local, public) unmatched funds were spent on these services to Medicaid enrolled clients, i.e. for the total number of Medicaid enrolled clients and services for which claims were submitted to AHCA for the

federal match. That way, local governments could establish a capacity for the services and forward the required local match dollars in one check to the treatment agency, if they prefer.

If two claims are required, the federal claim submitted through AHCA will not have to be altered to reflect just the federal portion of the total reimbursement. AHCA will work with the fiscal intermediary to establish reimbursement amounts for each claim that are equal to the "federal only" portion of the rate. The process and forms for submitting claims to the county will be decided at the local level, with AHCA approval as part of the county's "plan."

Other

Q35: Can the Florida Association of Counties come up with instructions to their counties for contract language and processes?

A35: FADAA will work with the Florida Association of Counties to draft certain products: service models, alternative accountability plans for submission to AHCA, and model contracts between a local government and an agency or provider network.

ATTACHMENT A

City/ County Written Agreement with AHCA

CERTIFIED MEDICAID MATCH AGREEMENT BETWEEN THE AGENCY FOR HEALTH CARE ADMINISTRATION AND _____ COUNTY FOR THE REIMBURSEMENT OF SPECIFIED SUBSTANCE ABUSE TREATMENT SERVICES FOR MEDICAID RECIPIENTS

The Agency for Health Care Administration (AHCA) and _____ County hereby agree to the principles, terms and effective dates specified in this Certified Medicaid Match Agreement and its Attachments. This Agreement is set forth to define each party's responsibilities in order to effectively administer the provision of, and reimbursement for, specified Medicaid substance abuse treatment activities and is necessary to implement parts of the Medicaid State Plan under Title XIX of the Social Security Act. AHCA is the single state Medicaid agency in Florida under Title XIX of the Social Security Act. Additionally, specific Federal regulations authorizing the use of certified public funds are found in 42 CFR, Subpart B, General Administrative Requirements State Financial Participation, Section 431.51. This initiative is authorized by the Florida Legislature in Proviso Language, Page 57, 2006 – 2007 Appropriations Act, Special Category 204.

I. **General Principles**

This Agreement is based on the following general principles:

1) The aforementioned parties have a common and concurrent interest in providing and reimbursing Medicaid substance abuse treatment services, within parameters set by the federal Centers for Medicare and Medicaid Services (CMS) and AHCA, and only as approved by CMS. Any changes in the program required by CMS are to be implemented by both of the aforementioned parties.

2) This Agreement is in no way intended to modify the responsibilities or authority delegated to the parties.

3) This Agreement is in no way intended to override or render obsolete any other agreements or memoranda of understanding which may already exist between these parties.

4) Any County contractors involved with specified Medicaid funded substance abuse treatment services are bound by this agreement with regard to administrative policies and procedures.

5) A lead County representing one or more other counties within the state for the purposes of billing Medicaid for specified substance abuse treatment services, shall also comply with the provisions of Attachment I of this agreement.

6) This Agreement provides a mechanism for payment of federal funds from CMS, and the parties agree that it in no way creates a requirement for AHCA to reimburse any County from AHCA state funds.

II. **Terms**

AHCA agrees to the following terms:

1) AHCA will develop a list and description of specified Medicaid reimbursable substance abuse treatment services to be performed by County-contracted providers. Specified substance abuse treatment services are found in Attachment II of this agreement. (The services and service requirements are formatted for inclusion in the Medicaid Community Behavioral Health Services Coverage and Limitations Handbook).

2) AHCA will reconcile all specified substance abuse treatment service claims for Medicaid reimbursement on a quarterly basis.

3) AHCA will reimburse the County's contracted providers for the federal portion of the approved rates for specified substance abuse treatment services.

4) AHCA will periodically monitor the participating providers for compliance with claims submission and service provision.

5) AHCA will produce any Medicaid specific reports deemed necessary for the participating counties.

6) AHCA will develop procedures for recoupment of funds from the participating providers if warranted by AHCA or CMS monitoring.

7) AHCA will notify the participating counties and providers in the event of any changes made by CMS to federal matching percentages or costs eligible for match.

8) AHCA will designate an employee to act as a liaison for the participating counties and providers for the Medicaid Match Program.

This space was intentionally left blank.

The County agrees to the following terms:

1) Any and all funds paid to providers for services rendered under the Medicaid Match program will be comprised exclusively of locally generated unmatched tax revenues and will in no way be comprised of any grants, donations, or other monies originating from a federal, state or private source.

2) The County must identify and select providers that agree to enroll in Medicaid as a Community Behavioral Health Services Provider (Type 05) and participate in the Medicaid Match program by providing the selected services to Medicaid recipients in compliance with all relevant requirements in Medicaid's Community Behavioral Health Coverage and Limitations Handbook.

3) The County will maintain an ongoing management information capability to ensure accountability, provide information necessary to support quarterly verifications and AHCA audit requirements, and account for county funds disbursed to participating providers.

4) Any recoupment of funds due to an audit exception, deferral or denial deemed as appropriate by CMS or AHCA will be the responsibility of the county and its identified participating providers.

5) The County must submit a quarterly certification report that identifies the local funds that have been used as match and which identifies the reimbursement to each participating substance abuse treatment provider for the specified substance abuse treatment services.

6) The County and its designated participating providers shall maintain and be able to produce within a specified time frame other requested records and material for CMS and/or AHCA audits.

7) The County will designate an employee to act as a liaison with AHCA for issues concerning this agreement.

III. Confidentiality

The County and the identified providers agree to safeguard the use and disclosure of information pertaining to current or former Medicaid recipients and comply with all state and federal laws pertaining to confidentiality of patient information.

IV. Effective Date, Changes, Life of this Agreement

1. The effective date of this Agreement will be the date it is signed by both parties.

2. Changes may be made to the Agreement in the form of amendments and must be signed by all parties.

3. Changes in the CMS matching percentage or costs eligible for match will not be made via this agreement but will be applied pursuant to changes in applicable Medicaid federal regulations and effective the date specified by CMS.

4. This Agreement will continue in effect until terminated by AHCA or the county. AHCA or the county may terminate this agreement without cause by providing a thirty (30) day written notification to the other party.

This document consists of the Certified Match Agreement, pages I through 4; Attachment I, Overview of the Program (pages 1 through 3) and Attachment II, Service Descriptions (pages 1 through 6).

SIGNATORIES:

_____ _____
Authorized County Representative Date

_____
County

_____ _____
Authorized AHCA Representative Date

ATTACHMENT B

AHCA Service Definitions:

Ambulatory Detoxification
Alcohol/ and or Drug Intervention
Comprehensive Community Support

Service Descriptions

Ambulatory Detoxification Services

Introduction

Ambulatory detoxification services involve the clinical and medical management of the physical and psychological processes of withdrawal from alcohol or other drugs on an outpatient basis in a community-based setting. This service is indicated when an individual experiences physiological dysfunction during withdrawal which can be life threatening if not properly managed.

This service is intended to physically and psychologically stabilize the recipient and apply appropriate detoxification protocols. Once the detoxification protocols are completed and the recipient's medical conditions have stabilized, the individual may then be referred to the least restrictive environment for medically necessary treatment. Placement for appropriate treatment should be based upon the ASAM PPC – 2R.

Only recipients with sufficient supportive environment that provides for safe detoxification in an outpatient setting are clinically appropriate to receive this service. In the absence of a supportive environment, inpatient or residential detoxification should be provided. Determination of appropriateness must include documentation demonstrating the recipient meets criteria for outpatient detoxification on the ASAM PPC – 2R.

The severity of the individual's symptoms will determine the amount of nursing and physician supervision necessary during the detoxification process. A physician, or an ARNP or a PA working under the supervision of a physician, must be available and on-call during operating hours. An RN, or an LPN working under the supervision of an RN, must be on-site during operating hours. A counselor must be on-site during operating hours.

Each recipient's treatment plan must indicate that services are provided in the least restrictive setting. The ambulatory detoxification provider must also have the capability and capacity to evaluate and determine if and when a recipient's physical and/or psychological condition or social environment deteriorate to a degree that necessitates a more restrictive level of care.

Description of Service

Ambulatory detoxification services includes the following:

- Medical interventions to manage and stabilize withdrawal symptoms.
- Substance use/abuse psycho-educational groups.
- Supportive counseling.
- Drug screening and urinalysis.

Who May Receive

Recipients must meet all of the following criteria to be eligible for ambulatory detoxification services:

- The individual has a substance abuse impairment (e.g., ASAM PPC-2, Dimension-1) that is incapacitating, destabilizing or distressing. If the severity is incapacitating, there must be sufficient optimization in other dimensions of the individual's life to provide for safe detoxification in an outpatient setting.
- Have an ICD-9-CM diagnosis of 291.0 through 292.9, 303.0 through 305.09 or 305.2 through 305.9.
- The individual's withdrawal symptoms from mood-altering drugs require medical supervision.
- The individual's living situation and support systems must be in place and sufficient to support recovery.

Exclusionary Criteria

Recipients who meet any one of the following criteria are NOT eligible for ambulatory detoxification services:

- The recipient's impairment due to substance abuse has incapacitated the recipient in all aspects of daily living and there is resistance to treatment as indicated in the ASAM PPC – 2R Dimension 4, relapse potential is high (Dimension 5), and the recovery environment is poor (Dimension 6);
- The recipient has a concomitant medical condition or other behavioral health issue(s) that warrant inpatient/residential treatment; or
- The recipient has a rating of "2" in the ASAM PPC – 2R dimensions 4, 5, or 6.

Who must provide

Medical interventions must be personally rendered by a physician or by a PA, ARNP, R.N or L.P.N under the supervision of a physician, and in accordance with medical protocols established by the provider facility's medical director.

Non-medical services such as supportive counseling, psycho-educational groups, etc., must be rendered by a licensed practitioner of the healing arts, a master's level Certified Addictions Professional (CAP), or a substance abuse counselor under the supervision of a licensed practitioner of the healing arts or a master's level C.A.P.

Minimum Time Requirements

Ambulatory detoxification must be provided for a minimum of three hours each day the service is billed to Medicaid. The three-hour period need not be continuous within the day. Services provided amounting to less than three hours in one day are not billable to Medicaid.

Reimbursement Limitations

This service is limited to 30 days per state fiscal year per recipient.

This service may not be reimbursed for the same recipient on the same day as any of the following:

- Behavioral Health Overlay Services – Juvenile Justice (H2022 HK)
- Methadone Administration (H0020)

Medicaid will not reimburse for provision of ambulatory detoxification services where there is a per diem reimbursement being paid by Medicaid for recipients (e.g. Nursing homes, SIPP, etc).

Medicaid will not reimburse for any component of ambulatory detoxification services, including medical interventions and counseling, when the same services are already being paid for by another source.

Billable unit = one hour
Suggested reimbursement rate: $90 per unit

Comprehensive Community Support Services for Substance Abuse

Introduction

Comprehensive community support services are a set of medically necessary clinical aftercare services that are directed toward individuals who have received substance abuse treatment within a correctional or other institutional setting or a community-based program, and need continued therapeutic services to maintain recovery as they re-enter the community. The principle purpose of comprehensive community support services is to provide integrative therapeutic supports and aftercare in collaboration with available and relevant ancillary medical and behavioral support services in the community and to ensure the receipt and effectiveness of those services. This service follows a recovery support services model that addresses interpersonal and coping skills in home, work, and school situations and assists in medication monitoring and symptom monitoring through therapeutic service provision. Identifying barriers that impede the development of skills necessary for independent functioning in the community will also be an integral part of these services. These services may be provided in a variety of community-based settings on an outpatient basis.

Description of Service

Comprehensive community support services include the following:

- Supportive counseling
- Specific recovery support services such as locating housing, vocational counseling, psycho-educational counseling, job skills training, etc.
- Aftercare planning
- Relapse prevention
- Ensuring and monitoring recipient progress toward meeting goals of the aftercare plan
- Coordinating any necessary services with other sources and subsequently making any referrals for medically necessary services.

Who May Receive

Recipients must meet the following criteria to be eligible for comprehensive community support services:

- Successful completion substance abuse treatment in a correctional/institutional or community-based setting
- Have an ICD-9-CM diagnosis of 291.0 through 292.9, 303.0 through 305.09 or 305.2 through 305.9
- Motivated to participate in the program

Clinical Exclusions	Recipients are NOT eligible for comprehensive community support services if they: • Have not successfully completed a substance abuse treatment program • Exhibit clinical symptoms that require a more restrictive level of care than can be provided through comprehensive community support services • Are not motivated to participate in comprehensive community support services
Who Must Provide	Services must be provided by a substance abuse counselor who has knowledge of existing support services within the community. Services shall be supervised by a licensed practitioner of the healing arts or a master's level C.A.P.
Minimum Time Requirements	Comprehensive community support services must be provided for a minimum of 30 minutes at a time.
Reimbursement Limitations	Reimbursement for this service is limited to 60 units per state fiscal year per recipient. Each unit must be 30 minutes in duration. This service may not be reimbursed for the same recipient on the same day as any of the following: • Behavioral Health Overlay Services – Juvenile Justice (H2020 HK) [BHOS-JJ] • Therapeutic Group Care Services (H0019) [TGCS] • Ambulatory Detoxification Services (H0014) • Behavioral Health Overlay Services – Child Welfare (H2020 HA) [BHOS-CW] • Specialized Therapeutic Foster Care (All Levels) [STFC] (S5145, S5145-HE; S5145-HK) Medicaid will not reimburse for provision of Community Support Services where there is a per diem reimbursement being paid by Medicaid for recipients (e.g. Nursing homes, SIPP, etc). Medicaid will not reimburse for any component of Community Support Services, including medical interventions and counseling, when the same services are already being paid for by another source.

Billable unit = one/half hour
Suggested reimbursement rate: $30 per unit

Alcohol and/or Drug Intervention Service

Introduction

This service is designed to detect alcohol or other drug problems and to provide a brief intervention for the purpose of arresting the progression of such problems, thereby obviating the need for more intensive levels of treatment as described in the ASAM PPC – 2R. These intervention services are provided prior to treatment and are delivered in community-based settings on an "outpatient" basis such as licensed substance abuse providers, schools, work sites, community centers, homes, etc. The goal is to identify current or potential risk factors for substance abuse and then identify and provide the medically necessary clinical services to minimize and ameliorate those factors as an alternative to a more restrictive level of treatment. Intervention services are provided for the purpose of early identification of substance abuse problems and rapid linkage to needed services.

Description of Service

Intervention services include the following:

- Clinical Screening and Evaluation
- Clinical and therapeutic intervention with family and peer involvement
- Supportive counseling
- Referral to clinically indicated services
- Identifying medically necessary treatment needs
- Ensuring referral appointments are met

Who May Receive

Recipients must meet the following criteria to be eligible for intervention services:

- Individuals who meet the ASAM PPC-2R Level 0.5 Dimensions 4, 5, or 6 under Early Intervention.
- Individuals at risk for substance abuse or dependence.

Recipients are NOT eligible for Intervention services if they:

- Fail to meet Dimension 4, 5, or 6 under ASAM PPC – 2R level 0.5
- Are currently receiving a residential or inpatient level of substance abuse treatment
- Individuals not considered at risk for substance abuse or dependence

Who Must Provide

Services must be delivered by a substance abuse counselor under the supervision of a licensed practitioner of the healing arts or a master's level C.A.P.

Minimum Time Requirements

Intervention services must be provided for a minimum of 30 minutes at one time.

Reimbursement Limitations

Reimbursement for this service is limited to 24 units or 720 minutes per state fiscal year per recipient.
Each unit of intervention services must last 30 minutes in order to claim Medicaid reimbursement.

This service may not be reimbursed for the same recipient on the same day as any of the following:

- Behavioral Health Overlay Services – Juvenile Justice (H2022 HK)
- Methadone Administration (H0020)
- Community Support Services (H2015)

Medicaid will not reimburse for any component of ambulatory detoxification services, including medical interventions and counseling, when the same services are already being paid for by another source.

Billable unit = one/half hour
Suggested reimbursement rate: $30 per unit

Attachment C

Administrative Models

Administrative Models for Local Medicaid Match Certification

County Responsibilities under the Match Program:

1) Submit Letter of Intent to AHCA to participate.
2) Identify and document funds available as match by source.
3) Select and specify eligible providers .
4) Sign Certified Medicaid Match Agreement with AHCA.
5) Submit County Plan for administration of the program to AHCA fpor approval.
6) Track and Certify Expenditures.
7) Submit Quarterly Certification Reports to AHCA.

Tasks necessary to administration of the local match program:

1) Claims submission to AHCA
2) Claims/expenditure tracking of local match expenditures
3) Credentialing of eligible agencies/programs per Medicaid Service description requirements
4) Auditing/verification of local expenditures;
5) Client eligibility
6) Client record documentation of services provided/billed
7) Service delivery consistency with AHCA descriptions
8) Preparation/submission of Quarterly Certification Reports

Structures/Models for local administration of the program:

A. Direct Administration by County:

1) County contracts grant funding to provider(s) designated as eligible to bill for these services:
   - ♦ Provider establishes separate account,
   - ♦ Provider debits account for eligible services,
   - ♦ Provider submits federal claim share to AHCA,
   - ♦ Provider submits Quarterly Report of Services to the County,
   - ♦ County completes spot audit of reported services, and
   - ♦ County submits Quarterly Certification report to AHCA.

2) County administers the program as a health plan:
   - ♦ Funds designated as match remain with the County in an account,
   - ♦ Provider submits claims for services provided to the County for match share,
   - ♦ County, based on claims submissions prepares Quarterly Report,
   - ♦ County spot audits claims at provider level, and
   - ♦ County certifies and submits Quarterly Report.

B. County subcontracts some/ program responsibilities to an ASO:

1) ASO monitors the program (one Billing Agent could serve multiple Counties):
   - ♦ County contracts grant funding to provider(s) designated as eligible to bill for this program;
   - ♦ Provider establishes separate account,
   - ♦ Provider debits account for eligible services,
   - ♦ Provider submits federal claim share to AHCA,
   - ♦ Provider provides Quarterly Report of Services to the designated ASO,
   - ♦ ASO completes spot audit of reported services,
   - ♦ ASO compiles Quarterly Report and submits to the County, and
   - ♦ County validates Report and submits Quarterly
   - ♦ Certification Report to AHCA.

2) ASO administers the County Plan submitted to AHCA:
   - ♦ County contracts eligible funds to ASO/Billing Agent,
   - ♦ ASO establishes separate fund management capability,
   - ♦ Provider submits claims for services provided to ASO,
   - ♦ ASO submits claims to AHCA for Federal share,
   - ♦ ASO/Billing Agent debits County Fund Account,
   - ♦ ASO/Billing Agent reimburses the provider,
   - ♦ Based on claims submissions ASO prepares Quarterly Report,
   - ♦ ASO spot audits provider claims, submits quarterly report to County, and
   - ♦ County validates report, submits certified Quarterly Report to AHCA,
   - ♦ ASO analyses billings, profiles service recipients and ensures the inclusion of analyses in local service evaluations, needs assessments and service integration activities.