National Alliance for Care at Home

Medicaid in the News: Federal and State Issues Impacting Home Care Services

7/24/2026

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Agenda

OBBA Provisions & Subsequent Federal Guidance

Program Integrity Actions

Other Home Care Issues

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OBBA Provisions & Federal Regulations

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Background

On July 4th, President Trump signed a "reconciliation" bill into law that made significant changes to Federal spending policy

- Reconciliation is necessary to pass legislation without any Democrat votes
- Comes with significant process and content restrictions

The core of the bill is an extension and expansion of lower taxes coupled with spending reductions to offset the budgetary impacts

Medicaid reductions represent a significant portion of the legislation

- Estimated at $911 billion over ten years
- KFF estimates the Florida share of the cuts will be $14 billion, but potentially as high as $17 billion.

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https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/

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Key Bill Provisions

Sec. 71108. Revising home equity limit for determining eligibility for long-term care services under the Medicaid program.	• Would drop the limit from 1.07million (indexed to inflation) to $1 million flat
Sec. 71112. Reducing State Medicaid Costs (aka Modifying retroactive coverage under the Medicaid and CHIP)	• Limit coverage from current 3-months to 1-month prior to application for ACA expansion enrollees; 2-months for everyone else
Sec. 71118. Requiring Budget Neutrality for Medicaid Demonstration Projects Under Section 1115	• Add additional structure and requirements for the process to ensure that 1115s do not increase Federal Costs

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1115 Budget Neutrality

Basic overview: 1115s cannot cost the federal government more than it would cost without the waiver

- Not new requirement, but new ways of enforcement and calculation

New Policies:

- CMS' Actuarial staff must sign off on the cost neutrality projections using generally accepted actuarial principles
  - Previously you would project out costs and then monitor the expenses to ensure that they fell below without-waiver projections;
  - Now, it will move to a prospective actuarial certification of budget neutrality – ie: not project-and-monitor, but instead a full actuarial assessment before approval.
- Limiting what can be counted as a "without waiver" cost – in essence, it's a more limited scope of what you can count towards the baseline that you have to spend less than. HCBS is directly implicated here.
- Shortening the "look back period"
- requiring a more nuanced analysis of the fiscal impact of each waiver component to be done individually

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Sec. 7115 Provider Taxes

Nonexpansion states:

- Provider tax threshold is frozen at whatever was in place on the date of enactment of the legislation
- States would not be permitted to expand taxes to new types of providers or services, nor would they be allowed to increase any existing tax rates

Expansion states:

- provider tax threshold is frozen
- the maximum allowable provider tax rate slowly decreases on the following schedule:
  - 5.5% for Federal fiscal year (FFY) 2028
  - 5% for FFY 2029,
  - 4.5% for FFY 2030
  - 4% for FFY 2031
  - 3.5% for FFY 2032 and beyond.
- Nursing facilities and intermediate care facilities for individuals with intellectual disabilities will not be subject to the lower threshold; taxes are frozen

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Sec. 71116. State Directed Payments

Nonexpansion states:

- Limited to 110 percent of the Medicare rate
- If there is no Medicare rate, then 110% of the Medicaid State plan rate

Expansion states:

- Limited to 100 percent of the Medicare rate
- If there is no Medicare rate, the Medicaid State plan rate
- January 1, 2028: SDPs that exceed these limits must decrease by 10% each year

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State Directed Payments

Proposed regulations

- Released on May 22nd
- Comments due July 21st
- https://www.federalregister.gov/documents/2026/05/22/2026-10292/medicaid-program-medicaid-managed-care-state-directed-payments-and-medicaid-fee-for-service-targeted

Applicability:

- SDPs -> the state specifically tells managed care plans what to pay in certain circumstances
- Three parts to the rule:
  - SDPs to hospital, nursing facility, and academic medical center practitioner services
  - SDPs to other providers
  - FFS "targeted practitioner services"

Changes appear more aggressive than expected:

- Projected savings of $510.1 billion compared to original CBO estimate of $149.4 billion
- Applied to every service in managed care
- Extended to targeted practitioner payments

Home Care Implications

- May impact PDN, Personal Care, and other HCBS in instances where the state imposed a uniform increase and/or provides limited availability for some providers to qualify

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SEC. 71121. Making Certain Adjustments to Coverage of Home or Community-Based Services Under Medicaid

Allows states to create a new 1915(c) waiver, beginning July 1, 2028, that serves individuals who do not meet the institutional level of care typically required for these waivers

- Clinical eligibility for these waivers uses a needs-based criteria
- Similar to the eligibility requirements for 1915(i) state plan HCBS

State must demonstrate

- The per-capita cost will be lower than the cost of institutional care for serving these individuals,
- The waiver will not result in increased waiting times for those who meet the institutional level of care criteria

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Olmstead Memorandum

Background
- Department of Justice memorandum in June reinterpreted Federal government's approach to HCBS and integration
- Memo focused on Olmstead vs. LC Supreme Court Decision, but implications are much broader

Issue
- What constitutes discrimination under Federal law and regulations?
- What are state obligations for community integration of people with disabilities?

Potential Ramifications
- Different DOJ approaches to litigation and consent decrees
- Changes to Federal regulations, such as Rehabilitation Act and ADA

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Fraud Oversight in Medicaid

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Fraud Oversight and Investigations

CMS has focused on program integrity as a top priority

- Includes care at home services in both Medicare and Medicaid

Immediate actions are occurring in Minnesota, California, Maine, New York, Ohio, and Florida

- Other states will likely be included in the future

Understanding the context can help prepare and protect your business

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Issue in Minnesota

State Medicaid Agency Identified 14 At-Risk Services	• Services found to be "at risk" of fraud • Not necessarily indicating substantiated fraud
State Medicaid Agency initiated prepayment reviews of 14 services	• Led to claims (even 'clean' claims) held to the Federal maximum timeframe
CMS asserted insufficient action	• Required corrective action plan by Dec. 31 • CAP rejected by CMS, triggering 'deferral'
Corrective Action Plan	• Large part of the plan was "off cycle provider revalidations" • Approved by CMS March 19

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14 Identified Services

Adult companion services.	Adult day services.
Adult rehabilitative mental health services.	Assertive community treatment.
Community First Services and Supports (CFSS)/ personal care assistance (PCA).	Early Intensive Developmental and Behavioral Intervention (EIDBI) services.
Housing Stabilization Services.	Individualized home supports.
Integrated community supports.	Intensive residential treatment services.
Night supervision services.	Nonemergency medical transportation services.
Peer recovery services.	Recuperative care services

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Administration & Congress "Crushing" Fraud

Focus: Care at home services – Medicare & Medicaid

- **January**:
  - Dr Oz visits LA County and meets with home health and hospice leaders
  - Numerous subsequent videos and stories released on California fraud
  - CMS issues notice of deferral to Minnesota Medicaid, alleging systematic fraud and lack of state oversight
  - CMS sends California Medicaid a letter requesting information on oversight
- **February**:
  - House Energy and Commerce Committee, Oversight & Investigations Subcommittee - Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid
  - CMS releases CRUSH RFI seeking feedback on strategies to address fraud in the system; Sends Maine oversight letter
- **March**:
  - House Energy and Commerce Committee, Oversight & Investigations Subcommittee - Protecting Patients and Safeguarding Taxpayer Dollars: The Role of CMS in Combatting Medicare and Medicaid Fraud
  - Witness – Kim Brandt, Deputy Administrator and Chief Operating Officer, Centers for Medicare & Medicaid Services
  - House Oversight Committee launches investigation into California hospice fraud
  - CMS sends New York and Florida Letters on Medicaid fraud

Administration & Congress "Crushing" Fraud

Focus: Care at home services – Medicare & Medicaid

- **April:**
  - House Ways and Means Committee Hearing, Protecting Patients and Taxpayers: Cracking Down on Medicare Fraud
  - All 50 states + DC receive CMS letter requesting plan for revalidating providers
- **May:**
  - National moratorium on Home Health and Hospice provider enrollment in Medicare
    - State option to implement Medicaid moratorium
  - $1.3 billion deferral to California Medicaid
- **June:**
  - Ohio partners with Administration to implement aggressive fraud crackdown, with homecare as a focus
  - House Energy and Commerce Subcommittee on Oversight and Investigations held a hearing on June 25, 2026, titled "State Medicaid Program Integrity: Examining Fraud Risks and Oversight Deficiencies"
  - New York & Hawaii MFCUs decertified
- **July:**
  - Florida MFCU receives "conditional recertification"

Considerations for Providers

Actions in one state are likely to inform other states & CMS

- Example: Minnesota's provider revalidation strategy becoming a national requirement via CMS subregulatory guidance

Audits and payment reviews likely to increase

Potential risk for payment delays/disallowances

Ensuring compliance will be crucial

- Improper payments are often treated similarly to fraud, even if not the same

Potential Activities: (1) internal reviews of authorizations, documentation, all proper paperwork and coding
(2) Review and ensure corporate compliance plan is updated
(3) Training staff on procedures and requirements

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Other Home Care Issues

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Self-Direction and Family Caregiving

- Self-direction has grown substantially over the past decade in Medicaid as a response to both COVID-19 social isolation policies as well as provider shortages
- A large proportion of self-directed workers are family members of the beneficiary
- Policymakers some advocacy organizations have expressed concerns about program integrity vulnerabilities within these service models:
  - For example – the Paragon Institute platform recommends, "Prohibit payment to relatives or household members for HCBS or personal care services."
- Additional concerns and controversy have arisen in states with large self-direction programs, such as NY and CA:
  - CDPAP Lawsuit in NY
  - CA Deferral (discussed earlier) centered around IHSS
- Simultaneously, other states have continued to expand certain family caregiving programs, such as the Family CNA program

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What about the Medicaid Access Rule?

- Delay/repeal not included in Reconciliation due to Congressional rules
- Rulemaking becomes likely avenue for changes
- OMB request for information regarding deregulatory actions
- Presidential order – repeal 10 regulations for every new rule

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Questions?


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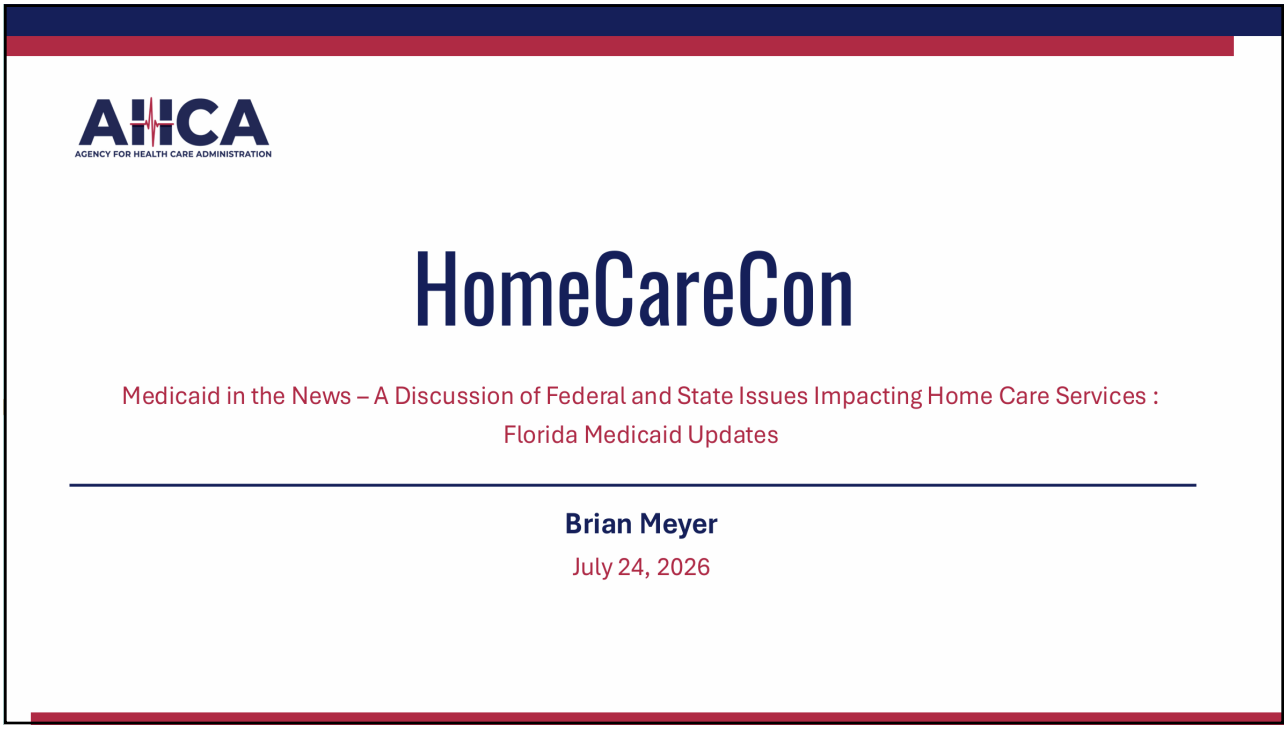
Thank you!


AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION
HomeCareCon
Medicaid in the News – A Discussion of Federal and State Issues Impacting Home Care Services :
Florida Medicaid Updates
Brian Meyer
July 24, 2026

What is Medicaid?

- Medicaid is a federal program through which states partner with the federal government to provide health care coverage to low-income children, families, elders, and people with disabilities.
- Medicaid serves more than 4 million of the most vulnerable Floridians.

Over 2.1 million	• Adults - parents, elderly, and disabled
48%	• Children in Florida
46%	• Birth deliveries in Florida (CY 2023)
60%	• Nursing home days in Florida

Statewide Medicaid Managed Care (SMMC) Program
- Implemented in 2013-2014
- 74% of Medicaid Enrollees

- Florida Medicaid estimated spending of over $37.5 billion in Fiscal Year 2025-26.
- Nearly 3.9 million Floridians are covered under the Medicaid program as of July of 2026.
- States that participate in the Medicaid program are required to provide certain mandatory services, including Home Health; and can choose to provide optional services, such as DME.

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Medicaid Home Health and Durable Medical Equipment

Florida Medicaid State Plan

Florida Medicaid covers medically necessary home and durable medical equipment and supplies.
Covered home health services include:
- Skilled Nursing
- Private Duty Nursing (PDN)
- Personal Care Services (PCS)
- Home Health Aide (HHA) Services
- Family Home Health Aide (FHHA) Services

Services can be provided by
- Home Health Agencies
- Independent Nursing Providers (in certain limited circumstances)

Florida Medicaid Waivers

Home and Community Based Services include additional Home-Based Services, including
- Homemaker
- Companion
- Attendant Care
- Respite
- FD and Model Waivers
- PACE

Services can be provided by
- Home health agencies or
- Independent Nursing Providers (in certain limited circumstances)

Florida Medicaid DME

Florida Medicaid covers medically necessary DME including
- Orthotics
- Prosthetics
- Respiratory
- Wheelchairs
- Hospital Beds
- Ambulatory Aids
- Continence
- Ostomy
- Wound Care
- Enteral and Parenteral Nutrition
- Specialized: Augmentative and Alternative Communication Systems, Pneumatic Compressor and Appliances, Phototherapy, Suction machines, Breast Pumps, Surgically Implantable devices

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Florida Medicaid Home Health: Innovating Solutions

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Florida Medicaid Home Health: Innovating Solutions

Problem: Availability of nurses, inability of family members to serve

Solution: FHHA

Problem: Burdensome requirements keeping qualified/needed PDN providers from enrolling

Solution: PDN only provider type

Problem: Nationwide shortage of healthcare workers, particularly in nursing

Solution: Workforce Training

Problem: Department of Justice (DOJ) Injunction stating Florida needs more nurses to ensure sufficient home-based care available

Solution: FHHA, and PDN Only providers: SMMC 3.0 and CMS Plan 3.0 Contract requirements

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The Family Home Health Aide Program

How the program works:

The Family Home Health Aide (FHHA) Program began in 2024 and allows an eligible family member or guardian to provide aide services for their medically fragile child (under 21 years old and qualified for Private Duty Nursing (PDN)) at home. The family member is employed by a participating home health agency.

FHHA hours are meant to supplement PDN and cannot duplicate or add to already authorized nurse hours. Services are coordinated so FHHA does not replace skilled nursing time nor run at the same time as PDN.

The home health agency is responsible for ensuring the family member completes Agency approved required training before providing services.
Services are overseen by a nonrelated registered nurse through the home health agency to ensure quality and safety.

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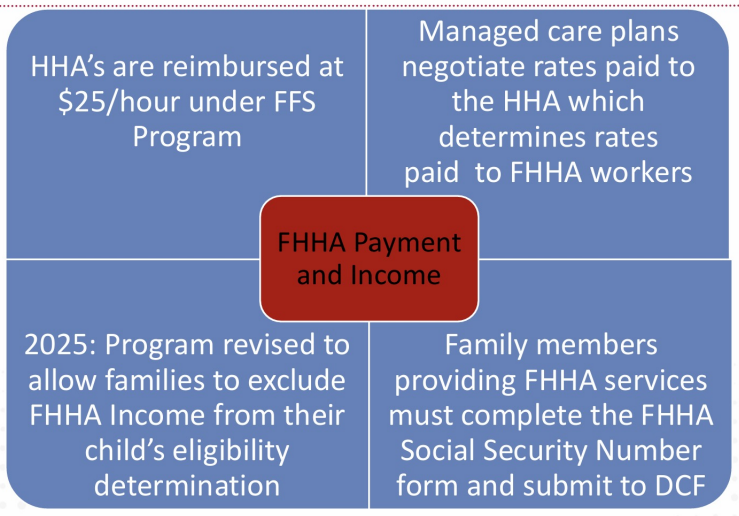
FHHA Payment and Income Provisions



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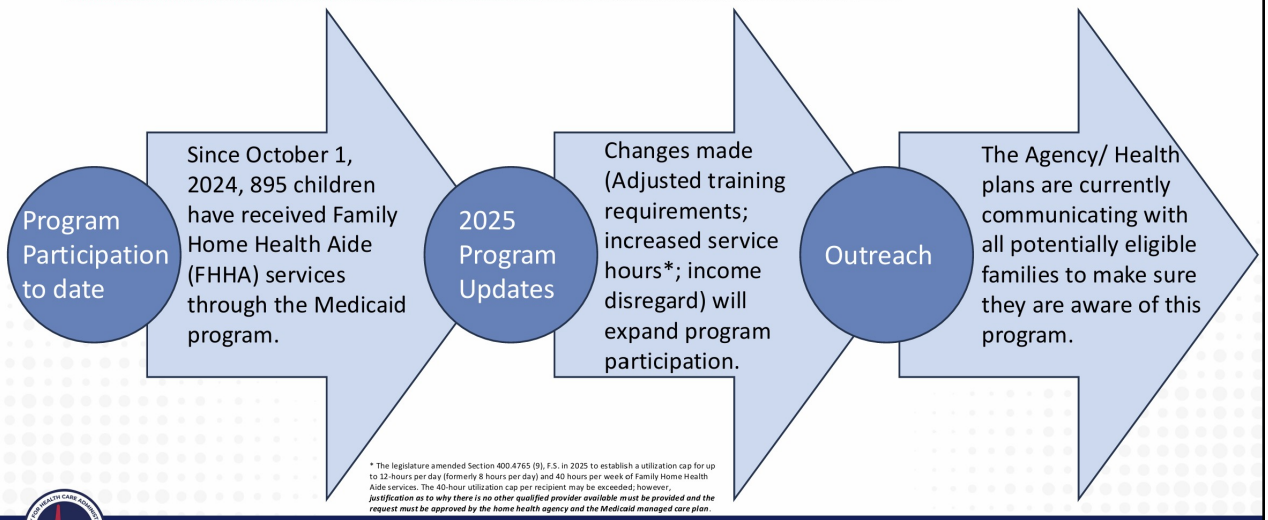
FHHA: Expanding the Program



* The legislature amended Section 400.4765 (9), F.S. in 2025 to establish a utilization cap for up to 12-hours per day (formerly 8 hours per day) and 40 hours per week of Family Home Health Aide services. The 40-hour utilization cap per recipient may be exceeded; however, ***justification as to why there is no other qualified provider available must be provided and the request must be approved by the home health agency and the Medicaid managed care plan.***

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PDN Only

- Prior to 2024, in order to provide skilled nursing services including Private Duty Nursing to children, Florida required compliance with federal regulation requiring that these providers meet Medicare certification requirement.
- Providers of skilled nursing services to children identified the Medicare requirements as burdensome and out of alignment with these services to children.
- In 2023, the Florida Legislature directed the Agency to create a pathway for PDN providers that did not require this certification to be licensed by Florida or to enroll and provide Medicaid services.
- By working collaboratively with our federal partners at Centers for Medicare & Medicaid Services, we were able to request and receive federal approval for this new provider type. (This new option was made available in April of 2024.)

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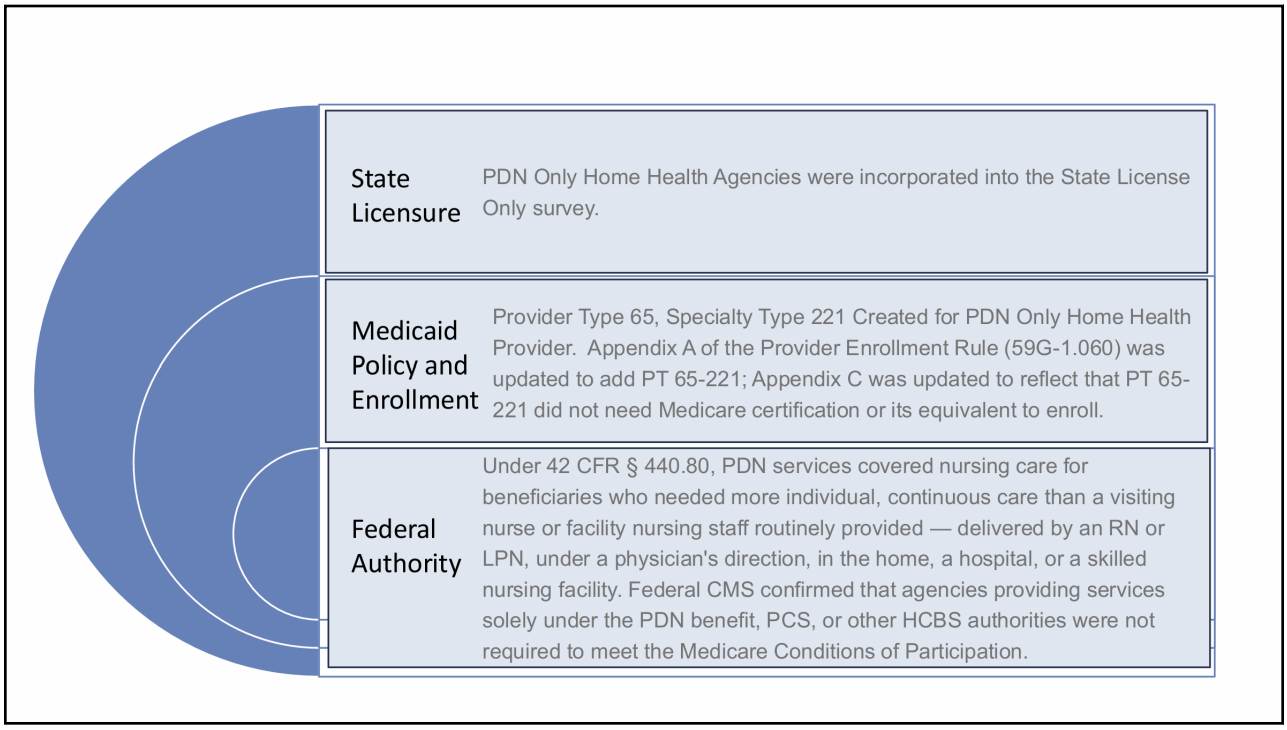

Statewide Medicaid Managed Care and Children's Medical Services Plan

- Florida Medicaid provides a majority of services through the Statewide Medicaid Managed Care program (SMMC), which include plans providing Managed Medical Assistance, Long-Term Care and Dental Services.
- In addition, the SMMC program includes a special plan to provide services to children with special healthcare needs, the Children's Medical Services Plan.
- The Agency periodically re- procures all contracts for these services:
  - New MMA, LTC and Dental Services plans went into effect February 1, 2025.
  - New Children's Medical Services Plan will go into effect October 1, 2026.
- The new contracts for each of these programs include many new features that will benefit recipients and providers.

Managed Medical Assistance (MMA)

COVERAGE:
Preventive, acute, behavioral, and therapeutics services, including pharmacy and transportation services.

ENROLLMENT:
Most Medicaid recipients must enroll in an MMA plan.

Long-Term Care (LTC)

COVERAGE:
Nursing facility, assisted living, and Home and Community-Based services.

ENROLLMENT:
65 years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

Requires Nursing Facility level of care or Hospital level of care for individuals diagnosed with cystic fibrosis.

Dental

COVERAGE:
Preventive and therapeutic dental services.

ENROLLMENT:
All Medicaid recipients in managed care and all fully Medicaid eligible Fee-For-Service individuals.

Children's Medical Services Plan
BY MOLINA HEALTHCARE

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Statewide Medicaid Managed Care

- Through the competitive procurement and new contracting cycle, the Agency was able to include numerous enhancements in the MMA, LTC, and Dental contracts:
  - Enhanced services for providers
  - Stronger quality incentive/disincentive programs to support significant increases in quality outcomes across plans
  - Other gains for providers include:

	MMA	Dental	LTC
Emphasis on Value-Based Agreements for provider reimbursement.	✓	✓	✓
Improved processing times for provider claims and prior authorization requests.	✓		✓
Increased transparency through public facing dashboards.	✓	✓	✓

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SMMC 3.0: Value Based Purchasing

- The SMMC contract includes more comprehensive value-based purchasing requirements, across provider types, with increased transparency with their participating providers and to the Agency
  - Managed care plans are required to have a value-based purchasing program that promotes the use of innovative health care delivery models, such as telehealth and patient-centered medical homes, that can enhance accessibility and coordination of care
  - Managed care plans are required to include certain elements to ensure transparency to providers so that they understand the reimbursement that they receive.
    - A detailed methodology on how enrollees are attributed to providers for calculation of final payment.
    - A detailed methodology on how each provider's target budget is calculated.
    - A detailed methodology on how data will be shared, at least quarterly, between the plan and the provider.
    - A detailed list of quality measures used for calculating shared savings or losses.

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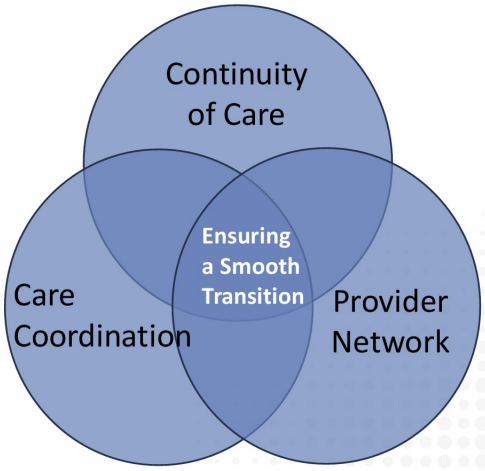
Children's Medical Services (CMS) Plan Transition

Care Coordination - Molina will extend offers of employment to all qualifying Sunshine care coordinators and will try to maintain care-coordinator assignments so that children retain their current care coordinators.

Provider Network - To ensure that children have the option to retain their current providers, including home health agencies, Molina will attempt to contract with providers that are not already within its provider network who are serving CMS Plan.

Continuity of Care - Molina will ensure continuity of care for enrollees in the CMS Plan.

- Recipients can see their current providers until May 31, 2027, or until new care plans are in place, whichever is earlier.
- During this period, Molina will honor all service authorizations in place at the time of the transition—allowing the child's current home health agency to continue to provide PDN services as before—and will reimburse each out-of-network provider at the same reimbursement rate the provider received immediately before the contract award.



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CMS Plan Transition – New Contract Requirements & Commitments

The new contract has many enhancements which may have a direct impact on providers of nursing services and the nursing workforce

Incentives to Maximize PDN Utilization- The Agency has put into place a Financial withhold structure to encourage Molina to deliver all authorized PDN hours.	**Family Transportation Support** – Up to 20 round trips per month for essential family activities when personal transportation is unavailable.
$75,000 Nursing Facility Transition Benefit –One-time, lifetime support for home-readiness needs (e.g., home/vehicle adaptions) to transition children from nursing facilities to the community.	**Home Health Agency Incentives** – Payments to agencies when children successfully transition home and remain in the community for one year.
$25,000 Home Maintenance Assistance Benefit- – Lifetime funding for non-covered home care needs to help children remain safely in the community.	**Nursing Education Investment** - $0.41 per-member-per-month (PMPM) investment to expand Florida's nursing workforce through scholarships and continuing education.
PDN Family Supports	**Reduced Care Coordinator Caseloads** – Lower ratios: max 10 children in nursing facilities, 10 children receiving 24/7 PDN, or 30 children receiving part-time PDN
PDN Cleaning & Chore Services – If needed, Monthly full-home cleaning (including deep clean of the child's sleep area) plus up to 5 hours/month of chore support.	**Family Home Health Aide Supports** – Incentives for FHHA participation, including agency payments, enhanced reimbursement during first year, and a one-time $250 gas stipend for non-resident family caregivers.

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U.S. v. Florida

- In July of 2023, an injunction was issued in this case, which had been pending since 2013.
- The injunction focused, in part, on increasing access to Private Duty Nursing services for children.
- A number of actions have resulted from this injunction that may impact home health care providers:
  - Increased focus on utilization of all functionality of EVV systems
  - Strong requirements for Managed care plans to ensure that children receive all authorized hours
  - Surveys of PDN nurses/ through home health agencies
  - Focus on provision of PDN services integrated into the CMS contract
  - Focus on transition of children out of nursing homes

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Florida's Programs Providing Home Based Services

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LTC and PACE

- Florida has two core programs that serve recipients who meet nursing home level of care – with the goal of providing services in their home or community for as long as possible, and desired, rather than in a nursing home.
  - The SMMC Long-Term Care Program provides long-term care services to eligible elderly and disabled Floridians on a statewide bases, through a network of Managed Care plans
  - The PACE program provides medical and long-term care services to the eligible elderly and is provided by an individual PACE site focused on a community with a locally based PACE center.

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LTC and PACE

	SMMC LONG TERM CARE PROGRAM	PROGRAM FOR ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)
Who enrolls in this program?	Those over the age of 65 who meet nursing facility level of care and income requirements; those over 18 with a disability who meet nursing facility or hospital level of care, and income requirements	Those over the age of 55 who meet nursing facility level of care and income requirements, are able to live safely in the community, and reside in a designated PACE area
What home based services are provided?	Companion care, attendant care, caregiver training, home accessibility adaptation, homemaker, intermittent and skilled nursing, medical equipment and supplies, personal care, respite care	Home care, personal care, homemaker, and all Medicare covered services
What additional services, equipment and supplies might be covered under this program?	Durable medical equipment and misc. items benefit- may include benefits such as mobility items, dental kits, etc., mobile personal emergency response systems, sensory/comfort items	N/A

- How do providers participate?
  - Here are the plans that participate in the LTC program: SMMC Plan Contacts for Providers 09.9.25.pdf
  - Here are the PACE providers in Florida: Workbook: PACE

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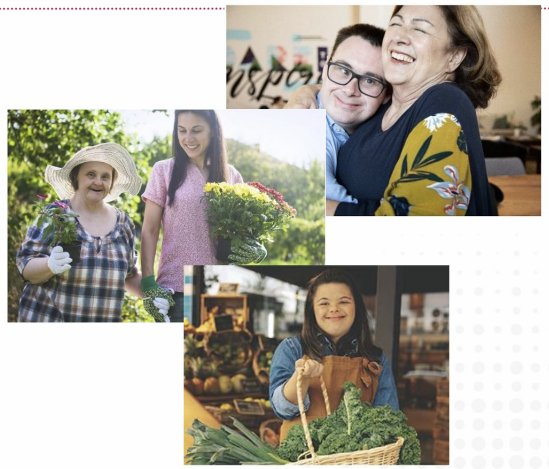
iBudget and ICMC

- Florida has two additional programs which provide services to recipients with a developmental disability – with the goal of maintaining and promote the health and functioning, supporting independence, promoting self-determination, and enhancing quality of life by providing them with the choice to receive services in their own homes or in the community, rather than in institutional settings
  - The iBudget program provides supportive services in the home and community to enabled peoples to live safely, independently and productively in their communities, through a fee-for-services network of provider.
  - The ICMC program provides safely enrollees with all of their regular healthcare services plus additional home and community-based services similar to those provided under the iBudget, through a single statewide managed care plan (Florida Community Care/FCC)



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iBudget and ICMC

	iBudget	ICMC
Who enrolls in this program?	People over the age of 3 who have a qualifying developmental disability, meet facility level of care, and who meet income requirements	People over the age of 18 who have a qualifying developmental disability, meet facility level of care, and who meet income requirements
What home based services are provided?	Adult Companion, Companion, Environmental Accessibility Adaptations, Homemaker, Intermittent and Skilled Nursing, Personal Care, Personal Supports, Private Duty Nursing/Attendant Care, Respite, Skilled Nursing, Unpaid Caregiver Training	Adult Companion Care, Attendant Nursing Care, Caregiver Training, Home Accessibility Adaptation, Homemaker, Intermittent and Skilled Nursing, Medical Equipment and Supplies, Personal Care, Respite Care, Companion, Personal Supports, Private Duty Nursing/ Attendant care, Skilled Nursing
What additional equipment and supplies might be covered under this program?	N/A	Durable Medical Equipment and Supplies –May include benefits such as Blood Pressure Monitors, Hospital beds, etc.;

- How do providers participate?
- Providers can contact FCC by emailing Send an inquiry to ProviderRelations@ilshealth.com or calling 1-866-962-6186 or 1-833.FCC.PLAN to speak with a Provider Relations team member
- **Here is a link to APD provider support information:** APD - Provider Supports - Agency for Persons with Disabilities - State of Florida

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Patient/ Consumer Directed Care

- These programs allows members to hire, train, supervise, and dismiss individuals of their choice to provide certain specific services. For the programs that utilize managed care (LTC and ICMC), members are allowed to utilize out of network providers if they choose.

ICMC
Intellectual & Developmental Disabilities Comprehensive Managed Care

The ICMC Program's PDO includes **PDN/attendant care, Life skills development Level 1 (Companion), Personal Supports, Adult Companion, Personal Care, Intermittent and Skilled Nursing, Skilled Nursing, and Homemaker.**

The LTC program's PDO includes **Adult Companion, Personal Care, Homemaker, Intermittent and Skilled Nursing, and Attendant Care.**

iBudget
apd
agency for persons with disabilities
State of Florida

The iBudget Program's PDO (which is known as the CDC+ program), includes **Life Skills Development Level 2 , Supported Employment, Adult Dental Services, Speech Therapy, Supported Living, Coaching, Specialized Mental Health Counseling, Environmental Accessibility Adaptations, Life Skills Development Level 3, Adult Day Training, Behavior Assistant Services, Dietitian Services, Life Skills Development Level 1, Companion, Respite, Residential Habilitation, Skilled Nursing, Personal Supports, Life Skills Development Level 4 , Prevocational Services, Physical Therapy, Personal Emergency Response System ,Support Coordination, Private Duty Nursing, Respiratory Therapy, Occupational Therapy, Residential Nursing, Behavior Analysis Services, Specialized Medical Equipment and Supplies, Transportation, Specialized Medical Home Care.**

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Combatting Fraud Waste and Abuse in Florida Medicaid

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Combatting Fraud, Waste and Abuse in Florida Medicaid

- Florida Medicaid has always been focused on program and operational choices that preserve state and federal Medicaid funds for the core constituency of the program as originally envisioned; the permanently disabled, and low-income children, pregnant women and parents in need of temporary assistance.
- This primary goal has always been supported by a fundamental responsibility to ensure that the program is as cost effective as possible to preserve funding for those core constituencies.
- Florida's current efforts include projects that align with Federal CMS' goal of protecting the integrity of the program and taxpayer funds from fraud, waste, abuse and corruption. These include:
  - Moratoria
  - Provider Revalidation

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Combatting Fraud, Waste and Abuse in Florida Medicaid

Current Situation: Moratoria

- Federal moratoria are in place for home health, hospice, and durable medical equipment providers.
  - Florida currently has a state Medicaid program moratorium in place for enrollment of new Durable Medical Equipment (DME) providers. The Agency will continue processing DMEPOS provider applications submitted on or before March 20, 2026. Existing DME providers may continue to provide and bill for authorized services.
  - In addition, Florida currently has a moratorium in place for Adult Day Health Care providers in Miami-Dade County (only).
  - Florida has used moratoria previously, for Home Health (2019-2021) and for Behavior Analysis (2018-2022).

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Combatting Fraud, Waste and Abuse in Florida Medicaid

Current Situation: Provider Revalidation

- Medicaid program have always been required to revalidate providers at least every five years.
- In April 2026, CMS announced that all state Medicaid programs must submit a process to revalidate all providers within two years.
  - Florida's revalidation strategy includes :
    - Risk stratification of all providers to identify high and moderate risk providers for prioritized revalidation
    - Enhanced screening and monitoring of high-risk providers
    - Enhanced monitoring and surveillance of the provider network utilization comprehensive AI-enabled provider revalidation
    - Leveraging the contractual obligations of Medicaid managed care providers
    - Maintaining a strong partnership with state and federal law enforcement

26

2026 Legislative Session

27

2026 Legislative Session –What's new?

- During the recent Legislative Session, the House and Senate passed, and Governor DeSantis signed into law, provisions which:
  - Expanded coverage of orthotics and prosthetics
  - Coverage of blood pressure monitors and blood pressure cuffs for pregnant women diagnosed with or at risk of hypertension
  - Added addition coverage of lung devices and therapies
  - Continued support for nurse workforce programs

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2026 Legislative Session –What's new?

- Direction to the Agency and the Medicaid program to add coverage of specific orthotic, prosthetic and lung therapy equipment and services:

Added New Coverage	Provided Funds for New Covered Codes	Provided Funds to Increase Payment for Existing Code	
		√ 20%	Healthcare Common Procedure Coding System (HCPCS) Level II L-codes: L5972, L0456, L1660, L1620, L1500, L5986, L7007, L7009, L6881, L6882, and L6935
		√13.2%	L1970, L2280, L1960, L1940, L1200, L5981, L5301, L5673, L2820, L5321, L5611, L5649, L5679, L5700, L5814, L3000, L2036, L1945, L5968, L0631, L5701, L1833, L5940, L5671, L5950, L2340, L5845, L5620, L5651, and L0482
√	√ Rate of $1,038		L1320
√	√ 65% of the Medicare Rate		L0637 through L0640, L1907, L3766, L5615, L5783, L5992, L6028, L6039, L6694, L6696, L6698, L6704, L6721, L6722, L7400, L7401, L7403, and L7404.
√			Coverage for eligible Medicaid recipients for combination oscillatory lung expansion devices for Oscillation and Lung Therapy durable medical equipment related to Healthcare Common Procedure Coding System (HCPCS) codes: E0469 and A7021.
√			A4670 (blood pressure monitor) and A4633 (cuff)

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2026 Legislative Session –What's new?

- Continued funding to support two nurse workforce programs, including:

Continued Funding/Authority	
√ $27 million program wide	**Training, Education, and Clinicals in Health (TEACH) Funding Program:** This program focuses on community-based health centers and funds those who train community-based providers, including APRNs pursuing a primary care specialty and nursing students, who receive their training in qualified settings including Federally Qualified Health Centers, Community Mental Health Centers, and Rural Health Clinics.
√ ~ $400 million	**Workforce Expansion and Education Program (FIRST N-IME)**: Nursing workforce expansion and education program for institutions participating in a nursing education program.

Florida Medicaid Resource Guide:

Rules relating to provision of in home based skilled and unskilled care:

- Home Health Services
  - Rule 59G-4.130
  - Home Health Visit Services Fee Schedule
- Private Duty Nursing and Family Home Health Aide
  - Rule 59G-4.261
  - PDN Fee Schedule
  - FHHA Fee Schedule
- Rules relating to provision of Durable Medical Equipment and Medical Supply Services
  - Rule 59G-4.072: Specialized
  - Rule 59G-4.073: Orthotic and Prosthetic
  - Rule 59G-4.074: Respiratory
  - Rule 59G-4.075: Wheelchairs, Hospital Beds, and Ambulatory Aids
  - Rule 59G-4.076: Continence, Ostomy, and Wound Care
  - Rule 59G-4.077: Enteral and Parenteral Nutrition
  - 2026 DME Fee Schedule


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