Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Florida** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Florida Long-Term Care Managed Care

C. Type of Request:new

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

(•) **3 years** ( ) **5 years**

[ ] **New to replace waiver**
Replacing Waiver Number:

[ ] **Migration Waiver** - this is an existing approved waiver
Provide the information about the original waiverbeing migrated
Base Waiver Number:
Amendment Number (if applicable):
Effective Date: *(mm/dd/yy)*

Waiver Number:FL.0962.R00.00
Draft ID: FL.41.00.00

D. Type of Waiver *(select only one):*
Regular Waiver

E. Proposed Effective Date: *(mm/dd/yy)*
07/01/13
Approved Effective Date: 07/01/13

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

● **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☑ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Florida Long-Term Care Managed Care, which is being submitted concurrently with this 1915(c) application.

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☑ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☑ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Florida Agency for Health Care Administration (AHCA/State) is submitting a 1915(b) and a 1915(c) waiver application to the Centers for Medicare & Medicaid Services (CMS) to implement the Florida Long-Term Care Managed Care Program mandated by the 2011 Florida Legislature. HB 7107 creates Section 409.978 of Florida Statutes to establish a statewide long-term care managed care program for Medicaid recipients who are (a) 65 years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability; and (b) determined to require nursing facility level of care. AHCA will implement and administer the Florida Long-Term Care Managed Care Program in partnership with the Department of Elder Affairs (DOEA).

The specific authorities requested in the 1915(b) and (c) waiver applications will allow the State to require eligible Medicaid recipients to receive their nursing facility, hospice, and home and community based services (HCBS) through long-term care (LTC) plans selected by the State through a competitive procurement process. Nursing facility level of care will continue to be determined by the existing Comprehensive Assessment and Review for Long-Term Care Services (CARES) Units. No HCBS funding will be used to fund Nursing Facility Services. Medicaid recipients eligible for the Florida Long-Term Care Managed Care Program will have a choice of plans and may select any plan available to them in their region. The State has been divided into eleven regions, each of which is required to have a specified number of long-term care plans, which will be selected through a competitive procurement. With the implementation of Florida Long-Term Care Managed Care, four of Florida's current HCBS waivers (Aged/Disabled Adult, Assisted living, Channeling for the Frail Elderly and Nursing Home Diversion)will be phased-out, and eligible recipients will receive HCBS through the Florida Long-Term Care Managed Care Program. Hospice is a state plan service covered under the 1915(b) waiver. The vast majority of long-term care plan members will be dually eligible for Medicare and Medicaid. As a consequence, most plan members' hospice services will be reimbursed through Medicare.

In implementing and operating the Florida Long-Term Care Managed Care Program, AHCA will, together with DOEA, develop specifications for procurement, monitor plan performance, measure quality of service delivery, identify and remediate any issues, and facilitate working relationships between LTC plans and providers. Through these efforts, the state will provide incentives to serve recipients in the least restrictive setting and eligible recipients should receive improved access to care and quality of care.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery.Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights.Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards.Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy.Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability.Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration.Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
  Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

- [ ] **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
  Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
AHCA held public meetings in each of the eleven regions in June of 2011. On average there were 160 attendees at each of these meetings, ranging from a low of 80 to a high of 266, and an average of 32 speakers (ranging from 19 to 43). Comments were made during the public meetings as well as by email and regular mail. Comments were considered in drafting the 1915(b) and 1915(c) applications. The opportunity for public comment will continue past the submission deadline of August 1. Specific information on the public notices and regional meetings can be located on AHCA's website at: http://www.fdhc.state.fl.us/Medicaid/statewide_mc/index.shtml.

J. **Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Abbott

First Name: Darcy

Title: AHCA Administrator, Bureau of Medicaid Services

Agency: Agency for Health Care Administration

Address: 2727 Mahan Drive, Mail Stop #20

Address 2:

City: Tallahassee

State: Florida

Zip: 32308

Phone: (850) 412-4236 **Ext:** ☐ **TTY**

Fax: (850) 414-1721

E-mail: Darcy.Abbott@ahca.myflorida.com

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: Florida

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Justin Senior

State Medicaid Director or Designee

Submission Date: Jan 28, 2013

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Senior

First Name: Justin M.

Title: Deputy Secretary for Medicaid

Agency: Agency for Health Care Administration

Address: 2727 Mahan Drive, Mail Stop #8

Address 2:

City: Tallahassee

State: Florida

Zip: 32308

Phone: (850) 412-4007 **Ext:** ☐ **TTY**

Fax: (850) 414-1721

E-mail: Justin.Senior@ahca.myflorida.com

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

The Florida Long-Term Care Managed Care Program will replace the Aged and Disabled Adult (A/DA), Assisted Living (AL), Nursing Home Diversion (NHD) and Channeling waivers currently operated by the State of Florida. AHCA will submit amendment requests to these waivers to close-out those waivers as the Florida Long-Term Care Managed Care program is implemented across the state. Medicaid recipients who, on the date long-term care (LTC) plans become available in their region, are enrolled in one of those waivers will be transitioned to the Florida Long-Term Care Managed Care Program.

In designing the service specifications for this 1915(c) waiver application, the State reviewed the service arrays offered under these waivers and the utilization of services to ensure all current HCB service needs of transitioned waiver participants can continue to be met under this new 1915(c)waiver. The provision of enrollment broker services prior to the implementation start date will help ensure current waiver services are delivered without interruption.

An independent enrollment broker will conduct the enrollment activities for transitioning recipients. These responsibilities will include (1) adhering to the State determined timeline for the transfer of recipients to LTC plans; and (2) transferring all necessary provider enrollment files to effectively coordinate the suspension of current waiver services and the commencement of new waiver services.

To further enhance continuity of care for transitioned recipients, the State will ensure: (1) payment to existing providers during the transition period is continued, and (2) LTC plans will provide for the use of out-of-plan services until the LTC plan has reviewed each new enrollee's current plan of care and has developed and implemented a new person-centered written plan of care with the enrollee.

The transition process is as folows:

The Agency will send affected Medicaid recipients a notice, followed by an enrollment information package, including important action dates prior to each region's transition date. Whether recipients are currently enrolled in a managed care plan or not they will be directed to review the materials and receive telephonic or face-to-face choice counseling to choose the best plan for their needs. The Agency will automatically enroll recipients into an LTC plan if they do not select a plan of their own volition based on the following criteria:

(a) Whether the plan has sufficient network capacity to meet the needs of the recipients. Considerations include, but are not limited to, the plan's enrollment capacity; whether the plan has established provider contracts with all required providers in the region (i.e., nursing facilities, hospices, aging services providers that have recently served recipients); network adequacy standards including whether the plan, at a minimum, has two providers for each service type per county; and, for nursing facilities, assisted living facilities, and adult day health care centers, the geographical proximity of the plan's providers to the recipient.

(b) Whether the recipient is enrolled in that plan through the Nursing Home Diversion waiver.

The State has determined the Choice Counseling process is the best vehicle to help transitioning and new recipients chose a managed care plan as follows:

•For recipients in the Nursing Home Diversion waiver whose current plan is chosen to participate in the LTCMC waiver, the State will automatically enroll them in their current plan's new program unless they elect to change.

•Choice Counselors will have provider listings for each plan's network. During the choice counseling process, the recipient and the counselor will discuss the recipient's needs and the providers available to them under each plan so the recipient may make the best enrollment decision.

•For recipients who do not engage in the choice counseling process, the State can access the recipient's Special Needs Plan and Medicare Advantage information when considering which plan to automatically enroll a recipient in.

Whether a recipient choses a plan, or is automatically enrolled, they retain the right to change plans during open enrollment and for cause thereafter.

Once a recipient has chosen or is assigned to a managed care plan, the Agency will notify the plan of the new enrollee. Managed care plans are required to send new enrollees a welcome enrollment package by the first day of enrollment or within five calendar days following receipt of the enrollment file from Medicaid or its agent, whichever is later. Managed care plans are required to continue a new enrollee's services for up to sixty days after enrollment, or until they complete the required case management and care plan assessments. Irrespective of whether an enrollee has transitioned from another plan or not, their care will continue unabated until the new managed care plan has finished its required assessments. Enrollees retain their right to a Fair Hearing to challenge plan determinations and their right to continue services at their current level until the appeal is exhausted. DOEA will audit care plans that are reduced as a result of the new managed care plan's assessments.

All current Nursing Home Diversion waiver managed care plans are required to develop transition plans for their enrollees on the basis of:

•If the plan is awarded a contract under the long-term care managed care program.
•If the plan is not awarded a contract and will continue to serve enrollees until the transition date in all regions served.
•If the plan is not awarded a contract and will end its contract early and stop serving enrollees prior to the date of transition.

DOEA will assess these transition plans to determine whether they meet the extensive transition plan requirements contained in its current provider contract and to determine which of the three options above the plan intends to pursue.

All managed care plans that win contracts to provide long-term care managed care services under the new waiver are required to submit transition plans. The Agency will assess the transition plans during the plan readiness period after contract awards and prior to the "go live" date in the region.

The state will ensure recipient services continue seamlessly by three means:

1)Recipients who do not complete choice counseling and select a managed care plan will be automatically enrolled in a plan by the State. The plan will then be responsible for delivering services and sending enrollment information to the recipient.

2)Plans are required to continue new enrollees' services unchanged and unabated for up to 60 days after enrollment, or until the plan completes its reassessments and service planning using a person-centered approach. Enrollees retain their right to a Fair Hearing to appeal a plan's assessment and the service levels in the person-centered plan. They may also appeal through the state's alternate Beneficiary Assistance Program. Plans must continue services at the current level until the end of the Fair Hearing process.

3)Plans are required to provide medically necessary services by any means. Accordingly, if a plan does not have a suitable provider for a medically necessary service in its network, it must arrange for a recipient to receive care by an out-of-network provider. Medical necessity is defined in Medicaid rule 59G-1.010(166), Florida Administrative Code.

Florida Statute (s. 409.982(1)(c)) requires every long term care managed care plan to offer network contracts to all nursing facilities, hospices, and to all current aging service providers in their region. This requirement will help ensure continuity of care by giving current long-term care service providers the opportunity to continue serving current clients.

Managed care plans are required to continue transitioning enrollees services at the same level, and with the providers identified in the transition plan and plan of care for up to 60 days after transition, or until the plan has completed its required reassessments, developed a new person-centered care plan, and made provision for services with providers. If a plan cannot deliver the services required with providers in its network, it must continue to make provisions for services with the enrollee's out-of-network provider. In the instance an enrollee's provider leaves the plan, the enrollee may select another service provider, or may request to change managed care plans. An enrollee may change plan within 90 days of enrollment for any reason, and for cause thereafter. The state considers for cause disenrollments on a case-by-case basis. A recipient wishing to switch plans in order to retain their historical service provider would be considered for good cause.

The State recognizes that during initial implementation, and due to the requirements for plans to adopt a person-centered approach to developing the new care plans, this may not be feasible for all transitioning recipients. While the plans are preparing to deploy significant resources to meet the five day target during transition, the State requires the 60 day service extension as a safeguard for new enrollees.

The State will use the same administrative process for appeals during transition as the on-going program's appeal process. For Fair Hearings, the Department Children and Family's Office of Appeals Hearings will handle all aspects of this process. Medicaid Agency contract managers will be responsible for assisting the hearing officer with evidentiary program documentation and policy. Likewise, the Medicaid Agency's Beneficiary Assistance Program's (BAP) will handle all aspects of appeals from adverse actions if the plan member selects this route to contest a decision. The BAP program is a supplemental dispute process. It is not required prior to a recipient accessing the Fair Hearing process and does not replace the right to a Fair Hearing. Medicaid Agency contract managers will be responsible for providing assistance to the BAP as necessary. Additional information on these processes will be provided to the transitioning enrollee as part of their plan enrollment packet.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The four waivers being replaced by this 1915(c) are operated by the Department of Elder Affairs (DOEA), which is a separate agency of the state that is not a division/unit of the State Medicaid Agency. This waiver will be operated by the State Medicaid Agency (AHCA), though certain functions, including level of care evaluation and specified monitoring and quality improvement functions, will be conducted by DOEA.

Please note, when referring to individuals enrolled in the waiver the State refers to them as recipients. When referring to waiver recipients who are enrolled in a Managed Care Plan, the State refers to them an enrollees.

LTC Transition Plan

Background Information
Florida's Long-Term Care Managed Care waiver will merge the following waivers into a single managed long-term care waiver: Aged/Disabled Adult, Assisted Living, Channeling for Frail Elders, and Nursing Home Diversion. The new program will operate under Section 1915 (b)(c) waiver authorities. Managed care plans will be selectively procured. Plan

members will be locked in for one year, once they have chosen or been assigned to a plan. Each of the enrolled waiver recipients as well as the individuals on the related program waiting lists will receive information about the new program, be counseled about their choice options, and be enrolled when an enrollment opportunity becomes available. The following charts detail current aging waiver enrollment and the LTC implementation schedule.

Feeder Waiver enrollment as 12-1-12

Aged/Disabled Adult-------10,015
Assisted Living ----------3,209
Channeling----------1,247
Nursing Home Diversion----21,381
Total----------35,852

LTC Implementation Plan by Region

August 2013------Region 7
September, 2013--Regions 8 and 9
October 2013-----None
November 2013----Regions 1,2 and 10
December 2013----Regions 11
January 2014-----None
February 2014----Regions 5 and 6
March, 2014------Regions 3 and 4

Recipient Enrollment Notice Letters Mailed

August 2013 Enrollment---------May 20,2013
September 2013 Enrollment------June 20,2013
November 2013 Enrollment-------August 20,2013
December 2013 Enrollment-------September 20,2013
February 2014 Enrollment-------November 20,2013
March 2014 Enrollment----------December 20, 2013

Anticipated LTC Enrollment by Month based upon 12-1-12 Enrollment Feeder Waiver Enrollment Levels

August 2013
Aged/Disabled Adult--------793
Assisted Living----------352
Channeling----------0
Nursing Home Diversion---2,155
Total----------3,300

September 2013
Aged/Disabled Adult------1,094
Assisted Living----------326
Channeling----------0
Nursing Home Diversion---3,689
Total----------5,109

November 2013
Aged/Disabled Adult------1,535
Assisted Living----------460
Channeling----------347
Nursing Home Diversion---2,429
Total----------4,771

December 2013
Aged/Disabled Adult------2,380
Assisted Living----------612

Channeling----------900
Nursing Home Diversion---6,614
Total----------10,506

February 2013
Aged/Disabled Adult------1,370
Assisted Living----------907
Channeling----------0
Nursing Home Diversion---4,576
Total----------6,853

March 2013
Aged/Disabled Adult------2,613
Assisted Living----------552
Channeling----------0
Nursing Home Diversion----2,148
Total----------5,313

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ◉ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:
   Division of Medicaid
   (Do not complete item A-2)

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   (Complete item A-2-a).

   ○ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within

the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

   AHCA contracts with long-term care plans in each region to provide all waiver services through their provider networks.

   Managed care plans will be responsible for delivering services congruent with the long-term care needs of enrollees, and supporting these services with an appropriate provider and customer service framework. Specific functions will include:

   - Operate member services hotline
   - Create and distribute enrollee and provider materials (handbooks, directory, forms, policies and procedures)
   - Quality improvement
   - Utilization review
   - Community outreach
   - Provider services including credentialing, enrollment/contracting, and reimbursement
   - Provider training materials
   - Monitoring and compliance information
   - Case management
   - Care planning
   - Enrollee complaint hotline
   - Provider and enrollee dispute resolution

   ○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ○ **Not applicable**

   ◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
AHCA, with assistance from the Department of Elder Affairs (DOEA), monitors and assesses the performance of long-term care plans.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The contract with long-term care plans requires plans to submit monthly, quarterly and annual reports on various aspects of program operations through which the State exerts control over program operations and assesses the performance of long-term care plans.The following long-term care (LTC) reports will be required:

•Administrative Subcontractors and Affiliates Report
•Case Management File Audit Report
•Case Management Monitoring and Evaluation Report
•Community Outreach Health Fairs/Public Events Notification
•Community Outreach Representative Report
•Critical Incident Report
•Critical Incident Summary Report
•Cultural Competency Plan (and Annual Evaluation)
•Enrollee Complaints, Grievances and Appeals Report
•Enrollee Facility Residence Transition Report
•Missed Services Report
•Annual Fraud and Abuse Activity Report
•Quarterly Fraud and Abuse Activity Report
•Suspected/Confirmed Fraud and Abuse Reporting
•Nursing Facility Transfer Report (number of enrollees transitioned)
•Participant Direction Option Report (PDO)
•Performance Measures Report LTC
•Provider Complaint Report
•Provider Network File

•Provider Termination and New Provider Notification Report
•Utilization Report
•Other Reports – This represents a placeholder for any other information that the state determines at a later date may be necessary

The second most important method to assess compliance with contract requirements is the annual contract compliance monitoring. This monitoring process assesses each contract requirement through a process that includes combined desk reviews and on-site visits as well as conducting face-to-face visits with a sample number of plan enrollees to determine satisfaction with program services and plans of care throughout the year. At the conclusion of the annual monitoring, any deficiencies are noted and plans are required to correct them within specified time frames. Each plan receives a copy of the completed monitoring report. Deficiencies involving plan member life and safety issues must be corrected immediately.

The third most important method used to assess plan performance is the annual evaluation of performance improvement plans (PIPs). By contract, plans are required to submit two PIPs for evalution by AHCA's External Quality Review Organization (EQRO). The EQRO assesses each plan's progress on completing the PIP in accordance with CMS PIP evaluation standards. The PIP evaluation process assesses the plan's performance in developing and performing PIPs and improving program services and enrollee outcomes.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☑	☐
Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☐
Level of care evaluation	☑	☐
Review of Participant service plans	☑	☐
Prior authorization of waiver services	☑	☑
Utilization management	☑	☑
Qualified provider enrollment	☑	☑
Execution of Medicaid provider agreements	☑	☐
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐
Quality assurance and quality improvement activities	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of LTC program level of care determinations processed by DOEA CARES by the effective date of enrollment. N: Number of LTC level of care determinations by DOEA CARES by the effective date of enrollment. D: Number of LTC Level of care determinations precessed by DOEA CARES.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DOEA	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DOEA	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of waiver expenditures less than or equal to approved legislative appropriations. N: Amount of waiver expenditures per month. D: Waiver appropriation amount divided into twelve equal amounts.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:
Waiver expenditures contained in Florida's MMIS will be compared with approved waiver enrollment.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DOEA	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of case record reviews conducted by DOEA in accordance with the approved sampling methodology. N: Number of case record reviews conducted by DOEA in accordance with the approved sampling methodology. D: Number of case records required in sample.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
MCO Required Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DOEA	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify: Random Sample Methodology.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DOEA	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of LTC MCPs' Performance Improvement Plans reviewed annually by DOEA. N: Number of LTC MCPs' Performance Improvement Plans reviewed annually by DOEA. D: Total number of required LTC MCP's Performance Improvement Plans required annually by program contract.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☑ **Other** Specify: DOEA	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DOEA	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report to CMS quarterly for the first two years of the approved waiver.

Performance Measure:
Percentage of LTC MCPs' Performance Improvement Plans evaluated annually by the External Quality Review Organization (EQRO). N: Number of LTC MCPs' Performance Improvement Plans evaluated annually by EQRO. D: Total number of LTC MCPs' Performance Improvement Plans required to be evaluated by the EQRO by program contract.

Data Source (Select one):
Other
If 'Other' is selected, specify:
The program contract contract requires LTC MCPs to submit their Performance Improvement Plans in accordance with CMS standards to the state for evaluation.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	

		☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of LTC direct calls (non-abandoned)processed by enrollment broker monthly. N: Number of direct LTC (non-abandoned)calls processed by enrollment broker processed monthly. D: Number of LTC direct calls (non-abandoned)by enrollment broker monthly.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Enrollment broker reports detail how call center operations concerning calls processed by this vendor.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Enrollment Broker	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Enrollment Broker	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: the state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:

Percentage of hours enrollment broker call system is operational monthly. N: Number of hours enrollment broker call system is operational monthly. D: Number of business hours monthly.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Enrollment Broker	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Enrollment Broker	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of program policies and procedures that are reviewed and approved by Medicaid before implementation by DOEA on an annual basis. N: Number of policies and procedures reviewed and approved by Medicaid before implementation on an annual basis by DOEA. D: Total number of policies and procedures developed and implemented by DOEA.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☑ Sub-State Entity	☑ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: DOEA	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☑ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DOEA	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Random Sample Methodology.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: DOEA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of MCP monitoring reports furnished by DOEA to AHCA. N: Number of MCP monitoring reports furnished by DOEA to AHCA. D: Number of MCPs enrolled in the program for the monitorig period.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

		Sampling Approach*(check each that applies):*

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DOEA	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☑ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DOEA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify: the state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of ALF subcontract templates reviewed by Medicaid Agency prior to execution that include approved HCB characteristics and community integration language. N: Number of ALF subcontracted templates reviewed by Medicaid Agency

prior to execution that include approved HCB characteristics and community integration D: Number of ALF subcontract templates reviewed by the Medicaid agency.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTC MCPs are required to have all their subcontract templates reviewed and approved by the Medicaid agency.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DOEA	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Random Sample Methodology
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DOEA	☐ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify: The state will report to CMS quarterly for the first two years of the approved waiver.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
AHCA contracts with an External Quality Review Organization (EQRO) to validate program performance improvement projects (PIPs) and performance measures.

The Medicaid program contracts with an emrollment broker to handle managed care program enrollments The current contract will be amended to add enrollment responsibilities for the Long-Term Care Managed Care program. Current performance measures detailed in that contract will apply to the new program.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
CARES management monitors timely level of care processing through review of reports generated by the CARES database and annual CARES program monitoring. If a level of care has not been processed timely, CARES management reviews the situation with the CARES unit and resolves the barrier to completing the level of care or develops a corrective action plan to address the deficiency within established time frames. CARES management verifies the implementation of the corrective action plan. Program applicants ultimately determined to be ineligible for Medicaid are referred to general revenue funded programs or other Medicaid waivers for services.

The State monitors the plans of care renewals as part of the annual contract compliance review. The program contract establishes the time standard for plan of care renewals. Plans found to have untimely plan of care renewals must submit a corrective action plan detailing the steps to correct the deficiency. When completed, the plan notifies the State that the plans of care are updated. The Agency will monitor DOEA on the follow-up on remediation of untimely care plan renewals. If DOEA does not keep track of the untimely care plan renewals, the Agency will require a corrective action plan to address this deficiency of the monitoring process.

As part of the annual contract compliance monitoring, the State verifies that plans contract with only qualified providers. If a deficiency is found, the plan is required to remedy any defect involving health and safety issues immediately. Other deficiencies are corrected through corrective action developed by the plan and approved and verified by the State. Enrollees served by the unqualified service providers are contacted and offered a choice of other qualified providers.

The LTC contract requires managed care plans to submit performance improvement plans (PIPs) to the Agency for review annually. If a plan fails to submit the required number of PIPs as required by the program contract, the MCPs' contract manager will require the plan to submit a corrective action to address the deficiency. Failure to implement the corrective action and remedy the deficiency will subject the plan to sanctions.

The managed care plan's contract requires them to submit performance improvement projects (PIPs) for evaluation by the External Quality Review Organization (EQRO). If a deficiency is determined, the plan is required to submit a corrective action to address the deficiency. If the EQRO fails to evaluate a submitted PIP, the EQRO is subject to sanctions ranging from delayed payment to reduced payment for PIP reviews.

The Agency contracts with an enrollment broker vendor to manage enrollment activities for the state's managed care programs. The current contract will be expanded to include the Long-Term Care Managed Care program. The current contract requires the enrollment broker to maintain records on the number and disposition of calls received. Abandoned calls cannot exceed 10% on a monthly basis. The broker's system

tracks abandoned calls and generates monthly reports. The Agency reviews the reports and sanctions the broker if abandoned calls exceed 10% of direct calls.

The Agency's contract with the enrollment broker details the monthly, allowable, abandonment rate percentage during normal business hours. If the abandonment rate exceeds the contract standard of 10%, the vendor may be placed on a corrective action for failure to comply with the contract, which may result in sanctions if the corrective action does not resolve the failure to meet the standard.

The LTC program requires the Agency to review DOEA's policies and procedures on an annual basis. During the annual LTC program review of delegated responsibilities, the Agency will review DOEA's LTC program policies and procedures. If a policy or procedure implemented by DOEA was discovered to be incorrect or inappropriate, the Agency would require corrective action to address the deficiency. The Agency would verify the implementation of the corrective action.

The LTC program requires DOEA to submit monitoring reports to the Agency. These reports form the evidence based validation of the Agency's waiver assurances to the Centers for Medicare and Medicaid Services (CMS). If reports due from DOEA were not provided as required, the Agency would require corrective action to address the issue. The Agency would verify the implementation of the corrective action.

Plans enrolled in the LTC program are required to enroll only Assisted Living Facilities (ALFs) and Adult Family Care Homes (AFCHs) that exhibit the characteristics described in the home and community-based characteristics framework. By contract, the Medicaid agency is required to review all plan network ALF and AFCH subcontract templates to verify compliance with the program contract. If the plan has failed to include the required framework language, a corrective action will be required to address this deficiency, and affected enrollees will be provided a choice of alternate, compliant, providers. A failure to include the required framework language will also subject the plan to penalities under the contract.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☑ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
	☐	**Aged**	65		☑
	☑	**Disabled (Physical)**	18	64	
	☐	**Disabled (Other)**			
Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
Mental Retardation or Developmental Disability, or Both					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Mental Retardation**			☐
Mental Illness					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

b. **Additional Criteria.** The State further specifies its target group(s) as follows:

The MEDS-AD population is excluded from this waiver. Pursuant to the special terms and conditions of the MEDS-AD waiver, individuals eligible for Medicaid under the 1115 MEDS-AD waiver will not be eligible for enrollment into any other waiver program. Individuals that would otherwise be eligible for enrollment in an approved waiver program under guidelines set forth by that waiver program design will be able to receive the same services through the authority of the 1115 MEDS-AD waiver in the same manner as those enrolled in the approved waiver.

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

There is no "transition" procedure for the disabled group aged 18 to 64. The age criteria for this population refers to the designation of disabled according to Social Security criteria. This group will continue to participate in the waiver.

Recipients may continue to participate in the waiver as there is no maximum age limit.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  The limit specified by the State is *(select one)*

  - **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - **Other**

    Specify:

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the State is *(select one)*:

  - **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

    - **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	36795
Year 2	36795
Year 3	36795

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	35852
Year 2	35852
Year 3	35852

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- **Not applicable. The state does not reserve capacity.**
- **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Transitioning Recipients	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup)*:

Transitioning Recipients

Purpose *(describe)*:

The State reserves capacity for recipients in the current four feeder waivers (Aged/Disabled Adult, Assisted Living, Channeling, Nursing Home Diversion) so they may transition to the Long-Term Care Managed Care waiver without threat of losing their waiver enrollment to a new recipient.

See Attachment 1 for complete transition plan information.

Describe how the amount of reserved capacity was determined:

The State determined enrollment levels in the four feeder waivers as of December 2012 and used this total to nominate the reserved capacity:

Aged/Disabled Adult 10,015
Assisted Living 3,209
Channeling 1,247
Nursing Home Diversion 21,381

Total enrollment 35,852

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	35852
Year 2	0
Year 3	0

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ○ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ◉ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Entrants must meet the following qualifications:
1. Be age 18 or older and determined disabled according to Social Security standards or be age 65 or older;
2. Meet nursing facility level of care criteria;
3. Be Medicaid eligible;
4. Reside in a region where the long-term care managed care program has been implemented; and
5. Not be enrolled in a Medicaid HCBS waiver other than the four waivers that are transitioning to the Long-Term Care Managed Care Program.

Recipients will make an informed choice of receiving home and community-based services in lieu of nursing facility care.

The State's requested number of waiver slots is based on its current feeder waivers' enrollment figures. By reserving capacity and transitioning all current waiver recipients prior to enrolling any new recipients in FL 0962, the State will ensure all current recipients will be enrolled in the waiver.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Waiver Phase-In/Phase-Out Schedule
Based on Waiver Proposed Effective Date: 07/01/13

a. **The waiver is being** (select one):

- (•) **Phased-in**
- ( ) **Phased-out**

b. **Phase-In/Phase-Out Time Schedule.** *Complete the following table:*

Beginning (base) number of Participants: 0

Phase-In/Phase-Out Schedule

Waiver Year 1
Unduplicated Number of Participants: 36795

Month	Base Number of Participants	Change	Participant Limit
Jul	0	0	0
Aug	0	3300	3300
Sep	3300	5109	8409
Oct	8409	0	8409
Nov	8409	4771	13180
Dec	13180	10506	23686
Jan	23686	0	23686
Feb	23686	6853	30539
Mar	30539	5313	35852
Apr	35852	0	35852
May	35852	0	35852
Jun	35852	0	35852

Waiver Year 2
Unduplicated Number of Participants: 36795

Month	Base Number of Participants	Change	Participant Limit
Jul	35852	0	35852
Aug	35852	0	35852
Sep	35852	0	35852
Oct	35852	0	35852
Nov	35852	0	35852
Dec	35852	0	35852
Jan	35852	0	35852
Feb	35852	0	35852
Mar	35852	0	35852
Apr	35852	0	35852
May	35852	0	35852
Jun	35852	0	35852

Waiver Year 3
Unduplicated Number of Participants: 36795

Month	Base Number of Participants	Change	Participant Limit
Jul	35852	0	35852
Aug	35852	0	35852
Sep	35852	0	35852
Oct	35852	0	35852
Nov	35852	0	35852

Phase-In/Phase-Out Schedule

Month	Base Number of Participants	Change	Participant Limit
Dec	35852	0	35852
Jan	35852	0	35852
Feb	35852	0	35852
Mar	35852	0	35852
Apr	35852	0	35852
May	35852	0	35852
Jun	35852	0	35852

c. Waiver Years Subject to Phase-In/Phase-Out Schedule

Year One	Year Two	Year Three
☑	☐	☐

d. Phase-In/Phase-Out Time Period

	Month	Waiver Year
Waiver Year: First Calendar Month	Jul	
Phase-in/Phase-out begins	Aug	1
Phase-in/Phase-out ends	Mar	1

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ◉ **§1634 State**
   - ○ **SSI Criteria State**
   - ○ **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ○ **No**
   - ◉ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☐ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No.The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

● **Yes.The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

● **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☑ **A special income level equal to:**

Select one:

● **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

- **100% of FPL**
- **% of FPL, which is lower than 100%.**

Specify percentage amount:

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

- **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - **Use spousal post-eligibility rules under §1924 of the Act.**
    (Complete Item B-5-b (SSI State) and Item B-5-d)
  - **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

- **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- **The following standard included under the State plan**

  Select one:

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**

(*select one*):

- **300% of the SSI Federal Benefit Rate (FBR)**
- **A percentage of the FBR, which is less than 300%**

Specify the percentage:

- **A dollar amount which is less than 300%.**

Specify dollar amount:

- **A percentage of the Federal poverty level**

Specify percentage:

- **Other standard included under the State Plan**

Specify:

- **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- **The following formula is used to determine the needs allowance:**

Specify:

Recipients in Assisted Living Facilities (ALF)
The recipient's personal needs allowance is calculated according to the following formula:
Three meals per day and the semi-private room rate (ALF Basic Room and Board Rate) + 20% of the Federal Poverty Benefit Rate (FBR).

Recipients in the community settings other than ALF's
The recipient's the personal needs allowance will equal the recipient's income up to the 300% SSI/FBR amount.

How is excess income treated?
Excess income is defined as the recipient's income after deductions for personal needs allowance, spousal
impoverishment allowance, and reasonable costs of incurred medical and remedial care as detailed in 42 CFR. For community waiver residents outside the ALF setting, all income up to the 300% FBR income limit is protected. For waiver recipients living in ALF's the income protected varies due to the facility specific ALF Basic Room and Board Rate included in the personal needs calculation.

As a Miller Income Trust state, Florida requires waiver applicants to place income over the 300% FBR income level into an approved income trust. Any income placed in the required income trust will be included in the excess income or patient responsibility calculation. Patient responsibility is collected by the LTC plan and applied against home and community-based service costs only. Plans are required to report patient responsibility collections to the state.

State's process for ensuring recipient responsibility is applied only to home and community-based services.

Managed care plans are responsible for collecting recipient responsibility payments as determined by the State's eligibility agency (Department of Children and Families) Notice of Case Action. The notice is sent to the recipient, and the plan.

The state established plan capitation rates based on its expected cost of waiver services which excludes recipient responsibility payments. Capitation rates therefore reflect the plan's responsibility to organize, and reimburse for waiver services net of recipient responsibility. By excluding recipient responsibility from the capitation rates, the State ensures plans do not receive duplicate payments from the state and enrollees overall. The state will review the plan's recipient responsibility collections annually to ensure enrollee individual responsibility payments are equal to, or less than, the total cost of the home and community based services the enrollee received. If an enrollee's recipient responsibility payment is found to be greater than the sum of services received, the state will make payment adjustments on an case-by-case basis to ensure the plan is not overcompensated.

- **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

- **Not Applicable**
- **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

The State does not establish reasonable limits.

The State establishes the following reasonable limits

Specify:

The State allows a deduction for the actual amount of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, incurred by a Medicaid recipient for programs involving post-eligibility calculation of a patient responsibility, as authorized by the Medicaid State plan. The actual amount paid will be used as a deduction subject to the following limit: the highest of a payment/fee recognized by Medicare, commercial payers or any other party payer for the same or similar item. Other enrollee health insurance policies will be treated as first payer and the enrollee will have to demonstrate that other insurance has not or will not cover the claims.

The medical/remedial care service or item must meet all the following criteria:
a. Be recognized under State law;
b. Be medically necessary;
c. Not be a Medicaid compensable expense; and
d. Not be covered by the facility or provider per diem.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

  Specify percentage:

- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised

- **The following formula is used to determine the needs allowance:**

  Specify formula:

- **Other**

  Specify:

  Personal needs allowance is defined as:

  For participants placed in an assisted living facility, the personal needs allowance is calculated according to the following formula:

  Three meals per day and the semi-private room rate (ALF Basic Room and Board Rate) + 20% of the Federal Poverty Benefit Rate (FBR).

  For waiver participants residing in the community outside the assisted living setting, the personal needs allowance will equal the participant's income up to the 300% SSI/FBR amount. In addition, excess income is defined as the recipient's income after deductions for personal needs allowance, spousal impoverishment allowance, and reasonable costs of incurred medical and remedial care as detailed in 42 CFR. For community waiver residents all income up to the 300% FBR income limit is protected. For waiver recipients living in assisted living facilities the income protected varies due to the facility specific ALF Basic Room and Board Rate included in the personal needs calculation.

  As a Miller Income Trust state, Florida requires waiver applicants to place income over the 300% FBR income level into an approved income trust. Any income placed in the required income trust will be included in the excess income or patient responsibility calculation. Patient responsibility is collected by the LTC plan and applied against home and community-based service costs only. Plans are required to report patient responsibility collections to the state. The collections are reviewed during the annual plan reconciliation to verify the application of the patient responsibility funds to reduce home and community based services only.

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR

§435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- **Allowance is the same**
- **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- **The provision of waiver services at least monthly**
- **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- **Directly by the Medicaid agency**

By the operating agency specified in Appendix A

By an entity under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The Comprehensive Assessment and Review for Long-Term Care Services (CARES) Unit under the jurisdiction of the Department of Elder Affairs is designated by state statute to perform level of care evaluations for all Medicaid nursing home admissions and conversions Sections 409.912 (15) and 409.985 , Florida Statutes; and 59G-4.290 and 59G-4.180, Florida Administrative Code). The CARES Unit is composed of a physician (M.D. or D.O.), a registered nurse (licensed in Florida), and other assessors with nursing or advanced social work degrees. The unit's assessors complete the level of care evaluations based on an assessment form completed by the case manager and a physician referral. The Level of Care Notification form (DOEA-CARES Form 603) is signed by a physician (M.D. or D.O.).

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The level of care criteria used to evaluate and reevaluate whether an individual needs waiver services is listed below and can be referenced at 59G-4.180, F.A.C.

To qualify for placement in a nursing facility, the applicant or recipient 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 meet the following criteria in order for services to qualify as Intermediate Level I or Intermediate Level II.

To be classified as requiring intermediate care services, the nursing or rehabilitation 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; and
(7) Consistent with the nature and severity of the individual's condition or the disease state or stage.

LEVEL I - Intermediate Care Services Level I is extensive health related care and services required by an individual who is incapacitated mentally or physically.

LEVEL II -Intermediate Care Services Level II is limited health related care and services required by an individual who is mildly incapacitated or ill to a degree to require medical supervision. Individuals requiring this level of care shall:
1. Be ambulatory, with or without assistive devices;

2. Demonstrate independence in activities of daily living;
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; and
4. Require the constant availability of medical and nursing treatment and care on a routine basis.

The level of care instruments are available to CMS upon request.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The initial assessment and level of care determination for waiver applicants are conducted by DOEA CARES program staff based upon DOEA Comprehensive Assessment Form 701B. CARES program staff review the completed assessment forms and physician medical certification to determine level of care and prioritization for waiver services, and complete the Level of Care Notification form (DOEA-CARES Form 603) to document whether waiver applicants meet level of care requirements.

The reevaluation process is the same as for evaluations except LTC plan staff conduct the assessment interviews for current enrollees. The complete 701B assessment instrument is submitted to DOEA CARES staff for review and determination that the enrollee continues to meet the required level of care for the program.

LTC plan case management and nursing staff receive the same training as the CARES staff in completing assessment forms. LTC plan case managers and nursing staff receive this training from local Assessment Training Teams comprised of area agencies on aging and CARES staff and must receive a passing test score to be certified assessors.

g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- **Every three months**
- **Every six months**
- **Every twelve months**
- **Other schedule**
  Specify the other schedule:

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- **The qualifications are different.**
  Specify the qualifications:

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

DOEA's CARES Unit's computerized management system generates reports listing enrollees due for reevaluation in the subsequent month. The LTC plans use these reports to prompt case managers to request level of care revaluations. This system ensures that reevaluations take place in a timely manner. In addition to the CARES' system, the LTC plans track the reevaluation due date as a component part of case management to ensure timely reevaluation.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Written records of evaluations and reevaluations of level of care are maintained in each of the local CARES unit offices. LTC plan case managers also maintain written copies of evaluations and reevaluations in individual case records. In addition, electronically retrievable documentation of all evaluations and reevaluations are maintained in the CARES Unit's computerized management system.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**

i. **Sub-Assurances:**

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of new applicants receiving a level of care evaluation prior to enrollment. N: Number of new applicants receiving a level of care prior to enrollment D: Number of new applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DOEA maintains records of each level of care determination in its system.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify: DOEA	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify: DOEA	☐ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of enrollees receiving annual redeterminations peformed within 365 days of previous level of care determination. N: Number of enrollees with annual redeterminations within 365 days of previous level of care determination. D: Number of enrollees enrolled for at least one year.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DOEA	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☑ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☑ Other Specify: DOEA	☑ Annually
	☑ Continuously and Ongoing
	☑ Other Specify: the state will report quarterly to CMS for the first two years of the approved waiver.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of enrollees having a current level of care based on the state approved assessment tool. N: Number of enrollees having a level of care based on the state approved assessment tool. D: Number of enrollees in the program.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☐ Representative Sample

		Confidence Interval =
☑ **Other** Specify: DOEA	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify: DOEA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of level of care determinations made by qualified evaluators. N: Number of level of care determinations made by qualified evaluators. D: Number of level of care plan determinations reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% (+/-5%)
☑ **Other** Specify: DOEA	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: DOEA	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If an applicant does not receive a level of care evaluation prior to enrollment, the individual's enrollment cannot move forward. The CARES unit would be contacted by the LTC plan and requested to complete the level of care within 10 days. Prospective enrollees ultimately determined to be ineligible will be referred to State-funded programs as necessary.

If enrollees do not receive annual reevaluations within 365 days of the previous level of care determination, the DOEA CARES unit will notify the LTC plan of the omission and request the completion of the 701B assessment instrument for determination of level of care by the CARES unit. Enrollees ultimately determined to be ineligible will be referred to State-funded programs for services. Should the LTC plan not timely comply with the request, the LTC plan is subject to penalties under the contract.

If applicants do not have a level of care based upon the state approved assessment tool, the LTC plan is required to correct the issue. If the LTC plan does not implement the corrective action within the approved time frame, the LTC plan is subject to sanctions ranging from new enrollment suspension to more frequent on-site reviews. Enrollees will continue to receive services while the level of care is determined. Applicants who are ultimately determined to be ineligible are referred to State-funded programs for services.

If a level of care determination is made by an unqualified evaluator, the DOEA CARES unit would be notified and requested to have a qualified evaluator review the determination within 10 days. If the level of care was determined correctly using the appropriate criteria, the qualified evaluator would issue a new level of care determination. The prospective enrollee would be notified immediately if the level of care determination was not issued by the qualified evaluator and given his/her Fair Hearing options to challenge the determination that level of care criteria were not satisfied. If the applicant is ultimately determined to be ineligible, he/she will be referred to state funded services.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DOEA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

As part of the level of care assessment conducted by the CARES Unit, CARES Unit staff informs prospective recipients of the long-term care alternatives (nursing facility or HCBS) available to them. Prospective recipients review and sign the "Certification of Freedom of Choice for Medicaid Long-Term Care Assistance" (DOEA Form 608). This form certifies the individual has been informed of the long-term care options (nursing facility or HCBS) and his or her right to choose between Medicaid long-term care programs, including the right to choose nursing home care.

All eligable recipients are given the freedom to choose a LTC plan that serves their county of residence. After the eligible recipient selects a LTC plan, the enrollment broker will process the enrollment and refer the recipient to the selected LTC plan for services. The recipient has the freedom to choose any qualified provider in the LTC plan's network to receive waiver services.

Each plan enrollee has a case manager, and the case manager must discuss with the enrollee his/her individual needs and develop the initial plan of care. The case manager is responsible for authorizing, coordinating, and monitoring the provision of waiver services according to the enrollee's written plan of care. The plan of care form includes a statement which confirms the plan of care has been discussed with and agreed to by the enrollee, and the enrollee understands he/she has the right to request a Fair Hearing if services are denied or reduced, or if the enrollee is denied a choice of qualified providers. The LTC plan must provide an enrollee with procedures to follow if they chooses to appeal through the LTC plan's grievance and/or the Fair Hearing process.

Enrollees are not required to exhaust the managed care plan's grievance process before requesting a Medicaid Fair Hearing through the Florida Department of Children and Families. However, the Agency also operates the Beneficiary Assistance Program (BAP) to aid enrollees who are unsatisfied with the outcome of the managed care plan's grievance process. Enrollees must have exhausted the managed care plan's grievance process, and must not have requested a Medicaid Fair Hearing to engage the BAP process. The BAP is a supplemental grievance process and does not restrict an enrollee's right to request a Fair Hearing. However, if an enrollee selects a Fair Hearing, they cannot also request a BAP hearing.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of the freedom of choice documentation are maintained by the LTC plans in the member's case files.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

LTC plans are required to develop and make available appropriate foreign language versions of all materials available to enrollees and prospective enrollees. The LTC plan is required to provide interpreter services in person where practical, but otherwise by telephone, for enrollees/prospective enrollees whose primary language is a foreign language. Foreign language versions of materials are required if, as determined annually by AHCA, the population speaking a particular foreign (non-English) language in a county is greater than five percent. LTC plans are prohibited from marketing the program directly to enrollees face-to-face. LTC plans may use mass marketing strategies, approved by AHCA, to communicate educational information regarding the program to prospective enrollees.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	Adult Day Health Care		
Statutory Service	Case Management		
Statutory Service	Homemaker		
Statutory Service	Respite		
Extended State Plan Service	Attendant Care		
Extended State Plan Service	Intermittent and Skilled Nursing		
Extended State Plan Service	Medical Equipment and Supplies		
Extended State Plan Service	Occupational Therapy		
Extended State Plan Service	Personal Care		
Extended State Plan Service	Physical Therapy		
Extended State Plan Service	Respiratory Therapy		
Extended State Plan Service	Speech Therapy		
Extended State Plan Service	Transportation		
Other Service	Adult Companion		
Other Service	Assisted Living		
Other Service	Behavior Management		
Other Service	Caregiver Training		
Other Service	Home Accessibility Adaptations		
Other Service	Home Delivered Meals		
Other Service	Medication Administration		
Other Service	Medication Management		
Other Service	Nutritional Assessment and Risk Reduction		
Other Service	Personal Emergency Response System (PERS)		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health Care

Service Definition *(Scope):*

Services provided pursuant to Chapter 400, Part V, Florida Statutes. For example, services furnished in an outpatient setting, encompassing both the health and social services needed to ensure optimal functioning of an enrollee, including social services to help with personal and family problems, and planned group therapeutic activities. Adult day health services include nutritional meals. Meals are included as a part of this service when the patient is at the center during meal times. Adult day health care provides medical screening emphasizing prevention and continuity of care including routine blood pressure checks and diabetic maintenance checks. Physical, occupational and speech therapies indicated in the enrollee's plan of care are furnished as components of this service. Nursing services which include periodic evaluation, medical supervision and supervision of self-care services directed toward activities of daily living and personal hygiene are also a component of this service. The inclusion of physical, occupational and speech therapy services and nursing services as components of adult day health services does not require the LTC plan to contract with the adult day health provider to deliver these services when they are included in an enrollee's plan of care. The LTC plan may contract with the adult day health provider for the delivery of these services or the LTC plan may contract with other providers qualified to deliver these services pursuant to the terms of the LTC managed care contract. All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Facility
Agency	Adult Day Care Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Health Care

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*
Chapter 429, Part I, Florida Statutes: Licensed assisted living facilities may provide adult day health care. Chapter 429.918, Florida Statutes provides a licensed assisted living facility,….may provide services during the day which include, but are not limited to, social, health, therapeutic, recreational, nutritional, and respite services, to adults who are not residents.
Certificate *(specify):*
Written approval of AHCA Health Quality Assurance office to provide adult day health service under Chapter 429.905 (2), Florida Statutes
Other Standard *(specify):*
LTC MCPs can contract with assisted living facilities to provide these services if the facility has adequate staffing and space per Rule 58A-5.023(30(a)2, F.A.C. and Rule 58A-5.019, F.A.C.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Direct care staff in assisted living facilities must encourage LTC enrollees to participate in community activities in the facility and the community at large.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Health Care

Provider Category:
Agency
Provider Type:
Adult Day Care Center
Provider Qualifications
License *(specify):*
Chapter 429, Part III, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.
Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Service Definition *(Scope):*

Services that assist enrollees in gaining access to needed waiver and other State Plan services, as well as other needed medical, social, and educational services, regardless of the funding source. Case management services contribute to the coordination and integration of care delivery through the ongoing monitoring of service provision as prescribed in each enrollee's plan of care.

For enrollees choosing participant direction, the case manager is responsible for assisting the enrollee, by arranging for training and through ongoing support, with the following duties: recruiting workers; ensuring that worker qualifications are verified and criminal background check completed; defining additional qualifications and duties within the scope of waiver definitions to meet the enrollee's specific needs; scheduling workers; training workers; supervising workers; evaluating worker performance; verifying time worked and timesheets; and, if necessary, dismissing workers and arranging for implementation of the Emergency Back-up Plan.

The State will assure conflict free case management and participant protections by reviewing sampled care plans, participating in Fair Hearings, and reviewing focused managed care plan reviews targeted at managed care plans with significant numbers of care plan related complaints. Managed care plans must be in compliance with program contract standards for case management and care planning. Failure to meet these standards subjects the managed care plan to enrollment moratoriums and liquidated damages.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Case managers employed or contracted by LTC plans
Agency	Center for Independent Living
Agency	Case Management Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Individual
Provider Type:
Case managers employed or contracted by LTC plans
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Case managers must be qualified in one of the following ways: (a) have a Bachelor's Degree in Social Work, Sociology, Psychology, Gerontology or related field, (b) be a Registered Nurse, licensed to practice in the State, (c) have a Bachelor's Degree in an unrelated field and at least two years of relevant experience, or (d) be a Licensed Practical Nurse (LPN) with four years of relevant experience. All case managers must have at least two years of relevant experience and four hours of in-service training annually in the identification and reporting of Abuse, Neglect, and Exploitation.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Center for Independent Living
Provider Qualifications
License *(specify):*

As defined under Chapter 413.371, F. S.

Case managers must be qualified in one of the following ways: (a) have a Bachelor's Degree in Social Work, Sociology, Psychology, Gerontology or related field, (b) be a Registered Nurse, licensed to practice in the State, (c) have a Bachelor's Degree in an unrelated field and at least two years of relevant experience, or (d) be a Licensed Practical Nurse (LPN) with four years of relevant experience. All case managers must have at least two years of relevant experience and four hours of in-service training annually in the identification and reporting of Abuse, Neglect, and Exploitation.

Certificate *(specify):*

Other Standard *(specify):*

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently if necessary.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Management Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The case management agency must be designated a Community Care for the Elderly Lead Agency by the DOEA in accordance with Chapter 430, Florida Statutes, or other agency meeting comparable standards as determined by the DOEA.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA

Frequency of Verification:

Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

Service Definition *(Scope):*

General household activities (meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Service includes pest control. Socialization is not the primary function of this service.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [x] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	PDO-Homemaker
Agency	Center for Independent Living
Agency	Homemaker/Companion Agency
Agency	Health Care Service Pools
Agency	Community Care for the Elderly (CCE) Providers
Agency	Home Health Agency
Agency	Nurse Registry

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Individual
Provider Type:
PDO-Homemaker
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Level II background screening and executed Participant Direction Service Work Agreement.
Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA or its designee
Frequency of Verification:
Annually or more frequently if necessary

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:
Center for Independent Living
Provider Qualifications
License *(specify):*
As defined under 431.371, F. S.
Certificate *(specify):*
N/A
Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.
Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA or its designee.
Frequency of Verification:
Annually or more frequently if necessary.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:
Homemaker/Companion Agency
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Registration in accordance with Chapter 400.509, Florida Statutes: Registration of particular service providers exempt from licensure; certificate of registration; regulation of registrants.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.
Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:
Health Care Service Pools
Provider Qualifications
License *(specify):*
Licensed per Chapter 400, Part IX. F S.
Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

A Health Care Services Pool as defined under Chapter 400.980, Florida Statutes, means any person, firm, corporation, partnership, or association engaged for hire in the business of providing temporary employment in health care facilities, residential facilities, and agencies for licensed, certified, or trained health care personnel including, without limitation, nursing assistants, nurses' aides, and orderlies. Chapter 409.982, Florida Statutes, requires health care services pools to be included in the LTC MCP's provider network.
Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA or its designee.
Frequency of Verification:
Annually of more frequently if necessary.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:
Community Care for the Elderly (CCE) Providers
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
As defined in Chapter 410 or 430, Florida Statutes

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.
Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Chapter 400, Part III, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
Optional to meet Federal Conditions of Participation under 42 CFR 484

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida

Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency

Provider Type:
Nurse Registry

Provider Qualifications

License *(specify):*
Chapter 400.506, Florida Statutes

Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

Service Definition *(Scope):*

Services provided to enrollees unable to care for themselves furnished on a short-term basis in the enrollees home due to the absence, or need, for relief of persons normally providing the care. Respite care does not substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist. Respite may be provided by direct service workers of the approved provider types listed in this application. All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Facility
Agency	Assisted Living Facility
Agency	Nurse Registry
Agency	Home Health Agency
Agency	Community Care for the Elderly (CCE) Providers
Agency	Homemaker/Companion Agency
Agency	Adult Day Care Center
Agency	Center for Independent Living

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Nursing Facility
Provider Qualifications
License *(specify)*:

Chapter 400, Part II, Florida Statutes

Certificate *(specify):*

Other Standard *(specify):*

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA

Frequency of Verification:

Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

Chapter 429, Part I, Florida Statutes

Certificate *(specify):*

Other Standard *(specify):*

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA

Frequency of Verification:

Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Nurse Registry

Provider Qualifications

License *(specify):*
Chapter 400.506, Florida Statutes

Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Home Health Agency

Provider Qualifications

License *(specify):*
Chapter 400, Part III, Florida Statutes

Certificate *(specify):*

Other Standard *(specify):*
Optional to meet Federal Conditions of Participation under 42 CFR 484

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:
Community Care for the Elderly (CCE) Providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
As defined in Chapter 410 or 430, Florida Statutes

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Homemaker/Companion Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Registration in accordance with Chapter 400.509, Florida Statutes

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Adult Day Care Center
Provider Qualifications
License *(specify):*
Chapter 429, Part III, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.
Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Center for Independent Living
Provider Qualifications
License *(specify):*
as defined under Chapter 413.371, F. S.
Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.
Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA or its designee.
Frequency of Verification:
Annually or more frequently as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Attendant Care

Service Definition *(Scope):*

Attendant care services differ in limits from the services offered under Home Health Services State Plan for adults. This service provides hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped enrollee. Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity. Supervision must be provided by a Registered Nurse, licensed to practice in the State. All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There are no limits for medically necessary service for enrollees under 21. Attendant Care services under the waiver are authorized based upon the medical necessity of the plan member's care needs reflected in the approved care plan designed to maintain the plan member in a safe and healthy manner in the least restrictive residential setting possible. Attendant Care Services can be authorized as necessary to manage the medically necessary care needs of the plan member.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [x] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Nurse, Licensed Practical Nurse
Agency	Home Health Agency

Provider Category	Provider Type Title
Agency	Nurse Registry

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Attendant Care

Provider Category:
Individual
Provider Type:
Registered Nurse, Licensed Practical Nurse
Provider Qualifications
License *(specify):*
Chapter 464, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA or its designee.
Frequency of Verification:
Annually or more frequently as necessary.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Attendant Care

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Chapter 400, Part III, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
Optional to meet Federal Conditions of Participation under 42 CFR 484

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does

not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as necessary.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Attendant Care

Provider Category:
Agency

Provider Type:
Nurse Registry

Provider Qualifications

License *(specify):*
Chapter 400.506, Florida Statutes

Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA or its designee.

Frequency of Verification:
Annually or more frequently as necessary.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service

Service Title:
Intermittent and Skilled Nursing

Service Definition *(Scope):*
Services provided when skilled nursing services under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from skilled nursing services furnished under the State Plan. Services listed in the plan of care that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Skilled nursing services must be listed in the enrollees's plan

of care and are provided on an intermittent basis to enrollees who either do not require continuous nursing supervision or whose need is predictable. All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollees independence, inclusion, and integration into the community.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There are no limits for medically necessary services for enrollees under age 21. Intermittent and Skilled Nursing Services can be authorized as necessary to manage the medically necessary care needs of the enrollee in the least restrictive residential setting possible.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	PDO - Intermittent and Skilled Nursing

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Intermittent and Skilled Nursing

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify)*:
Licnesed under Chapter 400, Part III, Florida Statutes
Certificate *(specify)*:

Other Standard *(specify)*:
Optional to meet Federal Conditions of Participation under 42 CFR 484

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida

Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA or its designee

Frequency of Verification:
Annually or more frequently as needed.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Intermittent and Skilled Nursing

Provider Category:
Individual

Provider Type:
PDO - Intermittent and Skilled Nursing

Provider Qualifications

License *(specify):*
Licensed under 400 III F.S.

Certificate *(specify):*
N/A

Other Standard *(specify):*
Service may be provided by a legally responsible person, relative or legal guardian.

Optional to meet Federal Conditions of Participation under 42 CFR 484

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA or its designee

Frequency of Verification:
Anually or as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service

Service Title:
Medical Equipment and Supplies

Service Definition *(Scope):*
Services that are provided when medical equipment and supplies under the approved State Plan are exhausted. Medical equipment and supplies, specified in the plan of care, include: (a) devices, controls, or appliances that

enable the enrollee to increase the ability to perform activities of daily living; (b) devices, controls, or appliances that enable the enrollee to perceive, control, or communicate with the environment in which he or she lives; (c) items necessary for life support or to address and enrollee's physicial conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State Plan that is necessary to address enrollee functional limitations; and (e) necessary medical supplies not available under the State plan, including consumble medical supplies such as adult disposable diapers.

Items reimbursed under the waiver are in addition to any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the enrollee. All items shall meet applicable standards of manufacture, design and installation. This service also includes repair of such items as well as replacement parts.

The case manager in consultation with a medical professional will authorize this service. All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There are no limits for medically necessary services for enrollees under age 21. Medical Equipment and Supplies services under the waiver are authorized based upon the medical necessity of the enrollee's care needs reflected in the approved care plan designed to maintain the enrolle in a safe and healthy manner in the least restrictive residential setting possible.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Pharmacy
Agency	Home Medical Equipment Company
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Medical Equipment and Supplies

Provider Category:

Individual

Provider Type:
Pharmacy
Provider Qualifications
License *(specify):*
Licensed under Chapter 465, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
Permit under Chapter 465, Florida Statutes

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA or its designee.
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
Home Medical Equipment Company
Provider Qualifications
License *(specify):*
Chapter 400, Part VII, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Chapter 400, Title III, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
Optional to meet Federal Conditions of Participation under 42 CFR 484

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service
Service Title:
Occupational Therapy
Service Definition *(Scope):*
Occupational Therapy services under the waiver are provided when occupational services furnished under the approved State Plan are exhausted. These services include treatment to restore, improve, or maintain impaired functions, which are aimed at increasing or maintaining the enrollee's ability to perform those tasks required for independent functioning as determined through a multidisciplinary assessment to improve an enrollee's capability to live safely in the home setting.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Occupational Therapy services through the waiver are provided when the limits of the State Plan service are exhausted. There are no limits on medically necessary services for enrollees under age 21. Occupational Therapy services under the waiver are authorized based upon the medical necessity of the enrollee's care needs reflected in the approved care plan designed to maintain the plan member in a safe and healthy manner in the least restrictive residential setting possible.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a

community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist
Individual	Occupational Therapist Assistant
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Individual

Provider Type:
Occupational Therapist

Provider Qualifications

License *(specify)*:
Chapter 468, Part III, Florida Statutes

Certificate *(specify)*:

Other Standard *(specify)*:
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Individual
Provider Type:
Occupational Therapist Assistant
Provider Qualifications
License *(specify):*
Chapter 468, Part III, Florida Stautes
Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Chapter 400, Part III, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
Optional to meet Federal Conditions of Participation under 42 CFR 484

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Personal Care

Service Definition *(Scope):*

Services that are provided when personal care services furnished under the approved State Plan limits are exhausted. Services include assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the enrollee, rather than the enrollee's family.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There are no limits on medically necessary services for enrollees under age 21. Personal Care services under the waiver are authorized based upon the medical necessity of the enrollee's care needs reflected in the approved care plan designed to maintain the enrollee in a safe and healthy manner in the least restrictive residential setting possible.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Community Care for the Elderly (CCE) Providers

Provider Category	Provider Type Title
Agency	Nurse Registry
Individual	PDO-Personal Care

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Personal Care

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Chapter 400, Part III, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
Optional to meet Federal Conditions of Participation under 42 CFR 484

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA or its designee.
Frequency of Verification:
Annually or more frequently as needed.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Personal Care

Provider Category:
Agency
Provider Type:
Community Care for the Elderly (CCE) Providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

As defined in Chapter 410 or 430, Florida Statutes

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Personal Care

Provider Category:
Agency

Provider Type:
Nurse Registry

Provider Qualifications

License *(specify):*
Chapter 400.506, Florida Statutes

Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Personal Care

Provider Category:
Individual

Provider Type:
PDO-Personal Care

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

May be provided by a legal guardian.

Level II background screening and executed Participant Direction Service Work Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Plan - ongoing

AHCA or its designee - annually

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

Service Definition *(Scope):*

Physical Therapy services under the waiver are provided when Physical Therapy services furnished under the approved State Plan are exhausted. Physical Therapy services provide treatment to restore, improve, or maintain impaired functions by the use of physical, chemical, and other properties of heat, light, electricity or sound, and by massage and active, resistive, or passive exercise. The services must be performed by a qualified physical therapist. There must be an explanation that the enrollee's condition will be improved significantly (the outcome of the therapies must be measurable by the attending medical professional) in a reasonable (and generally predictable) period of time based on an assessment of restoration potential, or a determnination that services are necessary to a safe and effective maintenance program for the enrollee.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There are no limits for medically necessary services for enrollees under age 21. Enrollees 21 and older may receive a specific amount of Physical Therapy through the State Plan in an outpatient setting as described in the Hospital Services Coverage and Limitations Handbook. The waiver will provide additional Physical Therapy treatments based upon the medical necessity of the enrollee's care needs reflected in the approved care plan designed to serve the enrollee in a safe and healthy manner in the least restrictive residential setting possible.

It is the state's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Physical Therapist Assistant
Individual	Physical Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Chapter 400, Part III, Florida Statutes
Certificate *(specify):*
Other Standard *(specify):*
Optional to meet Federal Conditions of Participation under 42 CFR 484

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.
Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Individual
Provider Type:
Physical Therapist Assistant

Provider Qualifications

License *(specify):*
Licensed under Chapter 486, F. S.

Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA or its designee.

Frequency of Verification:
Annaully or more frequently as needed.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Individual

Provider Type:
Physical Therapist

Provider Qualifications

License *(specify):*
Chapter 486, Florida Statutes

Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service
Service Title:
Respiratory Therapy
Service Definition *(Scope):*
Respiratory Therapy services are provided when Respiratory Therapy services under the approved State Plan are exhausted. These services include evaluation and treatment related to pulmonary dysfunction. Examples are ventilatory support; therapeutic and diagnostic use of medical gases; respiratory rehabilitation; management of life support systems and bronchopulmonary drainage; breathing exercises and chest physiotherapy.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There are no limits for medically necessary services for enrollees under age 21. Respiratory Therapy services under the waiver are authorized based upon the medical necessity of the enrollee's care needs reflected in the approved care plan designed to maintain the enrollee in a safe and healthy manner in the least restrictive residential setting possible.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Respiratory Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Respiratory Therapy

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Chapter 400, Part III, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
Optional to meet Federal Conditions of Participation under 42 CFR 484

Must employ respiratory therapists licensed under Chapter 468, Florida Statutes

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Respiratory Therapy

Provider Category:
Individual

Provider Type:
Respiratory Therapist

Provider Qualifications

License *(specify):*
Chapter 468, Florida Statutes

Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA or its designee.

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service
Service Title:
Speech Therapy
Service Definition *(Scope):*
Speech Therapy services under the waiver are provided when Speech Therapy services furnished under the approved State Plan are exhausted. Speech Therapy is the identification and treatment of neurological deficiencies related to feeding problems, congenital or trauma related maxillofacial anomalies, autism, or neurological conditions that affect oral motor functions. Therapy services include the evaluation and treatment of problems related to oral motor dysfunction.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There are no service limits for enrolees under age 21. Speech Therapy services under the waiver are authorized based upon the medical necessity of the enrollee's care needs reflected in the approved care plan designed to maintain the enrollee in a safe and healthy manner in the least restrictive residential setting possible.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Speech-Language Pathologist
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech Therapy

Provider Category:
Individual
Provider Type:
Speech-Language Pathologist
Provider Qualifications
License *(specify):*
Chapter 468, Part I, Florida Statutes
Certificate *(specify):*

Other Standard *(specify)*:
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA or its designee.

Frequency of Verification:
Annually or more frequently as needed.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech Therapy

Provider Category:
Agency

Provider Type:
Home Health Agency

Provider Qualifications

License *(specify)*:
Chapter 400, Part III, Florida Statutes

Certificate *(specify)*:

Other Standard *(specify)*:
Optional to meet Federal Conditions of Participation under 42 CFR 484

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service

Service Title:
Transportation
Service Definition *(Scope):*
Service offered in order to enable enrollees to gain access to waiver services specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the enrollee's plan of care. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, will be utilized.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee's independence, inclusion, and integration into the community.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There are no service limits for individuals under age 21.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Transportation Coordinator
Individual	Independent - (private auto, wheelchair van, bus, taxi)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Community Transportation Coordinator
Provider Qualifications
License *(specify):*
Chapter 316 and Chapter 322, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
In compliance with Chapter 41-2, F.A.C.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as necessary

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Transportation

Provider Category:
Individual

Provider Type:
Independent - (private auto, wheelchair van, bus, taxi)

Provider Qualifications

License *(specify):*
Chapter 322, Florida Statutes

Certificate *(specify):*

Other Standard *(specify):*
Residential facility providers that comply with requirements of Chapter 427, Florida Statutes

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA or its designee.

Frequency of Verification:
Annually or more frequently as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Adult Companion
Service Definition *(Scope):*
Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform discrete services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [x] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Health Care Service Pools
Agency	Nurse Registries
Individual	PDO-Adult Companion
Agency	Home Health Agency
Agency	Homemaker/Companion Agency
Agency	Community Care for the Elderly (CCE) Providers
Agency	Center for Independent Living

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion

Provider Category:
Agency

Provider Type:
Health Care Service Pools
Provider Qualifications
License *(specify):*
Licensed per Chapter 400, Part IX, F.S.
Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

If a service provider has been involuatarily terminated from the Medicaid program for reasons of inactivity, the provider is considered to be in good standing.

A Health Care Services Pool as defined under Chapter 400.980, Florida Statutes, means any person, firm, corporation, partnership, or association engaged for hire in the business of providing temporary employment in health care facilities, residential facilities, and agencies for licensed, certified, or trained health care personnel including, without limitation, nursing assistants, nurses' aides, and orderlies. Chapter 409.982, Florida Statutes, requires health care services pools to be included in the LTC MCP's provider network. They may provide Home Health Aides to recipients requiring Adult Companion services.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA or its designee.
Frequency of Verification:
Annually.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion

Provider Category:
Agency
Provider Type:
Nurse Registries
Provider Qualifications
License *(specify):*
Licensed per Chapter 400.506, F. S.
Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

If a service provider has been involuatarily terminated from the Medicaid program for reasons of inactivity, the provider is considered to be in good standing.

Verification of Provider Qualifications
Entity Responsible for Verification:

AHCA or its designee
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion

Provider Category:
Individual
Provider Type:
PDO-Adult Companion
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
May be provided by a legal guardian.

Level II background screening and executed Participant Direction Service Work Agreement.
Verification of Provider Qualifications
Entity Responsible for Verification:
Managed care plan - ongoing.
AHCA or its designee - annually
Frequency of Verification:
Annually or as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Chapter 400, Part III, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
Optional to meet Federal Conditions of Participation under 42 CFR 484

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.
Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion

Provider Category:
Agency
Provider Type:
Homemaker/Companion Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Registration in accordance with Chapter 400.409, Florida Statutes

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion

Provider Category:
Agency
Provider Type:
Community Care for the Elderly (CCE) Providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
As defined in Chapter 410 or 430, Florida Statutes

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as necessary

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion

Provider Category:
Agency

Provider Type:
Center for Independent Living

Provider Qualifications

License *(specify):*
As defined under Chapter 413.371, F. S.

Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

If a service provider has been involuatarily terminated from the Medicaid program for reasons of inactivity, the provider is considered to be in good standing.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA or its designee

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assisted Living

Service Definition *(Scope):*

Personal care services, homemaker services, chore services, attendant care, companion services, medication oversight, and therapeutic social and recreational programming provided in a home-like environment in an assisted living facility licensed pursuant to Chapter 429, Part I, Florida Statutes.

This service does not include the cost of room and board furnished in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Individualized care is furnished to persons who reside in their own living units (which may include dual occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The resident has a right to privacy. Living units may be locked at the discretion of the resident, except when a physician or mental health professional has certified in writing the resident is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door and all protections have been met to ensure individuals' rights have not been violated. The facility must have a central dining room, living room or parlor, and common activity areas, which may also serve as living rooms or dining rooms. The resident retains the right to assume risk, tempered only by a person's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each resident to facilitate aging in place.

Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect. Assisted living services may also include medication administration, periodic nursing evaluations and respite. The LTC plan may arrange for other authorized service providers to deliver care to enrollees residing in assisted living facilities in the same manner as those services would be delivered to an enrollee in their own home. ALF administrators, direct service personnel and other service personnel have a responsibility to encourage enrollees to take part in social, educational and recreational activities as they are capable of enjoying.

All services provided by the assisted living facility must be included in a care plan maintained at the facility with a copy provided to the enrollee's case manager. The LTC plan shall be responsible for placing enrollees in the appropriate assisted living facility setting. All direct service professionals providing LTC waiver services have the requisite responsibility to encourage plan members' independence, inclusion, and integration into the community.

Plans must include appropriate facilities in their provider network and are required to ensure facilities have a clear understanding of the requirement to operate according to the HCB characteristics as described the Appendix C of the waiver application. The State has provided language which must be incorporated into the plans' provider contracts. Plans are required to credential and monitor providers on their compliance with the HCB characteristics.

When an enrollee requires residential services, the plan will ensure recipients exercise their right to choice of network providers, and to receive assisted living services in an appropriate ALF that meets the waiver requirements, and can serve the enrollee's needs through:

•Person-centered care planning: The enrollee and the case manager will work together to identify the services the individual needs, identify the enrollee's goals and assess the choice of providers to determine which setting is most suitable.

•Home-like environment standards: Implemented by facilities and monitored by the plans and the State on an on -going basis.

•Continual information and contact: Plans are required to ensure enrollees are informed about the services available and their rights by a variety of means. Furthermore, case managers are required to maintain monthly contact with their enrollees to, among other requirements, determine the on-going validity and adequacy of the enrollee's services and living environment.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Facility

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assisted Living

Provider Category:
Agency
Provider Type:
Assisted Living Facility
Provider Qualifications

License *(specify)*:
Chapter 429, Florida Statutes
Certificate *(specify)*:

Other Standard *(specify)*:
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Additional qualifications: As a condition of Medicaid payment, ALFs must offer facility services to Long-Term Managed Care plan members with the following home-like characteristics as medically appropriate: a) access to typical facilities in a home such as a kitchen with cooking facilities; (b) provide privacy options in the living unit; (c) access to resources and activities in the community; (d) provide individuals with the option to assist in choosing what ALF activities will be conducting and (f) ensure individuals are allowed to conduct/hold unscheduled activities of their choosing.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Behavior Management
Service Definition *(Scope):*
This service provides an enrollee with persistent problematic behavior an evaluation of the origins and triggers of the problem behavior, development of strategies to address the behavior, implementation of an intervention by the provider and orientation and assistance for the caregiver to be able to intervene to improve the behavior and maintain the improved behavior.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agencies
Individual	Registered Nurse
Agency	Nurse Registries
Agency	Community Mental Health Center

Provider Category	Provider Type Title
Individual	Clinical Social Worker, Mental Health Counselor
Individual	Psychologist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Management

Provider Category:
Agency
Provider Type:
Home Health Agencies
Provider Qualifications
License *(specify):*
Licesned under Chapter 400, Part III, F. S.
Certificate *(specify):*
Other Standard *(specify):*
Optional to meet Federal Conditions of Participation under 42 CFR 484.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA or its designee.
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Management

Provider Category:
Individual
Provider Type:
Registered Nurse
Provider Qualifications
License *(specify):*
Chapter 464, Part 1 "Nurse Practice Act", Florida Statutes, and Chapter 64B9 "Board of Nursing", Florida Administrative Code
Certificate *(specify):*
Other Standard *(specify):*

Individual nurses who provide this service must have a minimum of two years of direct experience working with adult populations who are diagnosed with Alzheimer's disease or other dementias or persistent behavior problems.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Management

Provider Category:
Agency

Provider Type:
Nurse Registries

Provider Qualifications

License *(specify):*
Licensed under Chapter 400.506, F. S.

Certificate *(specify):*

Other Standard *(specify):*
Individual nurses who provide this service must have a minimum of two years of direct experience working with adult populations who are diagnosed with Alzheimer's disease or other dementias or persistent behavior problems.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA or its designee.

Frequency of Verification:
Annually or more frequently if necessary.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Management

Provider Category:
Agency

Provider Type:
Community Mental Health Center
Provider Qualifications
License *(specify):*
Chapter 394, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.
Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Management

Provider Category:
Individual
Provider Type:
Clinical Social Worker, Mental Health Counselor
Provider Qualifications
License *(specify):*
Chapter 491, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.
Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Management

Provider Category:

Individual

Provider Type:
Psychologist
Provider Qualifications
License *(specify):*
Chapter 490, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Caregiver Training
Service Definition *(Scope):*
Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to enrollees. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a person served on the waiver. This service may not be provided in order to train paid caregivers. Training includes instruction about treatment regimens and other services included in the plan of care, use of equipment specified in the plan of care, and includes updates as necessary to safely maintain the enrollee at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the enrollee. All training for individuals who provide unpaid support to the enrollee must be included in the enrollee's plan of care.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Nurse, Licensed Practical Nurse
Individual	Clinical Social Worker, Mental Health Counselor
Agency	Home Health Agency
Agency	Community Care for the Elderly (CCE) Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver Training

Provider Category:
Individual

Provider Type:
Registered Nurse, Licensed Practical Nurse

Provider Qualifications

License *(specify)*:
Chapter 464, Florida Statutes

Certificate *(specify)*:

Other Standard *(specify)*:
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver Training

Provider Category:

Individual

Provider Type:
Clinical Social Worker, Mental Health Counselor

Provider Qualifications

License *(specify):*
Chapter 491, Florida Statutes

Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver Training

Provider Category:
Agency

Provider Type:
Home Health Agency

Provider Qualifications

License *(specify):*
Chapter 400, Part III, Florida Stuatutes

Certificate *(specify):*

Other Standard *(specify):*
Optional to meet Federal Conditions of Particiaption under 42 CFR 484

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver Training

Provider Category:
Agency
Provider Type:
Community Care for the Elderly (CCE) Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
As defined in Chapter 410 or 430, Florida Statutes

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA or its designee.
Frequency of Verification:
Annually or more frequently as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Home Accessibility Adaptations
Service Definition *(Scope):*
Physical adaptations to the home required by the enrollee's plan of care which are necessary to ensure the health, welfare and safety of the enrollee or which enable the enrollee to function with greater independence in the home and without which the enrollee would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems to accommodate the medical equipment and supplies which are necessary for the welfare of the enrollee. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the enrollee, such as carpeting, roof repair, or central air conditioning. Adaptations which add to the total square footage of the home are not included in this benefit. All services must be provided in accordance with applicable state and local building codes.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State

will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	General Contractor
Agency	Center for Independent Living

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Accessibility Adaptations

Provider Category:
Individual
Provider Type:
General Contractor
Provider Qualifications
License *(specify):*
Licensed by the Department of Professional Regulation (DPR) under Chapter 489.131, Florida Statutes and locally under Chapter 205, F.S.
Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Center for Independent Living
Provider Qualifications
License *(specify):*
As defined under 413.371, F. S. and licensed by Departement of Professional Regualtion (DPR) under 489, F. S. and locally under Chapter Chapter 205, F. S.
Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.
Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA and its designee.
Frequency of Verification:
Annual or more frequently as necessary.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Home Delivered Meals
Service Definition *(Scope):*
Nutritionally sound meals to be deliverd to the residence of an enrollee who has difficulty shopping for or preparing food without assistance. All meals must provide a minimum of 33 1/3% of the current Dietary Reference Intake (DRI). The meals meet the current Dietary Guidelines for Americans, the USDA My Pyramid Food Intake Pattern and reflect the predominant statewide demographic.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Older American's Act Providers
Agency	Food Service Establishment
Agency	Food Establishment
Agency	Community Care for the Elderly (CCE) Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:
Older American's Act Providers
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
As defined in Rule 58A-1, Florida Administrative Code

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:
Food Service Establishment
Provider Qualifications
License *(specify):*
Chapter 509.241, Florida Statutes
Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.
Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:
Food Establishment
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Permit under Chapter 500.12, Florida Statutes

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.
Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA or its designee.
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:
Community Care for the Elderly (CCE) Providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
As defined in Chapter 410 or 430, Florida Statutes

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Medication Administration
Service Definition *(Scope):*
Pursuant to 400.4256, Florida Statutes, assistance with self-administration of medications, whether in the home or a facility, includes taking the medication from where it is stored and delivering it to the recipient; removing a prescribed amount of medication from the container and placing it in the enrollee's hand or another container;

helping the enrollee by lifting the container to their mouth; applying topical medications; and keeping a record of when an enrollee receives assistance with self-administration of their medications.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nurse Registry
Agency	Home Health Agency
Individual	Unlicensed Staff Member Trained Per 58A-5.0191(5), F.A.C.
Individual	Licensed Nurse, Licensed Practical Nurse

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Administration

Provider Category:
Agency
Provider Type:
Nurse Registry
Provider Qualifications

License *(specify)*:
Licensed per Chapter 400.506, F. S.

Certificate *(specify)*:

Other Standard *(specify)*:
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does

not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA or its designee.

Frequency of Verification:
Annuallly or more frequently if necessary.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Administration

Provider Category:
Agency

Provider Type:
Home Health Agency

Provider Qualifications

License *(specify):*
Licensed under Chapter 400, Part III, F. S.

Certificate *(specify):*
Optional to meet Federal Conditions of Participation under 42 CFR 484.

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA or its designee.

Frequency of Verification:
Annually or more frequently if necessary.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Administration

Provider Category:
Individual

Provider Type:
Unlicensed Staff Member Trained Per 58A-5.0191(5), F.A.C.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Trained in accordance with Chapter 58A-5.0191(5), Florida Administrative Code, and demonstrate ability to accurately read and interpret a prescription label

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Administration

Provider Category:
Individual

Provider Type:
Licensed Nurse, Licensed Practical Nurse

Provider Qualifications

License *(specify):*
Chapter 464, Florida Statutes

Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Medication Management
Service Definition *(Scope):*
AHCA's Assisted Living Unit of the Division of Health Quality Assurance has ongoing responsibility for monitoring medication regimens in assisted living facilities. Survey staff, including registered nurses, conduct surveys on a biennial basis. If the facility is licensed for limited nursing or extended congregate care, in addition to the surveys, monitoring activities are completed. Medication management is a part of the survey and monitoring process.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

For enrollees receiving medication administration within the home, the licensed nurse will provide medication management in conjuction with the enrollee's physician and according to the plan of care.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nurse Registries
Individual	Licensed Nurse, Licensed Practical Nurse
Agency	Home Health Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Management

Provider Category:
Agency
Provider Type:
Nurse Registries
Provider Qualifications
License *(specify):*
Licensed per 400.506, F. S.
Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA or its designee.

Frequency of Verification:
Annually, or more frequently if necessary.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Management

Provider Category:
Individual

Provider Type:
Licensed Nurse, Licensed Practical Nurse

Provider Qualifications

License *(specify):*
Chapter 464, Florida Statutes

Certificate *(specify):*

Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as necessary

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Management

Provider Category:
Agency

Provider Type:
Home Health Agencies

Provider Qualifications

License *(specify):*

Licensed under Chapter 400, Part III, F S.
Certificate *(specify):*

Other Standard *(specify):*
Optional to meet Federal Conditions of Participation under 42 CFR 484.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA or its designee.

Frequency of Verification:
Annually, or more frequently if necessary.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Nutritional Assessment and Risk Reduction

Service Definition *(Scope):*
An assessment, hands-on care, and guidance to caregivers and enrollees with respect to nutrition. This service teaches caregivers and enrollees to follow dietary specifications essential to the enrollee's health and physical functioning, to prepare and eat nutritionally appropriate meals and promote better health through improved nutrition. This service may include instructions on shopping for quality food and on food preparation.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Dietician/Nutritionist or Nutrition Counselor
Agency	Home Health Agency
Agency	Nurse Registry
Agency	Community Care for the Elderly (CCE) Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nutritional Assessment and Risk Reduction

Provider Category:
Individual
Provider Type:
Dietician/Nutritionist or Nutrition Counselor
Provider Qualifications
License *(specify)*:
Chapter 468, Part X, Florida Statutes
Certificate *(specify)*:
Other Standard *(specify)*:
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.
Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA
Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nutritional Assessment and Risk Reduction

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify)*:

Licensed under Chapter 400, Part III, F. S.

Certificate *(specify):*

Optional to meet Federal Conditions of Participation under 42 CFR 484.

Other Standard *(specify):*

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently if necessary.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nutritional Assessment and Risk Reduction

Provider Category:

Agency

Provider Type:

Nurse Registry

Provider Qualifications

License *(specify):*

Licensed under Chapter 400.506, F. S.

Certificate *(specify):*

Other Standard *(specify):*

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually, or more frequently if necessary.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nutritional Assessment and Risk Reduction

Provider Category:

Agency

Provider Type:

Community Care for the Elderly (CCE) Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
As defined in Chapter 410 or 430, Florida Statutes

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Personal Emergency Response System (PERS)

Service Definition *(Scope):*
The installation and service of an electronic device that enables enrollees at high risk of institutionalization to secure help in an emergency. The PERS is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The enrollee may also wear a portable "help" button to allow for mobility.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
PERS services are generally limited to those enrollees who live alone or who are alone for significant parts of the day and who would otherwise require extensive supervision.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Low-Voltage Contractors and Electrical Contractors
Individual	Alarm System Contractor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:
Individual

Provider Type:
Low-Voltage Contractors and Electrical Contractors

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Exempt from licensure in accordance with Section 489.503(15)(a-d), Florida Statutes and Section 489.503(16), Florida Statutes

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:
AHCA

Frequency of Verification:
Annually or more frequently as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:
Individual
Provider Type:
Alarm System Contractor
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Chapter 489, Part II, Florida Statutes
Other Standard *(specify):*
All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.
Verification of Provider Qualifications
Entity Responsible for Verification:
AHCA or its designee.
Frequency of Verification:
Annually or more frequently as needed.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

The LTC plans will conduct case management functions for enrollees, either through their staff or subcontracts

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) and (b): LTC plans and subcontractors are subject to mandatory criminal history background screenings. For each LTC plan, all owners, officers, directors, and managers must complete a Level II criminal history background screening as part of the Medicaid provider enrollment and re-enrollment processes whether or not they own a percentage of the company. The screening requirements listed below apply to the following health care facility or provider types which are licensed by AHCA and included as providers under this waiver program: Adult Day Care Centers; Assisted Living Facilities; Home Health Agencies; Homemaker, Sitter, Companion Agencies; Home Medical Equipment Providers; Nurse Registry; and Nursing Facilities. Each of these provider types is subject to screening as required by Florida Statutes as listed below.
Direct Care Staff - Level II Criminal History Screening
Owner/Administrator - Level II Criminal History Screening
Financial Officer - Level II Criminal History Screening

A Level II Criminal History Screening consists of a fingerprint check of State and Federal arrest and criminal history information conducted through the Florida Department of Law Enforcement (FDLE) and the Federal Bureau of Investigation (FBI).

(c) The managed care plan will be required to ensure that providers and requisite staff have a current Level 2 Criminal History and/or background investigation. The Managed Care Plan shall keep a record of all background checks to be available for Agency review upon request. Plans are required to keep this information in provider credentialing and re-credentialing files which the State will assess for compliance during the readiness review period, and during annual monitoring thereafter. Additionally, to ensure all background screening requirements have been met, interpretive guidelines for annual licensure surveys require state surveyors to conduct personnel record reviews to verify that facilities have evidence of required screening.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- **No. The State does not conduct abuse registry screening.**
- **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Adult Family Care Homes	
Assisted Living Facility	

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

ALF licensing regulations concerning facility and service delivery design (Ch. 429, F. S. and 58A, F.A.C.) promote home-like characteristics (HCB) for their residents. Florida's Assisted Care Communities Resident Bill of Rights is detailed in Ch. 429.28, F.S sets out an individual resident's rights in these settings. Facility services must be furnished in a way that fosters the independence of each enrollee. The enrollee retains the right to assume risk, tempered only by their ability to assume responsibility for the risk. AFCH's are not qualified providers under the 1915(c) waiver; however, the State recognizes enrollees may receive waiver services in this setting in the future. Accordingly, the state is requiring AFCH's to conform to the HCB characteristics.

The State will assure applicable providers maintain a home-like environment and community integration through the following processes:

Subcontract Agreements
The State requires all managed care plan subcontracts with ALFs and AFCHs include language provided by the State detailing the HCB characteristic requirements. This language is based on federal rules and guidance on HCB characteristics. The State requires plan subcontracts to reference that all assisted living providers must be in compliance with s. 429.28, F.S.

Subcontracts with service providers are required to be included in the plans' credentialing files. For ALFs and AFCHs, the State will review the subcontract to determine if the required HCB language is included in the subcontract. If this language is not included in the subcontract, the State will record it as a finding of non-compliance, and require corrective action from the long-term care managed care plan within 30 days.

Credentialing and Re-credentialing
Before contracting with a service provider and prior to the provision of services to long-term care managed care enrollees, plans are required to credential the service provider to ensure that it is qualified. Since the plans will be required to have language that promotes HCB characteristics in applicable subcontract agreements, plans will also be required to verify during the credentialing and re-credentialing process these environments exist in these facilities. This verification must include on-site review of the ALF or AFHC by plan staff prior to the plan enrolling waiver participants. Documentation must be included in the plans' credentialing files for each contracted ALF and AFCH. The State will review and approve each selected plans' policies and monitoring protocols including how the plan intends to assess providers for compliance with the HCB characteristics. The State will then assess the credentialing files for completeness and accuracy during the initial readiness process and during annual monitoring. The State is also incorporating HCB characteristics into its provider training and monitoring processes. In doing so, it will be able to compare its findings with those of the plans. (Also see Independent Validation by State)

Informing Residents of Their Rights
The State will require language in the enrollee handbook that informs enrollees of their right to receive HCBS in a home-like environment regardless of their living arrangement. Language will also be added that provides enrollees with information regarding the community integration goal planning process and their participation in that process. Through this process, the State intends to raise enrollees' awareness of their right to receive services congruent with the HCB characteristics, and to empower the enrollee to alert their case manager or the State if they are not able to exercise these rights.

Waiver enrollees residing in ALF's and AFCH's must be offered services with the following options

unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:
o Private or semi-private rooms;
o Roommate for semi-private rooms;
o Locking door to living unit;
o Access to telephone and length of use;
o Eating schedule;
o Participation in facility and community activities.

Ability to have:
o Unlimited visitation;
o Snacks as desired.

Ability to:
o Prepare snacks as desired;
o Maintain personal sleeping schedule.

Furthermore, ALFs and AFCHs will support the enrollee's community inclusion and integration by working with the case manager and enrollee to facilitate the enrollee's personal goals and community activities. This is part of the ongoing implementation of the enrollee's care plan. The handbook will be given to all new enrollees during their initial orientation and annually thereafter by the case manager who will also be responsible for continuously informing and educating enrollees on these rights.

During its annual desk review, the State will review the enrollee handbook to determine whether the required language that informs enrollees of their right to receive home and community-based services in an HCB compliant setting is included in the handbook. If this language is missing from the handbook, the State will record it as a finding, and require that the language be added to the handbook, and that an updated handbook be submitted to the State for another review within 30 days.

Additionally, on an ongoing basis, State quality assurance clinical monitors will review a random, representative sample of current enrollee files for each plan. As part of this review, the quality assurance monitors will evaluate the enrollee's case records to ensure certain activities are being conducted and documented by the case manager. The quality assurance monitors will evaluate whether the case record includes documentation the case manager discussed the enrollee's right to reside in an HCB compliant setting at least once annually. Upon receipt of findings, plans have 15 business days to both fix the deficiencies and submit accompanying documentation to the State, or if required by the State, to submit a corrective action plan.

Face-to-Face Interview with Enrollees and Observation of the ALF and AFCH
On an ongoing basis, State quality assurance clinical monitors will review a random, representative sample of current enrollee files for each plan, organized by region. As part of this review, the quality assurance monitors will visit a selection of enrollees in their homes, including ALFs and AFCHs. As part of this visit, the State will require the monitors to ask each enrollee who resides in an ALF or AFCH questions regarding the home-like environment of the facility. In addition, enrollees will be interviewed about whether their needs and personal goals are being met.

If through their interview with the enrollee and/or through their observations of the ALF or AFCH the quality assurance monitors determine an enrollee is not residing in an HCB compliant setting, the monitors shall contact the appropriate State contract manager immediately upon their return, who will follow up with the long-term care managed care plan within 24 hours. Plans must remediate the deficiencies and submit accompanying documentation and a corrective action plan detailing their ongoing actions to ensure future deficiencies do not occur in the same facilities to the State within 15 business days.

The following are some examples of interventions or remediation steps the State would expect to see a plan implement upon discovering an ALF or AFCH was not maintaining HCB compliant:
• Work with the ALF or AFCH administrators and staff to correct the identified deficiencies within a timeframe specified by the State.

• Stop referring new enrollees to the non-compliant ALF or AFCH until outstanding deficiencies are resolved.
• Terminate ALFs or AFCHs that consistently fail to exhibit HCB characteristics and that do not resolve outstanding issues from its network.
• Counsel enrollees who are not residing in a home-like environment that he or she will not be able to continue to receive home and community-based waiver services in a non-compliant facility. As a last resort, if the individual wishes to remain in the ALF or AFCH, move to disenroll them from the long-term care managed care waiver. As part of the transition plan for the enrollee, the plan will determine if there are any other services and supports available to help the individual stay in the ALF or AFCH.
• If the plan terminates a contract with an ALF or AFCH, and the enrollee agrees to move to a different ALF or AFCH, the plan will facilitate transferring the enrollee to an ALF or AFCH that meets the HCB requirements.

Enforcement by Agency's Licensure Division
In addition to the above processes and plan-sponsored remediation activities, the Resident Bill of Rights in 429.28, Florida Statutes, specifies no resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law. Every resident of a facility shall have the right to:
• Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.
• At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 days' notice of a non-emergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

The resident may be required to sign a legally enforceable admission contract with the ALF or AFCH that outlines each party's responsibilities. ALF's and AFCH's may be sanctioned by the licensing agency for contravening these agreements. If the case manager, contract manager, or anyone involved in the enrollee's care has knowledge of a violation, that individual is responsible for reporting the violation to the Agency's Division of Health Quality Assurance complaint line or field office.

Provider Education and Training
The State is conducting provider outreach and training on elements of provider responsibilities regarding HCBS waiver requirements, especially with regard to HCB characteristic requirements.

Independent Validation by the State
The State will follow the sampling methodology contained in the waiver when assessing the credentialing files for ALF's and AFCH's in each plans' network prior to recipient enrollment during the readiness review period. These files must contain evidence that applicable residential providers have implemented the HCB characteristics contained in Appendix C of the waiver application.

In addition to the desk review, the State will conduct site visits to a representative sample of network ALFs for secondary verification. The sample size will achieve a 95% confidence level with a +/- 5% confidence interval.

Currently, none of the transitioning recipients reside in an AFCH. Should an individual enroll who resides in an AFCH, or should an enrolled individual seek to move to an AFCH, the State will ensure the proposed residence is monitored for compliance with the HCB characteristics prior to the individual moving there.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Family Care Homes

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Home Accessibility Adaptations	
Caregiver Training	
Home Delivered Meals	
Nutritional Assessment and Risk Reduction	
Medication Management	☑
Transportation	
Adult Companion	
Assisted Living	
Respite	
Medical Equipment and Supplies	
Intermittent and Skilled Nursing	☑
Speech Therapy	☑
Personal Care	
Homemaker	
Attendant Care	
Medication Administration	
Adult Day Health Care	
Behavior Management	☑
Case Management	☑
Occupational Therapy	☑
Personal Emergency Response System (PERS)	
Physical Therapy	☑
Respiratory Therapy	☑

Facility Capacity Limit:

Up to 5 residents

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	

Standard	Topic Addressed
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Space used to include more information about AFCH's and ALF's per CMS request:

An Adult Family Care Home is statutorily defined as having five or less residents in a full-time, family-type living arrangement, in a private home, under which a person who owns or rents the home provides room, board, and personal care, on a 24-hour basis, for no more than five disabled adults or frail elders who are not relatives.

AFCH's may only provide Assistive Care, which is a State Plan service. Since waiver recipients may reside in AFCH's and receive other services in this setting, the State will require AFCH's to conform to the home and community based characteristics included in the waiver application.

An Assisted Living Facility is statutorily defined as having six or more residents in any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24-hours to one or more adults who are not relatives of the owner or administrator.

Please see C-2-c-ii for a complete explanation of the State's home-like environment and community inclusion characteristics.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Home Accessibility Adaptations	
Caregiver Training	
Home Delivered Meals	
Nutritional Assessment and Risk Reduction	
Medication Management	
Transportation	
Adult Companion	

Waiver Service	Provided in Facility
Assisted Living	☑
Respite	☑
Medical Equipment and Supplies	☑
Intermittent and Skilled Nursing	☑
Speech Therapy	☑
Personal Care	☑
Homemaker	☐
Attendant Care	☑
Medication Administration	☐
Adult Day Health Care	☑
Behavior Management	☐
Case Management	☑
Occupational Therapy	☑
Personal Emergency Response System (PERS)	☐
Physical Therapy	☑
Respiratory Therapy	☑

Facility Capacity Limit:

Facility specific and subject to State approval

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☐
Provision of or arrangement for necessary health services	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Space used to include more information about ALF's and AFCH's per CMS request:

An Assisted Living Facility is statutorily defined as having six or more residents in any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24-hours to one or more adults who are not relatives of the owner or administrator.

An Adult Family Care Home is statutorily defined as having five or less residents in a full-time, family-type living arrangement, in a private home, under which a person who owns or rents the home provides room, board, and personal care, on a 24-hour basis, for no more than five disabled adults or frail elders who are not relatives.

AFCH's may only provide Assistive Care, which is a State Plan service. Since waiver recipients may reside in AFCH's and receive other services in this setting, the State will require AFCH's to conform to the home and community based characteristics included in the waiver application.

Please see C-2-c-ii for a complete explanation of the State's home-like environment and community inclusion characteristics.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ( ) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed

to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

The State allows legally liable relatives to be paid providers of participant directed services identified in the plan of care.

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Not applicable. The waiver operates in combination with a waiver granted under 1915(b)(4) authority.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of all new MCPs that satisfy waiver service provider qualifications prior to delivery of services. N: Number of new MCPs satisfying waiver service provider qualifications prior to delivery of services. D: Number of new MCPs.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☐ Representative Sample Confidence Interval =
☑ Other Specify: DOEA	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☐ Other Specify:	☑ Annually
	☐ Continuously and Ongoing
	☑ Other Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
% of licensed subcontractors, by type, within the MCP provider network, evaluated by MCP's, that meet provider qualifications prior to delivering services. N: No. of licensed subcontractors, by type, within the MCP provider network, evaluated by MCP's, that meet waiver service provider qualifications prior to delivering services. D: No. of licensed subcontractors, by type, in MCP provider network.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTC plan quarterly reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Enrolled MCPs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **Other** Specify: DOEA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of licensed subcontractors, by type, within MCP's provider network satisfying service, evaluated by MCPs, that meet provider qualifications continuously. N: Number of licensed subcontractors by type, in MCP's provider network, evaluated by MCPs, satisfying service provider qualifications continuously. D: Number of licensed subcontractors, by type, in MCP's provider network.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCP's quarterly reports.

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify: MCPs	☑ **Annually**	☑ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify: DOEA	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of MCPs continuously qualified on an annual basis. N: Number of MCPs continuously qualified as program providers on an annual basis. D: Number of MCPs enrolled as program providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Managed Care Plans (MCPs) must report changes in their provider credentials monthly.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
% of non-licensed/non-certified subcontractors, by type, within the MCP network, satisfying waiver service provider qual's prior to the delivery of services. N: No. of non-licensed/non-certified subcontractors by type, within the MCP network, satisfying subcontractor qual's prior to the delivery of services. D: No. of non-licensed/non-certified subcontractors by type, in MCP provider network.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTC plan quarterly reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify: MCPs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DOEA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify: the state will report quarterly to CMS for the first two years of the waiver.

Performance Measure:
% of non-licensed/non-certified subcontractors,by type, within the MCP network, satisfying waiver service provider qual's continually. N: No. of non-licensed/non-certified subcontractors, by type, within the MCP network, satisfying subcontractor qual's continually. D: No. of non-licensed/non-certified subcontractors in MCP provider network.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTC plan quarterly reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: LTC plans	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: DOEA	☑ Annually
	☐ Continuously and Ongoing
	☑ Other Specify: the state will report quarterly to CMS for the first two years of the approved waiver.

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of subcontractors with staff mandated to report abuse, neglect and exploitation, verified by MCP that staff has received the appropriate training. N: Number of subcontractors, with staff mandated to report abuse, neglect, and exploitation, verified by MCP that staff has received the appropriate training. D: Number of subcontractors with staff that are mandated reporters.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTC plan reports

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☐ Representative Sample

		Confidence Interval =
☑ **Other** Specify: LTC plan	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: DOEA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of MCP case managers satisfying abuse, neglect and exploitation, and Alzheimer's disease and dementia training requirements. N: Number of MCP case managers satisfying abuse, neglect and exploitation and Alzheimer's disease and dementia training requirements. D: Number of case managers employed by or under contract MCP.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTC plan case management training records

Responsible Party for data		**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MCP	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify: the state will report quarterly to CMS for the first two years of the approved waiver.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Plans are required to ensure providers are in good standing with the state and maintain proof of this in the required credentialing and re-credentialing files. Plans also have access to the Agency's Florida Health Finder website which lists provider's status and adverse licensure actions. Additionally, the Agency's Health Quality Assurance division will continue to follow its licensing and monitoring protocols to ensure providers are in compliance with statutory licensing and facility requirements. The Agency notifies plans if a licensure action is taken against a provider, or if a provider is terminated from Medicaid for reasons other than inactivity. The Agency will require plans to remove a provider from its network if necessary.

Plans are required to notify affected enrollees in an appropriate formal communication, and via the case manager. The plans must then work with the affected enrollee to find an alternate provider and develop a transition plan as appropriate. The enrollee retains all of the rights described in this response and throughout the waiver application during the transition process.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

If a MCP does not satisfy waiver service provider qualifications prior to delivery of services, the Agency will not approve the MCP and the MCP must correct application deficiencies. Failure to correct the application deficiencies within established time frames results in the application being denied. The LTC program has competitively procured MCPS for this program. Selected MCP must still satisfy required program provider requirements during the program readiness phase of implementation including adequate provider networks before being approved for enrollment of plan members.

If an MCP's licensed subcontractors, by type, within the MCP provider network and evaluated by MCPs fail to meet provider qualifications prior to delivering services, the State will require the deficiencies be corrected within time frames based upon enrollee health and safety risks. LTC plans are required to submit at least quarterly provider network lists detailing new and continuing service providers. LTC plans are responsible for enrolling qualified subcontractors. If the State's review determines a LTC plan's service providers are unqualified, the LTC plan must correct the deficiency. The corrective action is approved by the State and must be implemented within established time frames depending on the severity of the deficiency. Enrollees served by the unqualified subcontractors would be given a choice of qualified subcontractors as soon as possible. The LTC plan enrolling the unqualified service provider would be subject to sanctions ranging from implementation of a corrective action to correct the deficiency to suspension of enrollment.

MCPs are required to verify subcontractors within their provider networks to determine if the service providers meet qualifications continuously. If the MCPs provider network reports indicate the program provider is utilizing unqualified service providers, the state will require the plan to submit a corrective action within 20 days to address the provider network deficiency and remedies to the MCP's credentialing process for service providers. MCPs determined to have authorized services with unqualified service providers are subject to sanctions for violation of the program contract including provider termination. DOEA has been delegated responsibility for program monitoring and will approve corrective action in consultation with the Medicaid agency.

If MCPs do not continue to satisfy waiver service provider qualifications on an annual basis, the State requires a corrective action be developed and implemented to correct the deficiencies within established timeframes. Adequate provider networks must be maintained. These networks are reviewed and approved by the State. LTC plans whose networks fail to maintain the full range of required qualified service providers are informed of the deficiencies and requested to submit a corrective action within established time frames based upon the severity of the deficiency. If the corrective action is not implemented timely, the LTC plan is subject to sanctions. DOEA has been delegated responsibility for program monitoring and will approve corrective actions in consultation with the Medicaid agency.

If non-licensed/non-certified subcontractors by type, fail to satisfy waiver service provider qualifications prior to the delivery of services, the MCP will be out of compliance with the program contract. MCPs must

submit their provider network lists on at least a quarterly basis to the Agency for validation. If the provider network is found to contain unqualified providers the MCP must submit a corrective action to address the deficiency and notify affected beneficiaries. The Agency will verify the corrective action implementation. The MCP can be sanctioned for this non-compliance.

If non-licensed/non-certified subcontractors by type, fail to satisfy waiver service provider qualifications continually, the MCP will be out of compliance with the program contract. MCPs must submit their provider network lists on at least a quarterly basis to the Agency for validation. If the provider network is found to contain unqualified providers the MCP must submit a corrective action to address the deficiency and notify affected beneficiaries. The Agency will verify the corrective action implementation. The MCP can be sanctioned for this non-compliance.

MCPs' must verify subcontractors with staff mandated to report abuse, neglect and exploitation have received appropriate training. During the annual contract compliance monitoring, MCP staff records are reviewed for compliance with these requirements. MCP found with training deficiencies must submit a corrective action within 20 days. If the MCP fails to implement the approved corrective action within the specified time frames usually 30 days are subject to sanctions including limitations on future enrollments.

LTC plans can provide case management services directly through case managers employed by the LTC plan. If case managers do not satisfy abuse, neglect and exploitation, and Alzheimer's disease and dementia training requirements, the LTC plan is out of compliance with the program contract. As part of the annual contract monitoring, the State would request a corrective action to address the deficiency within established timeframes based upon the severity of the deficiency. Failure to submit a corrective action and implement corrective actions timely usually within 30 days will subject the LTC plan to sanctions ranging from suspension of enrollment to payment suspension for non-compliance with the program contract.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

- [ ] **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.

- [ ] **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  Furnish the information specified above.

- [ ] **Other Type of Limit.** The State employs another type of limit.
  Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of care

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- ☐ **Social Worker.**

Specify qualifications:

- ☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The State will monitor plan of care development and implementation to ensure that plans of care are developed in the best interest of the enrollee. LTC plans are required to develop quality assurance tools and protocols that include internal safeguards for plan of care development in addition to the external monitoring by the State.

The care planning process is person-centered, with the enrollee directing the care plan development process with the help of the case manager, his authorized representative, or any other individuals he would like included. The enrollee may invite anyone of his choosing (family members, authorized representatives, friends, etc.) to participate in his care planning process. This includes allowing the enrollee to make decisions about service options and identification of personal goals. If none of these individuals are available for an enrollee, the State expects the case manager to solicit input from enrollee-approved individuals who are familiar with the enrollee's care needs and preferences.

The plan of care will be specific to the enrollee's needs and goals that are identified using, at a minimum, the level of care assessment form(s) provided to the long-term care managed care plan by the Agency and the DOEA. The enrollee or legal guardian and the guardian advocate, caregiver, primary care physician or authorized representative must be consulted in the development of the plan of care. The plan of care will include goals and objectives, service schedules, medication management strategies, barriers to progress, and detail of interventions. When service needs are identified, the enrollee must be given information about the available network providers so that an informed choice of providers can be made. The entire care planning process is to be documented in the case record. If the enrollee disagrees with the assessment and/or authorization of placement/services (including the amount and/or frequency of a service), the case manager must provide the participant with a written notice of action that explains the enrollee's right to file an appeal.

The case manager assists the enrollee with filing for an appeal.

The state consulted with plans, and reviewed its contracts for current managed care providers and determined five days would ordinarily be sufficient for plans to develop a person-centered care plan for new enrollees. During transition, the state recognized the number of enrollees may inhibit the plans' ability to meet this deadline. It is for this reason the state required that plans provide for up to 60 days continuation of current services. The plans are marshaling extra resources to address the requirements during transition. The plans and the state have noted it would be counterproductive to all concerned to rush care plan development or attempt to alter enrollee services unnecessarily as an enrollee's right to a Fair Hearing is not affected as a result of this transition and plans would have to continue services unabated until the completion of the Fair Hearing process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) Services and supports included in the plan of care are determined by the LTC Managed Care Plan (MCP) in conjunction with the initial assessment information provided by the CARES Unit (as part of the level of care assessment) in consultation with the enrollee or his or her representative. The plan of care addresses all health and social service needs of the enrollee identified through the assessment. LTC plans are responsible for ensuring that the periodic review of the plan of care is performed through face-to-face contact at least every third month with the enrollee to determine the appropriateness and adequacy of services. During a periodic review, the LTC plan must involve the enrollee or representative in assessing whether the services furnished are consistent with the nature and severity of the enrollee's needs. Revisions to the plan of care must be done in consultation with the enrollee in addition to the caregiver and primary care provider when applicable.

(b) Enrollees have the authority to determine who is included in the development, review, and revision of their plan of care. This includes the enrollee's representative and/or family, caregivers, and physicians.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Each enrollee will have one person-centered plan of care. The managed care plan is required to develop an individualized written plan of care in a format approved by the State, for every enrollee within 5 business days of the effective date of enrollment for those enrolled in a community setting (any exceptions beyond this timeframe must be documented).

The LTC program will use an Individualized Person-Centered Care Plan development process. The provision of the long-term care services in the LTC waiver will be guided by the creation and implementation of the individualized, person-centered care plan. The person-centered care plan is based on a comprehensive assessment that identifies an individual's physical, functional, and psychosocial needs by assessing the individual's health status, physical and cognitive functioning, environment, social supports, end-of-life decisions, and his or her desired outcomes and preferences (herein referred to as personal goals). The enrollee directs the person-centered planning process. The person-centered care plan fosters the participation of family members and others chosen by the individual, as appropriate, in the care planning and service delivery process. By identifying barriers and exploring potential

solutions with the enrollee, the person-centered care plan attempts to enhance an individual's independence and quality of life through community presence, choice, competence, respect, and community participation. Examples of personal goals that an enrollee may choose to focus on include (but, are not limited to):

- Deciding where and with whom to live.
- Making decisions regarding supports and services.
- Choosing what activities are important.
- Maintaining relationships with family and friends.
- Deciding how to spend each day.

Enrollee Information
Enrollees will be informed of the benefits and services available in the waiver through the enrollment packet that will be provided to each enrollee through the enrollment broker prior to implementation. The enrollment packet will provide a comparison of benefits between plans and the services available by each managed care plan. Upon enrollment, each plan will provide its members with an enrollee handbook that includes plan network information and services. Managed care plan network information will also be made available online and by contacting the enrollment broker's call center. In addition, during the development of the enrollee's plan of care, the long-term care managed care plan and/or case manager will inform the enrollee of the services available in the plan and work with the enrollee and/or the enrollee's designated representative in developing a plan of care that best meets the enrollee's long-term care needs.

The Comprehensive Assessment
Prior to developing the person-centered care plan, the case manager is required to conduct a comprehensive assessment. When developing the initial care plan, the case manager is not only required to complete an MCP-specific assessment, but is also expected to use the initial eligibility and level of care assessment conducted by the state via CARES assessors. The comprehensive assessment includes evaluations of the plan member's health status, physical and cognitive functioning, environment, social supports, end-of-life decisions, and personal goals, while also considering the enrollee's medical history. Case managers are also required to assess the immediacy of the enrollee's service needs and personal goals.
The case manager is responsible for conducting the initial comprehensive assessment which guides the development of the person-centered care plan. Following an initial orientation, the case manager is required to contact the enrollee at least once a month by telephone, and visit the enrollee face-to-face once every 90 days, in addition to being available on a 24 hour basis, if needed. As a routine, the case manager and the plan member discuss, evaluate, and revise if necessary the plan of care monthly and during the 90-day face-to-face visits. Immediate and intermittent needs (including service needs or personal goals) may be addressed at any time when an enrollee contacts the MCP or case manager. The case manager is also required to update the enrollee's person-centered care plan following a significant change in their health or functional status. Additionally, the case manager is responsible for authorizing the enrollee's services and coordinating their care on an ongoing basis.

Care Plan Development
To ensure that the care planning process is person-centered, the enrollee directs the care plan development process with the help of the case manager, his authorized representative, or any other individuals he would like included. The enrollee may invite anyone of his choosing (family members, authorized representatives, friends, etc.) to participate in his care planning process. This includes allowing the enrollee to help make decisions about service options and identification of personal goals. If none of these individuals are available for an enrollee, the state expects the case manager to solicit input from enrollee-approved individuals who are familiar with the enrollee's care. When developing the care plan for all enrollees, LTC case managers are required to:

•Assess the immediacy of the enrollee's service needs and personal goals, and include a description of the enrollee's condition, as identified through an appropriate comprehensive assessment and a medical history review.

Recognize and support the enrollee's self-care capabilities.

Identify any existing care plans and service providers and assess the adequacy of current services.

Ensure continuity of care by providing for continuous care to the new enrollee if the enrollee is receiving services and supports prior to the effective date of enrollment.

Ensure that the care plan contains information about the enrollee's medical condition, the type of services to be

furnished, the amount, frequency and duration of each service, and the type of provider to furnish each service (regardless of whether Medicaid is the primary payer source) for all enrollees whether they reside at home or in an assisted living facility.

•

Ensure that service interventions address identified problems, needs, and conditions.

•

Encourage integration of formal and informal supports including the development of an informal volunteer network of caregivers, family, neighbors, and others to assist the enrollee or primary caregiver with services. These services will be integrated into an enrollee's care plan when it is determined through multi-disciplinary assessment and care planning that these services would improve the enrollee's capability to live safely in the home or community setting and are agreed to and approved by the enrollee or the enrollee's authorized representative.

•

Determine whether enrollees have advance directives, health care powers of attorney, do not resuscitate orders, or a legally appointed guardian. This information will become part of the enrollee's case record and these orders and preferences will be integrated into the care coordination process. For enrollees who do not have advance directives or do not resuscitate orders, the case manager will discuss with the enrollee the importance of these documents and note the enrollee's response in the case file.

•

Establish personal goals and engage in ongoing personal goal planning activities.
Goals address the enrollee's physical, functional, and psychosocial needs, and are built on the enrollee's strengths. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination processes, and the care plan includes steps that the enrollee will take to achieve the goal.

Enrollee goals must:

•

Be measurable;

•

Specify a plan of action/interventions to be used to meet the goals;

•

Include a timeframe for the attainment of the desired outcome; and

•

Be reviewed at each 90-day face-to-face visit and progress must be documented in the enrollee's case record.

Progress means information regarding whether interventions to achieve a goal were successful, potential barriers, changes that need to be made to the goal, changes that need to be made to the intervention, if the goal has been achieved, and the reasons for continuing the goal after it has been achieved (if it was a one-time goal). Personal goal planning activities are included in the care plan development process. Through these activities, the state ensures that the enrollee's personal goals are incorporated into the care plan and that, in addition to meeting physical and functional needs, his psychosocial needs (including participation and integration with his community) are also met. This process is directed by the enrollee with the help of the case manager, any authorized representative, or any other individuals he would like included in the care planning process. The purpose of the personal goal planning process is to identify activities or interventions that promote the enrollee's ability to participate in his community and that foster his independence and autonomy within his community. Examples of these types of activities could include arranging for transportation to the local senior center; arranging for a homemaker companion to visit an enrollee for a game of chess in his home twice a week; or helping an enrollee remember to call her daughter twice a week.

When developing or reviewing an enrollee's care plan, the case manager and the enrollee will discuss the goals that the enrollee would like to accomplish to be integrated and connected to his community. This discussion shall include identifying the goals and any barriers that exist to achieving those goals. The case manager will then work with the enrollee, authorized representative, family members or others who care about the enrollee, all other home and community-based service providers, and the ALF (for those enrollees residing in an ALF) to implement interventions to overcome the identified barriers, and will follow up with the enrollee at least monthly to determine the status of his goals. At every 90 day face-to-face visit, the case manager and enrollee will discuss the status of his goals, and will again work to identify any new goals and barriers. As with all other care planning activities, all identified goals, barriers, interventions, and status updates must be documented in the enrollee's case record. Additionally, any discussions that the case manager has with the ALF or other service providers that contribute to implementing an intervention must be documented in the case record.

Because case managers are also required to assess the immediacy of the enrollee's service needs and personal goals, the enrollee may contact his case manager at any time during the month for any reason. If contacted, the case manager will follow up with the enrollee regarding his inquiry or request in a timely manner. The community integration goal setting process attempts to ensure that waiver enrollees remain integrated with their communities, and that they maintain their independence and autonomy. Case managers are therefore expected to provide enrollees with the tools to exercise their independence and to seek out community activities on their own if they so choose, as well as to facilitate participation on behalf of enrollees who cannot do so for themselves.

Care Plan Implementation
Managed Care Plan case managers are tasked with developing and implementing care plans using a person-centered approach. The case manager is responsible for ensuring it is implemented appropriately. LTC managed care plan case managers are the lead case managers for individuals receiving Medicaid services. As such, they are responsible for:

•Working with the enrollee to develop a plan of care that includes all services needed, regardless of payor source, and that identifies the source of all resources needed to meet personal goals.

•Ensuring the requisite service authorizations are approved, regardless of payor source (e.g., commercial health insurance, Medicare, or Medicaid medical).

•Assisting the enrollee to access services by helping to find providers, set appointments, arrange transportation, etc.

•Monitoring implementation of the plan of care through at least monthly contact to ensure that services are being delivered as planned and are meeting the enrollee's needs.

•Adjusting the care plan as needed to accommodate changes in enrollee needs, goals, health status, etc.

Monitoring Activities by the State for the Care Planning Process
On an ongoing basis throughout the calendar year, state quality assurance (QA) clinical monitors review a random, representative sample of current enrollee files for each MCP, organized by planning and service area. As part of this review, the QA monitors evaluate the enrollee's care plans to ensure that the MCP case managers are performing the required care planning activities, including the required elements in the care plan, and that those activities are being documented in the case record by the case manager. For all deficiencies cited by the clinical monitors, upon receipt of the findings, MCPs have 15 business days to fix the deficiencies and submit accompanying documentation to the state, and to submit a corrective action to the state detailing their ongoing actions to ensure future deficiencies do not occur. As a part of the CAP submission, the MCP's will be required to identify evidence-based practices that will yield improved performance. During the remediation process, the MCO shall submit progress reports to the state with data that demonstrates improvement.

The monitors will evaluate the following elements related to the care plan and care planning process:
•
Whether care plan services provided by the MCP and through informal supports meet the enrollee's assessed needs and personal goals
•
Whether the care plan includes documentation of interventions and services provided to enrollee from all sources
•
Whether the following events are documented in the case record:

oOrientation, including a discussion of the enrollee's appearance and demeanor, medical diagnoses, cognitive deficits, ADL and IADL deficits, the enrollee's environment, and how care plan needs are addressed
oEvery 90 day face-to-face care plan review
oMonthly contact (telephone or face-to-face)
oUpdates on the enrollee's medical conditions, hospitalizations and placement in facilities
oAnnual reviews including the documentation of the completion of the state assessment tool
oDocumentation of service receipt, and enrollee satisfaction with services and supports

To better ensure that the MCPs' case managers are conducting and properly documenting community integration goal planning activities, the state also requires the MCLTC MCPs to audit a random representative sample of currently enrolled enrollee's case records for the following elements specifically related to community integration

goal planning activities:
• Identified goals
• Identified barriers to achieving goals
• Identified interventions for overcoming barriers
• Identified timeframes for goal attainment
• Progress updates
Progress means information regarding whether interventions to achieve a goal were successful, potential barriers, changes that need to be made to the goal, changes that need to be made to the intervention, if the goal has been achieved, and the reasons for continuing the goal after it has been achieved (if it was a one-time goal).

On a quarterly basis, MCPs are required to collect, aggregate and submit data regarding the above activities to the state for review. The state will use this data and the data obtained by the clinical monitors to determine if barriers exist across enrollee experience and if trends exist across particular settings and to resolve any issues revealed by the data.

Services included in the plan of care will be driven by the plan member's goals in conjunction with the initial assessment information provided by the CARES Unit, in consultation with the enrollee or representative and must be necessary to address all health and social service needs of the enrollee identified through the assessment. (42 CFR 438.208 (c) (3) and (c) (4))

The plan of care must be based on a comprehensive assessment of the enrollee's health status, physical and cognitive functioning, environment, social supports, and end-of-life decisions. The following minimum components must be included in the plan of care:

1. Enrollee's name,
2. Enrollee's Medicaid ID number,
3. Plan of care effective date,
4. Plan of care review date,
5. Services needed, including routine medical and waiver services,
6. Begin date and end date,
7. Providers,
8. Amount, frequency, and duration,
9. Case manager's signature and
10. Enrollee signature & date.

Each LTC plan will have the flexibility to design a plan of care form or system that includes these minimum components and is subject to the review and approval of the State.

The plan of care must clearly identify barriers to the plan member and caregivers, if applicable. The case manager must discuss barriers and explore potential solutions with the plan members, and caregivers when applicable. The plan of care must detail all interventions designed to address specific barriers to independent functioning. The plan of care may include services provided through the plan member's own informal network or by volunteers from community social service agencies or other organizations. Primary caregivers, family, neighbors and other volunteers will be integrated into an plan member's plan of care when it is determined through multi-disciplinary assessment and care planning that these services would improve the enrollee's capability to live safely in the home setting and are agreed to by the enrollee.

The plan of care must be: (1) developed by the plan member's case manager in conjunction with the plan member participation and consultation with any providers caring for the plan member where appropriate; (2) approved by the LTC plan in a timely manner, if the LTC plan requires an approval; and (3) developed in accordance with any applicable State quality assurance and utilization review standards. Copies of the plan of care must be forwarded to the eplan member's primary care provider and, if applicable, to the facility where the plan member resides within 10 days of development.

Revisions must be done in consultation with the enrollee, the caregiver, and when feasible, the primary care provider (PCP). If the primary care provider is not under contract with the LTC plan, an effort must be made by the case manager to obtain the PCP's input regarding plan of care revisions. Changes in service provision resulting from a plan of care review must be implemented within five business days of the review date.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

As part of person-centered care planning the enrollee, their advocates, primary care provider and the case manager will develop a back-up plan congruent with the individual's primary plan of care. Additionally, risk mitigating services are included as waiver services (e.g., nutritional needs assessment and home delivered meals). While enrollees retain the right to refuse to participate in developing a mitigation plan, the managed care plan is required to develop overall emergency back-up plans and the case manager is required to inform recipients of any risks identified and invite them to participate in developing a mitigation plan to address them. Aspects of this, such as alternate contacts in the event of a natural or man-made disaster, are automatically incorporated into the recipient's service plan and communicated to enrollees by their case manager, and via the managed care plan's written materials whether the enrollee engages or not. System-wide emergency back up plans are submitted by each LTC plan on an annual basis to the State. In addition, the plan of care development process includes the identification of procedures for enrollees to follow if service providers are unavailable or other emergent conditions arise.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.**Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Each LTC MCP is required to develop printed and online provider network directories to assist enrollees in selecting from qualified providers. These directories are available to the enrollment broker. LTC plans also make trained staff available that can link enrollees to waiver providers in their area. Case managers are trained to provide unbiased information regarding qualified providers of waiver services to each enrolleee. Enrollees are free to select among any available provider in the LTC plan's network. Prior to implementation, the network sufficiency of each LTC plan will be assessed to ensure that there is an adequate number of available waiver providers in the network.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.**Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Agency and DOEA will conduct a readiness review of each chosen plan which will consist of a desk review and onsite monitoring to assess whether the plan can fulfill its obligations under the contract. Readiness reviews include, but are not limited to:

•Reviewing the plans provider network for service adequacy and credentialing.
•Reviewing the policies and procedures plans were required to develop.
•Reviewing outreach/enrollee/provider materials for adequacy and congruence with the plans' contractual obligations.
•Assuring the plan has a sufficient information technology and communications infrastructure.
•Assuring the plan is appropriately staffed and staff are properly credentialed.

The Agency also requires plans to send a comprehensive list of reports to be reviewed on an ad-hoc, monthly, quarterly and annual basis. These reports may result in the State conducting on-site or desk reviews of the plan if aberrant trends are detected.

Finally, the Agency and DOEA will monitor the plans on-site on an annual basis. Annual monitoring will check the accuracy of the various plans' reports and determine whether they are performing according the contractual obligations and the State's performance measure set forth in the waiver application.

The Agency will require remediation of any issues discovered during these monitoring activities and will impose penalties and/or sanctions as appropriate.

The long-term care managed care plans shall ensure that the service plans are developed and updated timely. The DOEA will have primary responsibility to conduct the case reviews. The Agency for Health Care Administration, Florida's Medicaid agency, will be responsible for making sure that a representative number of case reviews have been completed in a timely manner, and that any remediation has been adequately addressed.

To ensure a representative sample, parameters will be set for a specified time period at a 95% confidence level, a 5.0% margin of error and 50% response distribution, in order to draw a representative sample at the program level. This random sample will then be apportioned across the Managed Care Plans (MCP), so that the percent of the sample drawn randomly from each MCP matches the percent of the overall population served by that MCP. Proportionate random sampling ensures that all Managed Care Plans are represented in the sample, and helps to minimize bias.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- **Every three months or more frequently when necessary**
- **Every six months or more frequently when necessary**
- **Every twelve months or more frequently when necessary**
- **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

Many managed care plans that bid on the managed long term care contract have secure, centralized electronic case management systems that are the repository for all information about enrollees. If paper records are required, they are to be secured at the managed care plan's/case manager's local office. Case management records are maintained in secure filing cabinets and in HIPAA compliant electronic filing systems.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Reviews will be conducted by the managed care plan and DOEA. The managed care plan will review the quality of care for its enrollees. DOEA will review a representative sample of care plans as part of the annual case record review. The Agency's contract managers will accompany DOEA during annual monitoring trips to verify

compliance with a representative sampling of care plans and to review DOEA's quality review process during the annual oversight review.

DOEA conducts retrospective reviews of a representative sample of plans of care to ensure plans have been developed in accordance with applicable policies, ensure the health and welfare of enrollees, and are used to effectively deliver waiver services that are furnished in accordance with the plan on an annual basis.

In addition, the plans must conduct quarterly reviews to monitor the quality of care for enrollees in this waiver. The reviews must include quarterly monitoring of long-term care enrollee records who have received services during the previous quarter. The contractor's selection of conditions and issues to study should be based on enrollee profile data. Review elements include management of diagnosis, appropriateness and timeliness of care, comprehensiveness of and compliance with the plan of care, and evidence of special screening for, and monitoring of, high-risk persons and conditions. To complement the plans' quarterly quality of care reviews, the State will conduct annual LTC MCP monitoring. The sampled plans of care will be reviewed to determine plan of care and service adequacy to address care needs identified in the enrollee assessments as well as health and safety risks presented by the enrollee's health and residential circumstances.

b. Monitoring Safeguards. *Select one:*

- **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The State requires that responsibility for monitoring plan of care implementation and enrollee health and welfare within the plan be independent of any direct waiver services to avoid conflict of interest issues.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

a. *Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of enrollees with care plans meeting all assessed needs and risks. N: Number of enrollees with care plans meeting all assessed needs and risks. D: Total number of records reviewed.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☑ Monthly	☐ Less than 100% Review
☑ Sub-State Entity	☑ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: DOEA	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☑ Other Specify: Proportional random sample methodology
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☑ Other Specify: DOEA	☑ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of enrollees with care plans documenting personal goal setting and community integration goal setting. N: Number of enrollees with care plans documenting personal goal setting and community integration goal setting. D: Number of records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify: Random Sample methodology
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☐ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: DOEA	☐ Annually
	☑ Continuously and Ongoing
	☑ Other Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of enrollees' plans of care being distributed within 10 days of development to the primary care physician (PCPs). N: Number of enrollees' plans of care being distributed within 10 days of development to the enrollees' PCPs. D: Total number of enrolee records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample

		Confidence Interval =
☑ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Random Sample Methodology
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: DOEA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of plan of care/summaries where enrollee participation is verified by signatures. N: Number of plans of care/summaries where enrollee participation is verified by signatures. D: Total number of enrollee plans of care/summaries reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DOEA	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Random Sample Methodology
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: DOEA	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:

Percentage of enrollees' care plans reviewed on a face-to-face basis at least every three monthes and updated as appropriate. N: Number of enrollees' care plans reviewed on a face-to-face basis at least every three monthes and updated as appropriate. D: Number of enrolee records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DOEA	☐ **Annually**	☑ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify: Random Sample Methodology.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DOEA	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of enrollees' care plans updated at least annually. N: Number of enrollees with updated plans of care at least annually. D: Total number of enrollee records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DOEA	☑ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☑ **Other** Specify: Random Sample Methodology
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DOEA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify: the state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of enrollees whose care plans are updated when needs change. N: Number of enrollees whose care plans are updated when needs change. D: Number of records indicating a significant change.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☑ **Other** Specify: DOEA	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify: Random Sample Methodology
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: DOEA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of enrollee services delivered according to the care plan as to service type, amount, frequency, duration and scope. N: Number of enrollee services delivered according to the care plan as to service type, amount, frequency, duration and scope. D: Total number records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Random Sample Methodology
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **Other** Specify: DOEA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of new enrollees with freedom of choice forms indicating Managed Care provider choice in their enrollment packets. N: Number of new enrollees with freedom of choice forms indicating Managed Care provider choice in their enrollment packets. D: Number of records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **State Medicaid Agency**	☑ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other**	☑ **Annually**	☐ **Stratified**

Specify: DOEA		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify: Proportional Random Sample Methodology
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify: DOEA	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of new enrollees with freedom of choice forms indicating choice between waiver services and institutional care in their enrollment packets. N: Number of new enrollees with freedom of choice forms indicating choice between waiver services and institutional in their enrollment packets. D: Total number of records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DOEA	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify: Proportional Random Sample Methodology
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: DOEA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of all new enrollees with signatures on the care plan indicating choice of services and subcontractors. N: Number of new enrollees with signatures on the care plan inciating choice of service and subcontractors. D: Number of records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify: DOEA	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Random sample methodology.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DOEA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	The state will report quarterly to CMS for the first two years of the approved waiver.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
N/A.

Since the remediations for this appendix require more space than allocated to the text box, the last six remediations are listed in this space.

The LTC contract requires MCPs to update beneficiary care plans when needs change. During the annual contract monitoring, a random sample of MCP beneficiary care plans and case notes are reviewed to determine if care plan are changed when the beneficiary has changes in their conditions or circumstances. If the MCP case manager is not updating the care plan in response to these changes, the MCP will have to submit a corrective action within 20 days to address the deficiency. DOEA will verify the implementation of the corrective action. The MCP is subject to sanction for this failure to comply with care planning standards.

By contract, MCPs must review plan members' care plans following the report of a significant change. If the MCP fails to review the member's care plan after the report, the plan is out of compliance with the program' care plan standards. The MCP's failure to record the review in the plan member's case notes is a significant care omission. If the omission involved health and safety issues, the MCP would be required to address the deficiency immediately. If non-health and safety issues were involved, the MCP would have to correct the deficiency within 30 days. In addition, the MCP would be subject to sanctions.

By contract, approved plan of care services must be delivered as to service type, scope, amount, duration and frequency as detailed in the plan of care. If the contract review monitoring determines a deficiency with service delivery as detailed in the plan of care, the LTC plan must submit a corrective action to address this deficiency. If the monitoring process found a deficiency in the service delivery of care plan services, the MCP would be carefully reviewed by DOEA to determine if the problem was wide spread among the plan's care plans. If the problem was wide spread, the MCP would be subject to intensive follow-up monitoring to correct the care plan service delivery problems. If the LTC plan failed to implement the corrective action within 30 day, the LTC plan is subject to sanctions including payment suspension and provider termination.

By contract, new beneficiaries must have with freedom of choice forms indicating Managed Care provider choice in their MCP case files. If during the annual contract review, a deficiency with freedom of choice documentation exists, the MCP must address the issue within 20 days. If the MCP does not correct the issue within 30 days, the plan is subject to sanctions including admissions suspension.

The LTC program contract requires new beneficiaries to have freedom of choice forms indicating choice between waiver services and institutional care in their enrollment packets. During the annual contract review, if a deficiency with freedom of choice documentation exists, the MCP must submit a corrective action to address this case file deficiency within 20 days. If the MCP does not implement the corrective action within 30 days, the plan is subject to sanctions including admissions suspension. DOEA will verify the implementation of the corrective action.

The LTC program contract requires new beneficiaries to document their choice of services and subcontractors with their signature on the approved care plan. During the annual contract review, if a deficiency with freedom of choice documentation exists, the MCP must submit a corrective action to address this case file deficiency within 20 days. If the MCP does not implement the corrective action within 30 days, the plan is subject to sanctions including admissions suspension. DOEA will verify the implementation of the corrective action.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
By contract, approved plans of care must address all assessed needs including risk factors. If the contract review determines a deficiency with plan of care development, the LTC plan must submit a corrective action to address this deficiency. If the deficiency involves the health and safety of the enrollee, the deficiency must be remedied immediately. Health and safety care plan issues are corrected on the same day of the finding. Other care plan care issues will be corrected within 30 days with the necessary services. DOEA in consultation with the Medicaid agency will verify the implementation of the corrective action. If the MCP plan fails to implement the corrective action timely, the MCP is subject to sanctions up to provider payment recoupment and provider termination.

LTC MCPs must use an integrated care planning process that encourages the beneficiary to set personal goals and pursue community interests. During the annual contract monitoring, MCP care plans are reviewed to verify beneficiary goals and community interests are included on the care plan. MCPs with deficit care plans must develop corrective actions to address these deficits. The Agency will consult with DOEA in verifying the timely implementation of these deficiencies. MCPS are subject to sanctions for this deficiency.

By contract, plans of care should be distributed within 10 days of development to their primary care provider. If the contract review determines a deficiency with plan of care distribution, the LTC plan must submit a corrective action to address the deficiency. This deficiency would require the MCP to change their policies and procedure regarding care planning process. If a deficiency was found, the MCP would be required to review all plan members' care plans and determine if the care plans were sent to the primary care provider. The State verifies the implementation of the corrective action. If the LTC plan fails to implement the corrective action within 30 days, the LTC plan is subject to sanctions.

The LTC program requires care plan/summaries to be signed by beneficiaries to verify their participation in the development of the document. During the annual on-site contract review a random sample of beneficiary care plans/summaries are selected for review. If the review determines the MCP's case managers are not complying with either the beneficiary participation or obtaining the beneficiary''s signature on the care plan/summary, the MCP will be required to submit a corrective action within 20 days. DOEA will verify implementation of the corrective action. MCPs failing to include beneficiaries in the care plan/summaries development process are subject to sanctions.

By contract, plans of care must be reviewed on a face to face basis at least every three months and updated as appropriate. If the on-site contract compliance review determines a deficiency with the plan of care review, the LTC plan must submit a corrective action within 20 days to address this deficiency. DOEA will verify implementation of the corrective action. If the LTC plan fails to implement the corrective action timely, the LTC plan is subject to sanctions.

By contract, approved plans of care must be updated at least annually. If the contract compliance review determines a deficiency with the plan of care update requirement, the LTC plan must submit a corrective action within 20 days to address this deficiency. If the deficiency involves health and safety issues, the corrections will be made on the same date as the finding. Other care plan update issues will be required to be corrected within 30 days. If the LTC plan fails to implement the corrective action timely, the LTC plan is subject to sanctions up to provider payment or an admissions suspension.

By contract, MCPs must review plan members' care plans following the report of a significant change. If the MCP fails to review the member's care plan after the report, the plan is out of compliance with the program' care plan standards. The MCP's failure to record the review in the plan member's case notes is a significant care omission. If the omission involved health and safety issues, the MCP would be required to address the deficiency immediately. If non-health and safety issues were involved, the MCP would have to correct the deficiency within 30 days. In addition, the MCP would be subject to sanctions.

See text box Appendix E (ii) for the remainder of the remediations for Appendix D's performance measures.

ii. **Remediation Data Aggregation**
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies)*:	Frequency of data aggregation and analysis *(check each that applies)*:
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☐ Other Specify:	☑ Annually
	☐ Continuously and Ongoing
	☑ Other Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one)*:

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how

participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participant direction is offered to all enrollees who live in their own personal home or the home of a family member and who have a participant direction eligible service on their authorized care plan. Enrollees wishing to participate in participant direction, but who do not have the capacity to manage services may choose a representative willing to take on these duties. Individuals enrolling in the waiver are presented with information about participant direction both as part of the enrollment broker process and during the care planning process. The State expects 10% of the population will choose participant direction, based on enrollment in the State's Consumer-Directed Care Plus (CDC+) program, authorized under a Section 1915(j) State plan amendment (SPA).

Participant direction is offered for five of the waiver services: adult companion, homemaker, attendant care, intermittent and skilled nursing, and personal care. The participant is responsible for training direct service workers, setting hours during which services will be provided, and submitting timesheets to the managed care plan.

Supports for the enrollee are offered in the form of a case manager, who trains, or arranges for training, in all aspects of the participant direction process. The plan is responsible for Fiscal/Employer Agent (F/EA) functions and must process, file, and pay all state and federal taxes on behalf of participants and their direct service workers. The Managed Care Plan must operate as a Vendor Fiscal/Employer Agent (F/EA) or subcontract this function. The F/EA is required by contract to operate in accordance with Section 3504 of the Internal Revenue Code, per Revenue Procedure 70-6 and Section 3504 Agent Employment Tax Liability proposed regulations (REG-137036-08) issued by the IRS on January 13, 2010. The F/EA must meet all applicable PDO-related Federal and State requirements. These requirements will be assessed as part of the Plan Readiness Review by the State prior to providing PDO services to recipients. Also, ongoing monitoring of all plans and their approved subcontractors will ensure these requirements are maintained.

Enrollees may also choose a representative to handle participant direction responsibilities. Potential conflict of interest is mitigated by prohibiting the representative from also serving as a paid caregiver for the enrollee they represent.

The waiver does not require participant direction in order to receive services from the program. An enrollee who chooses participant direction may choose to terminate it at any time and will be assisted by the case manager to transition to provider managed services without any lapse in service. In specified circumstances (i.e., a representative is necessary for participation but is not available or consumer health or safety at risk), an enrollee may be involuntarily disenrolled from participant direction. In such a case, the enrollee's case manager will be responsible for ensuring transition to provider managed services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [ ] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☒ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- **Waiver is designed to support only individuals who want to direct their services.**
- **The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Any enrollee wishing to participate in participant direction and their chosen representative, if applicable, must first complete the PDO Pre-Screening Tool with the case manager. The enrollee and representative, if applicable, must also complete participant direction training and submit accurately completed documents to the managed care plan.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Information about participant direction opportunities, including the benefits, responsibilities, and potential liabilities of participant-direction, will be provided to enrollees at various times. For both individuals gaining eligibility for HCBS at the same time as Medicaid and those already Medicaid eligible, this information will be presented by the case manager during the care planning process.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- **The State does not provide for the direction of waiver services by a representative.**
- **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☐ **Waiver services may be directed by a legal representative of the participant.**

☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Process for appointment of a representative: The enrollee must indicate to the case manager that he or she wishes to choose a representative to manage the Participant Direction Option (PDO). The potential representative will meet with the case manager to complete a PDO pre-assessment tool, which will be used to inform the prospective representative of all responsibilities and also provide critical thinking exercises for the prospective representative to determine if he or she is willing and able to manage all the enrollee's responsibilities under the PDO. Each prospective representative will be Level 2 background screened to ensure that there are no disqualifying offenses as per Chapter 435 and section 408.809, F.S. The participant-chosen representative must sign a Representative Agreement indicating the willingness to manage the PDO responsibilities on behalf of the participant.

Once appointed, the representative can hire and fire workers and sign worker timesheets.

Safeguards: The representative may not be paid to act as the representative or be a paid provider of the enrollee's waiver services. The enrollee may change representatives at any time by notifying the case manager. The case manager remains involved as part of the enrollee's care team and continues to facilitate the care planning process and maintain regular contact with the enrollee. This provides oversight of the representative to ensure there is not an abuse of authority. There is also monitoring of the representative's responsibilities by the managed care plan, and the State.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Adult Companion	☑	☐
Intermittent and Skilled Nursing	☑	☐
Personal Care	☑	☐
Homemaker	☑	☐
Attendant Care	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☑ **Private entities**

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

FMS are covered as the waiver service specified in Appendix C1/C3

The waiver service entitled:

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The LTC plans may contract with qualified entities to furnish FMS.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

LTC plans compensate FMS entities for the activities they perform, if they subcontract this function.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [ ] **Assists participant in verifying support worker citizenship status**
- [ ] **Collects and processes timesheets of support workers**
- [ ] **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

Specify:

The FMS agency will assume responsibility for verifying and reviewing the results of background screening.

Supports furnished when the participant exercises budget authority:

- [ ] **Maintains a separate account for each participant's participant-directed budget**
- [ ] **Tracks and reports participant funds, disbursements and the balance of participant funds**
- [ ] **Processes and pays invoices for goods and services approved in the service plan**
- [ ] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- ☐ **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☐ **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☐ **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The State conducts on-site monitoring of the plan on an annual basis or more frequently as needed. The plan submits encounter data to the State that details utilization of participant directed services and FMS. The plan is responsible for monitoring all sub-contracted FMS entities, if applicable, to ensure the integrity of the financial transactions they perform. Through the retrospective review of service plans and paid timesheet records, the State ensures that plans of care have been developed in accordance with applicable policies and that both FMS and participant directed waiver services are furnished in accordance with the plans of care.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case managers provide this function for enrollees. Case managers assist enrollees in gaining access to needed waiver and other State plan services, as well as other needed medical, social, and educational services, regardless of the funding source. Case management services contribute to the coordination and integration of care delivery through the ongoing monitoring of service provisions as prescribed in each enrollee plan of care. For enrollees choosing participant direction, the case manager is responsible for assisting the enrollee, by arranging for training and through ongoing support, with the following duties: recruiting workers; ensuring that worker qualifications are verified and criminal background check completed; defining additional qualifications and duties within the scope of waiver definitions to meet the enrollee's specific needs; scheduling workers; training workers; supervising workers; evaluating worker performance; verifying time worked and timesheets; and, if necessary, dismissing workers and arranging for implementation of the Emergency Back-up Plan.

☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Home Accessibility Adaptations	☐
Caregiver Training	☐
Home Delivered Meals	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
	☐
Nutritional Assessment and Risk Reduction	☐
Medication Management	☐
Transportation	☐
Adult Companion	☐
Assisted Living	☐
Respite	☐
Medical Equipment and Supplies	☐
Intermittent and Skilled Nursing	☐
Speech Therapy	☐
Personal Care	☐
Homemaker	☐
Attendant Care	☐
Medication Administration	☐
Adult Day Health Care	☐
Behavior Management	☐
Case Management	☐
Occupational Therapy	☐
Personal Emergency Response System (PERS)	☐
Physical Therapy	☐
Respiratory Therapy	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

An enrollee may voluntarily terminate participant direction at any time. The enrollee will work with his or her case manager to find providers for the services within the LTC plan's network as Emergency Back-up providers.. Since the LTC plan is required to maintain a full network of service providers at all times and the Emergency Back-up Plan is updated annually, providers will be available to serve the enrollee in a timely manner. The care manager will work with the participant directed providers and the network providers to develop a transition plan so that continuity of care is assured and there is no lapse in services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The State may involuntarily terminate the use of participant direction under certain circumstances. The State will review the documentation and make a determination of whether to terminate upon recommendation by the LTC plan. The LTC plan may not terminate participation without prior approval by the State.

The State may involuntarily terminate participant direction for the following reasons:
•Enrollee health or safety is at risk;
•Enrollee is unable to employ or manage workers;
•Enrollee is admitted to a long-term care facility;
•Enrollee moves out of the State;
•Enrollee loses Medicaid eligibility;
•Enrollee fails to choose a representative, when needed; or
•Enrollee submits inaccurate time sheets to the managed care plan.

If the enrollee is not able to employ or manage workers, or if they submit inaccurate time sheets, the managed care plan and the State will require the enrollee choose a representative if they do not have one. If the enrollee already has a representative and is unable to meet all necessary criteria for participant direction, the State and the managed care plan will require them to choose a different representative. If the enrollee refuses to choose a representative, the managed care plan and the State will involuntarily terminate them from the participant directed option.

If the enrollee is terminated from the participant directed option, then they must transition back to utilizing home and community-based waiver services from the managed care plan's network of service providers. The case manager is central to assisting the enrollee to implement their Emergency Back-up Plan, and to ensuring there is no interruption in services.

All enrollees choosing the participant directed option will have an emergency back-up plan in place which is developed in coordination with the case manager. Providers identified for the backup plan are chosen from the currently enrolled home and community-based waiver service providers available to all enrollees from the managed care plan's network provider list. The use of service providers that are currently enrolled in the plan network will assure quick access and prevent a gap in service delivery during the transition from participant-direction to traditional home and community based services delivery.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	50	
Year 2	100	
Year 3	200	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. **Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Plans are required to pay for the cost of background screenings for 1 provider per eligible service per year (up to 5 services) and for the representative (if appointed). If an enrollee hires multiple providers for 1 service, the excess providers are responsible for paying for the background screening.

- [ ] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [ ] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [ ] **Determine staff wages and benefits subject to State limits**
- [ ] **Schedule staff**
- [ ] **Orient and instruct staff in duties**
- [ ] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- [ ] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility.*Select one*:

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The State provides Fair Hearings under 42 CFR Part 431 subpart E, 42 CFR 438.400(a)(I) and 42 CFR 438.404. The Fair Hearing policy and process is detailed in Rule 65-2.042, F.A.C. Each enrollee is informed of his or her right to a Fair Hearing when action has been taken regarding his/her Medicaid eligibility or services are denied, terminated, reduced, or suspended. Actions related to decisions regarding Medicaid eligibility include determinations an applicant does or does not meet Medicaid financial, clinical, or technical criteria or failure to act in a timely manner for eligibility determination. The individual receives from the Florida Department of Children and Families (DCF) a Notice of Case Action (HRS-AA Form 2266) which contains the following statement: "If you have reason to believe this action is incorrect, your eligibility specialist will be glad to discuss it with you. You also have the right to request a hearing before a State Hearing Officer. A request for a hearing should be made within 90 days from the date at the top of this notice. You can bring with you or be represented at the hearing by a lawyer, relative, or person designated by you."

In accordance with 42 CPR 438.402, all LTC plans are required to develop an internal grievance system, including appeal and grievance processes, which shall state that the enrollee has the right to request a Fair Hearing at any time, in addition to pursuing the contractor's grievance process. Parties to the Fair Hearing include the LTC plan as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

When the State proposes to alter a recipient's Medicaid eligibility or entitlements, the recipient receives a notice detailing the planned changes, their right to a Fair Hearing and the Fair Hearing process including provision that services will continue unabated until a final adjudication is made. The case manager is required to notify enrollees of any adverse decisions and the Fair Hearing process which includes the continuation of services through the appeals process. Additionally, enrollee materials (for example the managed care plan's enrollment welcome package), will contain this information. The managed care plan is also required to notify enrollees of any adverse decisions by mail and provide Fair Hearing informational materials. Copies of these notices are kept in the enrollee's case file. All enrollee grievances shall be reported to the State on a monthly basis.

Fair Hearings may be requested verbally or in writing. No specific form is required. To request a Fair Hearing, individuals are directed to contact:

Office of Appeal Hearings, Department of Children and Families
(The telephone number for the local DCF office is included on the notice.)

Fair Hearings are conducted by the Office of Appeal Hearings, Department of Children and Families.

In addition, procedural steps for requesting a Fair Hearing must be clearly specified in the member handbook for enrollees and the provider manual for providers and must be shared with enrollees upon enrollment and providers upon entrance into a provider subcontract.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The State operates a Critical Event or Incident Reporting and Management Process *(complete Items b through e)*

No. This Appendix does not apply *(do not complete Items b through e)*
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Florida Department of Children and Families (DCF) receives reports of abuse, neglect, and exploitation of vulnerable adults through its management of the statewide abuse reporting hotline. DCF responds to critical events or incidents through referrals to the Adult Protective Services program or local law enforcement for investigation as required by Chapter 415, F.S. Plans are required to report critical incidents related to enrollees to AHCA. Managed care plan contracts and subcontracts specify incident reporting format, requirements, processes and timeframes for responding to critical events or incidents, including conducting investigations. Through the State's ongoing monitoring activities, plans' adherence to these requirements will be monitored and observed for any necessary remediation.

Provider(s) must report critical incidents to the long-term care plan within 24 hours of the incident.The long-term care plan shall report suspected abuse, neglect and exploitation of participants to the Agency immediately.The long-term care plan shall report to the Agency, any death and any adverse incident that could impact the health or safety of an enrollee (e.g., physical or sexual abuse) within 24 hours of detection or notification. A Critical Incident Report shall be reported in written form via email. A Critical Incident Report Summary shall be reported monthly and aggregated quarterly and annually in written form via email. Timeframes and reporting formats will be the same for each LTC managed care plan.

AHCA must submit a report annually to the Florida Legislature on ALF adverse incidents by category of types of incidents, the type of staff involved, types of liability claims filed, and disciplinary action taken against staff. Incidents that relate to persons licensed under Chapter 458, Chapter 459, Chapter 461, or Chapter 465 of the Florida Statutes are reviewed by AHCA to determine whether any of the incidents involved the conduct of a health professional who is subject to disciplinary action in accordance with 456.037, F.S. AHCA may investigate, as it deems appropriate, any such incident and prescribe measures that must be taken in response.

Critical incidents include:
oDeath by suicide, homicide, abuse/neglect or that is otherwise unexpected
oInjury or major illness
oSexual battery
oMedication errors
oSuicide attempts
oAltercations requiring medical intervention
oElopement

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Managed care plans are required to submit reports to AHCA regarding critical incidents affecting enrollees, including allegations of abuse, neglect, or exploitation. In addition, plans or their subcontractors must include educational information in enrollee materials on the various types of abuse and available reporting mechanisms. This may include the posting of information on how to report allegations of abuse, neglect, or exploitation to Florida's toll

-free abuse reporting hotline operated by the Department of Children and Families. (1-800-96-ABUSE). Plans or their subcontractors are also required to train direct care staff to report incidents of abuse, neglect or exploitation.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Florida Department of Children and Families receives reports of abuse, neglect, and exploitation of vulnerable adults through its management of the statewide abuse reporting hotline. DCF responds to critical events or incidents through referrals to the Adult Protective Services program or local law enforcement for investigation as required by Chapter 415, F.S.

Managed care plan providers are required to report critical incidents related to enrollees to AHCA. Plan contracts and subcontracts specify incident reporting formats and requirements, as well as processes and timeframes for responding to critical events or incidents, including conducting investigations. Through the State's ongoing monitoring activities, plans' adherence to these requirements will be monitored and observed for any necessary remediation.

Critical Incident reports are evaluated as follows:
•The managed care plan shall identify and track critical incidents and review and analyze critical incidents to identify and address/eliminate potential and actual quality of care and/or health and safety issues. If the managed care plan fails to comply with this requirement, the Agency will require corrective action within time frames that are based upon the severity of the deficiency. If the managed care plan fails to implement the corrective action timely, the plan is subject to sanctions ranging from enrollment suspension to larger on site case file reviews.

•Adverse incidents involving health and safety issues are reported to the Department of Children and Family's Adult Protective Services (APS) for investigation and resolution. The managed care plan must assist as necessary to address health and safety issues. If the managed care plan fails to comply, sanctions ranging from enrollment suspension to contract termination may be assessed.

•If APS reports are not investigated within 24 hours, DOEA contacts the APS office for an explanation for the delay. Unexplained delays are reported to APS management. If the APS delays are not timely corrected the Agency will report the unexplained delay to the Department of Children and Families management division responsible for the APS program.

AHCA must submit a report annually to the Florida Legislature on ALF adverse incidents by category of types of incidents, the type of staff involved, types of liability claims filed, and disciplinary action taken against staff. Incidents that relate to persons licensed under Chapter 458, Chapter 459, Chapter 461, or Chapter 465 of the Florida Statutes are reviewed by AHCA to determine whether any of the incidents involved the conduct of a health professional who is subject to disciplinary action in accordance with 456.037, F.S. AHCA may investigate, as it deems appropriate, any such incident and prescribe measures that must be taken in response.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

AHCA is responsible for overseeing the reporting of and response to critical incidents or events that affect enrollees. In addition, the Department of Children and Families and the Florida Department of Law Enforcement are responsible for overseeing the reporting of and response to critical incidents or events for all Floridians, including managed care plan enrollees.

The Agency will collaborate with the Department of Children and Families – Adult Protective Services and other State agencies. The Agency will foster increased oversight of the long-term care managed care plans and providers regarding critical incidents and other health, safety and welfare sub-assurances required for the successful operation of the long-term care waiver program. The State has developed performance measures for capturing and reporting critical incidents. These performance measures may be found in Appendix G (Quality Improvement) of the waiver application.

Furthermore, the State's long-term care managed care contract requires health, safety, and welfare issues, be

reported to the Agency by the plan within 24 hours. If the managed care plan fails to comply with this contract requirement, the State will require corrective action within time frames that are based upon the severity of the deficiency. If the managed care plan fails to implement the corrective action timely, the managed care plan is subject to sanctions ranging from enrollment suspension to increased on-site case file reviews. The managed care plan must ensure enrollees involved with the reported health, safety and welfare issues are contacted and necessary services are provided to address the problem. Adverse incidents involving health and safety issues are reported to Adult Protective Services (APS) for investigation and resolution. Managed care plans must assist as necessary with services to address the health, safety and welfare issues. If the managed care plan fails to comply with the reporting requirement and assistance with enrollee services, sanctions ranging from enrollment suspension to contract termination may be assessed.

If Adult Protective Service (APS) reports are not investigated within 24 hours, DOEA will contact the APS office for an explanation for the delay. Unexplained delays will be reported to APS management. Enrollees will be monitored for service provision and health and safety issues. The managed care plans must assist with services necessary to address health, safety and welfare needs as well as plan of care services. If the APS delays are not corrected timely, the Agency will report the unexplained delays to Department of Children and Families Division management responsible for the APS program. For APS reports that are not investigated, the Agency will request from the Department of Children and Families management an explanation of the decision to not investigate the report.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

◉ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

For enrollees living in their homes, case managers review care standards with enrollees and caregivers. Case managers must conduct face-to-face care plan reviews with enrollees and caregivers at least once every three months. Case managers are responsible for reporting the use of restraints or seclusion to the State's Adult Protective Services program, and the plan is responsible for submitting adverse incident reports on enrollees who are being physically restrained or secluded against their will. Upon receipt of the adverse incident report, AHCA verifies the Adult Protective Services reporting and work with this program to correct the enrollee's living situation.

AHCA's Health Quality Assurance Division, surveys licensed assisted living facilities at least biannually. As part of the licensing survey, facilities must indicate their policies on the use of physical restraints and seclusion. Facilities with survey violations involving the use of physical restraints or seclusion are subject to fines and loss of licensure.

○ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

- **The State does not permit or prohibits the use of restrictive interventions**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

  For enrollees living in their homes, case managers review care standards with enrollees and caregivers. Case managers must conduct face to face-care-plan reviews with enrollees and caregivers at least once every three months. Case managers are responsible for reporting the use of restrictive interventions to the State's Adult Protective Services program, and the plan is responsible for submitting adverse incident reports on enrollees who are being subjected to restrictive interventions against their will. Upon receipt of the adverse incident report, AHCA verifies the Adult Protective Services reporting and works with this program to correct the enrollee's living situation.

  AHCA's Health Quality Assurance Division, surveys licensed assisted living facilities at least biannually. As part of the licensing survey, facilities must indicate their policies on the use of restrictive interventions. Facilities with survey violations involving the use of restrictive interventions are subject to fines and loss of licensure.

- **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

  i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

  ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- **No. This Appendix is not applicable** *(do not complete the remaining items)*
- **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Medication administration, supervision and assistance may be provided to enrollees as long as qualified staff are available to render the service. Medication supervision and administration can only be provided by licensed nurses. Assistance with self-administered medications can be provided either by a licensed nurse or, with a documented request and informed consent, an unlicensed staff member. The unlicensed staff member must be trained to assist residents with self-administered medications, in accordance with Chapter 58A-5.0191(5), Florida Administrative Code, and must demonstrate the ability to accurately read and interpret a prescription label. Pursuant to Chapter 429.256 (3), Florida Statutes, assistance with self-administration of medications, whether in the home or a facility, includes taking the medication from where it is stored and delivering it to the recipient; removing a prescribed amount of medication from the container and placing it in the recipient's hand or another container; helping the recipient by lifting the container to their mouth; applying topical medications; and keeping a record of when a recipient receives assistance with self-administration of their medications. Plans are responsible for delivering all services contained in the enrollee's care plan. Accordingly, plans must ensure medication administration assistance is available to an enrollee as necessary.

The State monitors providers on an annual basis to assess whether managed care plans are in compliance with State and Federal medical management and administration regulations. This may include reviewing medication reports, recipient case files for prescriptions and the provider's critical incident reports as necessary. The State will cross reference its information with the LTC plan's monitoring findings to determine whether the plan is adequately monitoring providers.

On an on-going basis, the State monitors medication administration via critical incident reports. Medication errors are deemed a critical incident and so are required to be reported to the plans, who in turn report them to the State on an ad-hoc and quarterly basis. The State uses the information in these reports to determine trends in medication administration practices and to determine its provider education and training practices. It also uses this information to take punitive action against providers when necessary.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Waiver providers must document all medication errors. In addition, medication errors resulting in an adverse incident for an enrollee must be reported as required per the critical incident reporting requirements.

AHCA's Division of Health Quality Assurance surveys licensed assisted living facilities at least biennually. Medication administration practices are reviewed at this time.

In addition, AHCA is responsible for verifying provider qualifications for all waiver providers, including those involved in assisting enrollees with the self-administration of medications. The monitoring of all waiver services for enrollees living in a community home is completed annually as part of the overall LTC managed care program Quality Management Strategy or more frequently as needed.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. **Provider Administration of Medications.** *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.*(complete the remaining items)*

ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medication administration, supervision and assistance may be provided to enrollees as long as qualified staff is available to render the service component. Medication supervision and administration can only be provided by licensed nurses. Assistance with self-administered medications can be provided either by a licensed nurse or, with a documented request and informed consent, an unlicensed staff member. The unlicensed staff member must be trained to assist residents with self-administered medications, in accordance with Chapter 58A-5.0191(5), Florida Administrative Code, and must demonstrate the ability to accurately read and interpret a prescription label. Plans are required to provide the means for enrollees to receive medications or ensure they move to a more appropriate setting.

Pursuant to 429.256, Florida Statutes, assistance with self-administration of medications, whether in the home or a facility, includes taking the medication from where it is stored and delivering it to the recipient; removing a prescribed amount of medication from the container and placing it in the recipient's hand or another container; helping the recipient by lifting the container to their mouth; applying topical medications; and keeping a record of when a recipient receives assistance with self-administration of their medications.

iii. **Medication Error Reporting.***Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

All medication administration errors must be documented. For medication administration errors resulting in an adverse incident for an enrollee, the LTC plan must submit an adverse incident to AHCA within 48 hours of notification.

iv. **State Oversight Responsibility.**Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

For enrollees residing in assisted living facilities or adult family care homes, AHCA's Division of Health Quality Assurance is responsible for monitoring these facilities. These facilities are responsible for reporting adverse incidents including medication administration errors to their local licensure offices. Adult family care homes are surveyed annually, and assisted living facilities are surveyed at least biannually.

AHCA is responsible for monitoring LTC plans. LTC plans must send in their adverse incident reports quarterly and the annual on-site monitoring verifies the reports received against incident report records. Data concerning medication administration errors and medication management errors will be acquired from adverse incidents reports, and case note reviews. From these data the long-term care managed care program management will determine if any trends or patterns need to be addressed.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of enrollees with substantiated reports of abuse neglect, or exploitation that had appropriate follow-up by the MCP. N: Number of enrollees with substantiated reports of abuse, neglect or exploitation that had appropriate follow-up by the MCP. D: Total number of enrollees with substantiated reports of abuse, neglect or exploitation where follow-up was required.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of enrollees provided with handbooks containing directions on reporting abuse, neglect and exploitation. N: Number of enrollees who received handbooks containing directions on reporting abuse, neglect and exploitation. D: Total number of enrollee records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DOEA	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportional Random Sample Methodology
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☑ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DOEA	☐ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of enrollee case files that include evidence advance directives were discussed with the enrollee. N: Number of case enrollee files with advance directives discussion evidence in files. D: Number of of records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DOEA	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Proportional Random Sample Methodology
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DOEA	☐ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of health safety and welfare issues reported in adverse incident reports within 48 hours. N: Number of health safety and welfare issues reported in adverse incident reports within 48 hours. D: Number of records reviewed.

Data Source (Select one):
Other

If 'Other' is selected, specify:

LTC plans are required to report adverse incidents within 48 hours of notification

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of enrollees with reports of abuse, neglect or exploitation whose investigations were commenced within 24 hours of being reported to Adult Protective Services. N: Number of enrollees with reports of abuse, neglect or exploitation with investigations started within 24 hours of being reported. D: Number of enrollees with reports of abuse, neglect or exploitation.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of enrollees who received a telephone contact at least every thirty days to assess their health status, satisfaction with services and any additional needs. N: Number of enrollees who received a telephone contact at least every 30 days to assess their health status, satisfaction with services and any additional needs. D: Number of records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DOEA	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Random Sample Methodology.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DOEA	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify: the state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of enrollees with information on reporting grievance and complaint procedures as evidenced by a signed acknowledgement present in the case record. N: Percentage of enrollees with information on reporting grievance and complaint procedures as evidenced by a signed acknowledgement present in the case record. D: Number or records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DOEA	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify: Random Sample Methodology.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DOEA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify: the state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of enrollees' grievances that received recommended follow-up. N: Number of enrollees' grievances that received recommended follow-up. D: Number of records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DOEA	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify:

		Random Sample Methodology.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify: the state will report quarterly to CMS for the first two years of the approved waiver.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
By contract, MCPs must respond to Adult Protective Services request for assistance with beneficiaries involved in substantiated reports of abuse, neglect or exploitation with appropriate follow-up. During the annual contract compliance review, case files records are reviewed for compliance with Adult Protective Services' requests and MCP assistance. Plan members who are the subject of substantiated reports of abuse, neglect or exploitation should have appropriate follow-up from their MCP. MCPs must contact the plan member and address the care needs as soon as necessary can be authorized. Health and safety issues must be addressed immediately. MCPs failing to provide appropriate follow-up are subject to a corrective action and sanctions for failing to plan member's care needs. Failure to comply with these requests will not only result in a corrective action request but also consideration of an enrollment moratorium for non-compliance. DOEA will verify implementation of the corrective action. Failure to provide appropriate follow-up for substantiated Adult Protective Services requests is subject to sanctions.

By contract, enrollees must be provided with handbooks containing directions on reporting abuse, neglect and exploitation problems. If the annual contract review reveals a deficiency, the MCP must develop a corrective action within established time frames based upon the severity of the deficiency. If the corrective action is not implemented timely, the LTC plan is subject to sanctions ranging from enrollment suspension to more frequent on-site reviews of enrollee case files.

As part of the annual LTC contract monitoring, case files are reviewed to verify compliance with required elements. If sampled case file records do not include evidence that advance directives were discussed with the enrollee, the MCP will be required to submit a corrective action to address this deficiency within 20 days. DOEA will verify the implementation of the care plan. If the approved corrective action is not implemented as approved, the contractor is subject to sanctions ranging from more frequent on-site enrollee file reviews to enrollment suspension.

By contract, health safety and welfare issues must be reported in adverse incident reports by the LTC plan to AHCA within 48 hours. If the LTC plan fails to comply with this contract requirement, the State will request a corrective action be developed within time frames based upon the severity of the deficiency. If the LTC plan fails to implement the corrective action timely, the plan is subject to sanctions ranging from enrollment suspension to larger on site case file reviews. Plan members involved with the reported health, safety and welfare issues are contacted by the LTC plan and necessary services are provided to address the problem. Adverse incidents involving health and safety issues are reported to Adult Protective Services (APS) for investigation and resolution. LTC plans must assist as necessary with services to address the health, safety and welfare issues. If LTC plans fail to comply with the reporting requirement and assistance with enrollee services, sanctions ranging from enrollment suspension to program termination may be assessed.

If Adult Protective Service (APS) reports are not investigated within 24 hours, DOEA contacts the APS office for an explanation for the delay. Unexplained delays are reported to APS management. Enrollees are monitored for service provision and health and safety issues. LTC plans assist with services necessary to address health, safety and welfare needs as well as plan of care services. If the APS delays are not corrected timely, the Agency will report the unexplained delays to Department of Children and Family Division management responsible for the Adult Protective services program. For Adult Protective Service reports that are not investigated, the Agency will request from the Department of Children and Family management an explanation of the decision to not investigate the report.

By contract, plan members must be contacted by telephone at least every 30 days, and these contacts must be documented in the case record. If the case record review determines a deficiency with the monthly telephone contact requirement, the MCP must submit a corrective action to address this deficiency. If the MCP fails to implement the corrective action timely, the contractor is subject to sanctions.

By contract, LTC MCPs are required to provide information on reporting grievances and complaints to beneficiaries at least annually. LTC MCPs are required to provide copies of their enrollee handbooks that contain information on reporting grievance and complaints at least annually. During the annual desk review of MCP enrollee handbooks, the Agency will verify compliance with this requirement. Should the MCP fail to submit their enrollee handbook for review as required, sanctions up to an enrollment moratorium will be considered as well as monetary fines.

By contract, beneficiary grievances and complaints must be followed up. Evidence of the follow-up should appear in the beneficiary's case notes and the MCP grievance and complaint log. During the contract monitoring, MCP grievance and complaint logs will be examined and follow-up activities will be verified in the relevant case files. If a deficiency is found, the MCP will be required to submit a corrective action within 20 days for non- health and safety issues. Health and safety issues will required immediate follow-up and verification. DOEA will verify the implementation and verify the elimination of the grievance and complaint process defect.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;

- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

AHCA will establish a Quality Improvement Team for the Long-Term Care Managed Care Program that will include staff from AHCA and DOEA. The team will be responsible for reviewing all program reports related to quality improvement activities as well as trending, prioritizing and developing recommendations for implementation of system quality improvements. The team will meet monthly to review program data collection and performance measures that aggregate data on a monthly and quarterly basis.

For the performance measures with monthly or quarterly data collection, the Quality Improvement Team will begin their review and trending of the aggregated data after the first three months of program operations. If the completed aggregated data indicate performance rates are outside of the expected rates or other program data indicate the need for changes, the team will develop recommendations for addressing the performance rates for consideration by AHCA and DOEA management. If approved, the recommendations will be implemented based upon the prioritized program improvement schedule. Prioritization of the program improvement schedule will be guided by the following considerations: high risk (e.g., possibility of adverse incidents); high volume (e.g., affects a large number of beneficiaries); or high cost (e. g., financial reserve concerns).

With the large number of performance measures that issue annual performance measure reports, the team may meet more often than monthly to review the annual performance measures and develop the annual program report. Should the performance measure reports reveal performance levels below 100% of the expected performance rates, or other program data indicate the need for change, the team will develop recommendations to address the reasons for the poor performance. The recommendations will be considered by AHCA and DOEA management. If approved, the recommendations will be implemented based upon the program's prioritized improvement schedule. All team meetings will keep meeting minutes. The approved meeting minutes will be maintained by AHCA. The annual program report will include performance measure results for individual LTC plans as well the overall program performance on the measures detailed in Appendices A, B, C, D, G and I and high volume complaints, adverse incidents and other program data. All revisions, additions or deletions to performance measures listed in the application's appendices will be submitted for approval by CMS through the waiver amendment process.

The annual program report on Quality Improvements will list individual LTC plan performance rates as well as overall program performance on the program performance measures. The approved annual report will be available on the AHCA website.

The Medicaid agency, in consultation with the DOEA, will be responsible for implementing program changes and following up on program results.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☑ **Other** Specify: DOEA	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Quality Improvement Team will review performance measure results to determine if the policy change or other program adjustment resulted in improvement in the identified problem. If the revised policy change or other program adjustment (i. e., new forms, conducting necessary training or improving a program process)has not resulted in improving the problem within six months or one year, the Quality Improvement Team will develop recommendations to address performance in the problem area. The team will focus on the expected performance rate as contrasted with the actual LTC plan rate for performance measures.

Quality measures involving AHCA's and DOEA's performance on quality measures will be reviewed by the team and contrasted with the expected performance rates. Should the performance rates not equal the expected rate, the team will develop recommendations for consideration and approval by AHCA and DOEA program management. Program management will approve new program performance standards for agency quality measures. The Medicaid agency in consultation with DOEA will follow up on program results.

AHCA will announce performance measure changes and other program policy changes to enrolled LTC plans through their program memorandums and the contract amendment process. All revisions, additions or deletions of performance measures listed Appendices A, B, C, D, G, H and I will be submitted to CMS through the waiver amendment process. Changes to the Quality Improvement Strategy (QIS) will also be reported on the annual CMS 372 report.

The annual report will be available on the AHCA website.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Until outcome based performance measures are available for this program's targeted populations, the listed performance measures will be used to evaluate MCPs' performance in this program. The program's ITN states that participating MCPs must adopt additional performance measures upon 30 days notice. When the outcome based performance measures are approved, the State will amend this waiver to reflect the new measures.

Survey parameters will be set to achieve a 95% confidence level, a 5.0% margin of error and 50% response distribution, in order to draw a representative sample at the program level. When necessary, this random sample will then be apportioned across the Managed Care Plans (MCP), so that the percent of the sample

drawn randomly from each MCP matched the percent of the overall population served by that MCP. Proportionate random sampling ensures that all Managed Care Plans are represented in the sample, and helps to minimize bias.

For the first year, the Quality Improvement Strategy will be evaluated after the annual report is approved. Since the majority of the performance measures will have annual data aggregation, considering program wide adjustments to the Quality Improvement Strategy will be premature. The team, AHCA and DOEA program staff will meet to evaluate the strategy and make any adjustments.

For the later years in the waiver period, the Quality Improvement Strategy, will be reviewed at least yearly or more often as issues arise that require re-evaluation of the strategy.

Quality Improvement Strategy re-evaluation meetings will be held as necessary to consider revisions to the strategy. The team, AHCA and DOEA program staff will attend these meetings. All evaluation meetings will keep meeting minutes. Approved meeting minutes will be maintained by AHCA.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Financial accountability is assured through the State's Automated Management Accounting System and the Accounting Procedures manuals which include federal reporting requirements. Capitated LTC plans are paid a monthly capitation rate, which is paid prospectively on or around the first of the month. Non-capitated LTC plans are paid a monthly administrative allocation that is a percentage of what the plans would have been paid if they were capitated. Non-capitated LTC plans review provider claims and forward authorized claims to the Medicaid fiscal agent. The fiscal agent makes payments directly to the providers for authorized claims.

Payments for those individuals whose eligibility is canceled will be recovered. All enrollee, provider, and service utilization/payment data will be available through FMMIS, a federally certified Medicaid Management Information System that is designed and operated by a contracted entity (the State's fiscal agent) and managed by AHCA.

In addition, the Department of Financial Services, Office of Insurance Regulation determines whether LTC plans seeking to be licensed health maintenance organizations meet financial solvency standards and review quarterly financial reports from the HMOs to ensure that solvency standards are maintained. The Department of Financial Services is also responsible for the State financial audit program. For other LTC plans (non-HMOs), AHCA reviews their annual financial statements and also verifies compliance with LTC plans' required insolvency protection and surplus accounts.

Provider Service Networks (PSN's) are unique to Florida and may bill on a fee-for-service basis for the first two years of their operation. With the exception of billing, PSN's operate in the same way as capitated managed care organizations with an emphasis on efficient care delivery. Since all fee for service billing must come from the PSN, rather than directly from the service provider, the State has determined that specific non-duplication edits could inappropriately restrict the PSN's flexibility to provide the most appropriate services to prevent institutionalization. However, the State will perform post payment audits to review utilization and cost-effectiveness using claims data collected from its MMIS and by comparing PSN spending and performance to capitated managed LTC plans.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of monthly capitation payments made to capitated MCPs for qualified enrollees. N: Number of monthly capitation payments made to capitated MCPs for qualified enrollees. D: Number of monthly capitation payments.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☑ Annually
	☑ Continuously and Ongoing
	☑ Other Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

Performance Measure:
Percentage of capitation payments issued to MCPs using appropriate rate. N: Number of capitation payments issued using appropriate rate. D: Number of capitation payments made.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☐ Other Specify:	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify: The state will report quarterly to CMS for the first two years of the approved waiver.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Florida's certified Medicaid Management Information System is programmed to verify all LTC plan and recipient enrollment eligiblity criteria before approving a recipient's enrollment and generating a capitation payment. The Medicaid program has established edits to check LTC plan and recipient eligiblity criteria before each payment is made. No capitation payments are made to ineligible LTC plans for ineligible enrollees.

Each managed care plan is required to submit a complete copy of its independently audited financial Statements and the auditor's report (pertaining to its pertinent lines of business, not umbrella or parent company business) to the Agency on an annual basis. Managed care plans must also submit financial reports to the Agency on a quarterly basis. These are reviewed by the Agency's Bureau of Managed Health Care to ensure continued provider solvency, and congruence with payment information contained in the State provider payment system.

The Agency's Medicaid Program Integrity (MPI) analyzes billing data on a weekly basis and conducts provider audits if it detects errant billing practices and, per Florida Statute, randomly audits 5% of Medicaid providers on an annual basis. MPI, along with the Agency's Inspector General investigate financial complaints made against providers by various parties. Investigations may result in a claims and payment audit.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
AHCA operates the State's Medicaid Management Information System. This system contains the system programming for all LTC plan and recipient eligibility as well as payment rates. If monthly payments are made to a LTC plan for non-qualified enrollees, the system error is researched and necessary programming changes are implemented. LTC plans receiving the improper payments are notified that the payment will be

recouped.

If incorrect payments are made to LTC plans, the payment will be researched. Based upon the research findings related to the payment error, the LTC plan will be notified and the incorrect payment would be voided and the correct payment paid. In addition, necessary programming revisions would be made to prevent future payment errors.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify: the state will report quarterly to CMS for the first two years of the waiver.

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

AHCA and DOEA are currently working with an actuarial firm to develop an appropriate capitation rate methodology for capitated LTC plans. The following is a brief description of the proposed methodology for developing the capitation payments. Medicaid claims and encounter data for recipients eligible for the Florida Long-Term Care Managed Care Program will be compiled. Claims/encounters for each covered service type, e.g., nursing facility and HCB waiver services, will be examined. The claims may be further segmented by eligibility categories, level of care, age, gender, diagnosis, or other factors that demonstrate predictability. It is anticipated that there will be two major rate cell categories for enrollees receiving HCB services: (1) HCBS Enrollees 65+ enrolled in Medicare; and (2) All other HCBS Enrollees.

Base year gross payment rates will be adjusted and trended forward to derive the capitation rates for waiver. These factors will include adjustments for claims submission lag, annual inflation factors, and adjustments for incurred but not reported (IBNR) and third party collections. Adjustments will be made for major policy and program changes.

The methodology and resulting reimbursement rates will be certified actuarially sound each year and approved by CMS.

Payments for providers in non-capitated LTC plans are claims-based. These rates were developed by comparing the same service rates in other approved waivers serving the elderly and adults with disabilities and researching Medicaid State plan services costs for the same services.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The Florida Medicaid Management Information System (FMMIS) has recipient eligibility and provider inforamtion. The recipient information is updated as part of the eligibility redetermination process. When a recipient is enrolled in the Long-Term Care Managed Care Program/a LTC plan, this will be reflected on his/her eligibility file. Provider information is established upon enrollment of each LTC plan. Capitated payments to capitated LTC plans and administrative payments to non-capitated LTC plans flow directly from FMMIS to the LTC plan. For each recipient enrolled with a LTC plan, a monthly payment is generated. Capitated LTC plans are responsible for paying provider claims and submitting encounters to the State. Edits in FMMIS are designed to ensure that claims for enrollees for services covered by a capitated LTC plan will be denied.

Non-capitated LTC plans review provider claims and forward authorized claims to the Medicaid fiscal agent. The fiscal agent makes payments directly to the providers for authorized claims. The claims are processed through the system edits established for the Long-Term Care Managed Care Program. Providers receive remittance advices detailing the claims paid, denied or suspended.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- ○ **No. State or local government agencies do not certify expenditures for waiver services.**
- ● **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

☑ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

The Department of Elder Affairs submits documentation supporting work completed by their staff and by the Aging and Disability Resource Centers. The CPE cost details are part of the Cooperative Agreement between the Agency and the Department of Elder Affairs governing program operations. The Agency for Health Care Administration, Florida's Medicaid agency, verifies that the certified public expenditures are eligible for Federal financial participation.

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State

verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Florida's Medicaid Managment Information System (FMMIS) has edits to ensure that, prior to generating a payment to a LTC plan, the enrollee is eligible for the Long-Term Care Managed Care Program and is enrolled with the LTC plan. For non-capitated LTC plans, program edits specific to the Long-Term Care Managed Care Program in the FMMIS verify billing elements and pay the appropriate claims. In addition, monitoring conducted by the State includes a review of sampled payments to ensure that services were provided and were included in the enrollee's approved plan of care.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments – MMIS** (*select one*):

- **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Payments to LTC plans are made by the Florida Medicaid Management Information System (FMMIS). The FMMIS has recipient eligibility and provider information. The recipient information is updated as part of the eligibility redetermination process. When a recipient is enrolled in the Long-Term Care Managed Care Program/a LTC plan, this will be reflected on his/her eligibility file. Provider information is established upon enrollment of each LTC plan. Payments flow directly from FMMIS to the LTC plan. For each recipient enrolled with a LTC plan, a monthly payment is generated.

Non-capitated LTC plans review provider claims and forward authorized claims to the Medicaid fiscal agent. The fiscal agent makes payments directly to the providers for authorized claims.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☑ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

N/A

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- ◉ **No. The State does not make supplemental or enhanced payments for waiver services.**
- ○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- (●) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ( ) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

The payment to capitated LTC plans is not reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

◉ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I -2-c:

(a) DOEA receives the general revenue match for the Long-Term Care Managed Care Program.
(b) Monthly, AHCA bills DOEA for the value of general revenue match for the Long-Term Care Managed Care Program payments made during the previous month. Upon receipt, DOEA reviews the bill and approves the journal transfer to AHCA through the state automated accounting system.

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- ◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ○ **The following source(s) are used**

  Check each that applies:

  ☐ **Health care-related taxes or fees**

  ☐ **Provider-related donations**

  ☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Assisted living services are furnished in residential settings other than the personal residence of the enrollee, and the following methods exclude Medicaid payment for room and board. Edits are in place in the Florida Medicaid Management Information System (FMMIS) to ensure that all enrollees are blocked out of the fee-for-service payment system for services covered by capitated LTC plans, and the LTC plans only receive the monthly capitation payments. Any payment from a capitated LTC plan to assisted living facilities is made explicitly for the provision of assisted living services as defined by this waiver. Payments for assisted living services to enrollees in non-capitated plans are made directly by FMMIS using the established payment rates, and payment rates do not include room and board. As part of the on-going monitoring process of all LTC plans, the State will ensure that payments to assisted living facilities are based solely on service costs.

Other services (e.g., respite services) can be furnished in residential settings other than the enrollee's personal home, but the payment is explicitly for the purpose of the specified service as defined by this waiver and does not include room or board.

NOTE: Adult Day Health Care providers receive payment for services that include board as allowed in 42 CFR §441.310 (a)(2). The Adult Day Health Care service definition includes nutritional meals as a part of this service only when the enrollee is at the center during meal times, which does not constitute the full nutritional regime for enrollees.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- **Nominal deductible**
- **Coinsurance**
- **Co-Payment**
- **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	11345.82	3019.00	14364.82	42887.00	7879.00	50766.00	36401.18
2	11680.96	3107.00	14787.96	44131.00	8107.00	52238.00	37450.04
3	12014.83	3197.00	15211.83	45411.00	8342.00	53753.00	38541.17

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 7)

a. **Number Of Unduplicated Participants Served.**Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	36795	36795
Year 2	36795	36795
Year 3	36795	36795

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 7)

b. **Average Length of Stay.**Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average stay for this waiver is derived from the 2008-2009 (year basis varies between the five waivers being combined into this waiver) CMS 372 Lag reports' average length of stay for the five waivers. The average length of stay of 264.9 days for this waiver is derived by summing Days of Waiver Enrollment on each waiver's CMS 372 Lag report and dividing by the sum of unduplicated Participants on each waiver's CMS 372 Lag report.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 7)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D was derived from actual Medicaid HCBS service costs for FY 2009-2010 for the five waivers. FY 2009-2010 was the latest year that complete cost and utilization data was available for the Assisted Living, Adult Day Health Care, Aged and Disabled Adult waivers (three of the five existing waivers that are being combined into this waiver) [Note: The Adult Day Health Care waiver ceased operations on March 31, 2012. All waiver enrollees chose and were enrolled in other existing waivers.] For the Nursing Home

Diversion and Channeling waivers (the other two former waivers), information was derived from encounter data and service utilization data, as well as the CMS-372 Report on Home and Community-Based Services Waivers for State Fiscal Year 2008-2009 (July 1, 2008 through June 30, 2009). The data thus reflects costs from all five waivers. The projected annual units per user and average unit costs have been calculated to reflect a single unit definition across the five waivers. The costs and utilization of new services are based on similar services in other states. It was assumed that the availability of new services will not drive the average plan of care cost up because current plans of care are based upon enrollee's assessed needs and services necessary to maintain enrollees in their homes safely. Average unit costs were trended forward using a 2.9% annual inflation factor, reflecting the latest Consumer Price Index (CPI) inflation factor for medical services. For waiver renewal years 2 through 3 the same inflation factor was used.

After the adjustments were made and service costs determined for each renewal period, the projected Factor D was derived by dividing total service costs each year by 36,795(the total estimated unduplicated count of waiver participants).

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was derived from actual Medicaid service costs for recipients in the five existing waivers during FY 2009-2010. Medicare recipients receive prescription drug coverage through Medicare Part D. Therefore, Factor D' does not include these already excluded Part D costs. Factor D' was calculated by dividing the actual costs by the number of recipients during FY 2009-2010. Per capita costs were trended forward for the first year using a 2.9% annual inflation factor. For waiver renewal years 2 through 3 the same inflation factor was used. Factor D' values were rounded to the nearest integer. The Factor D' calculated was compared to a weighted average of the Factor D' for all five of the existing waivers and found to be comparable.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was derived from actual nursing facility costs of residents who were either 65 years of age or older or between the ages of 18 and 64 and eligible for Medicaid by reason of a disability during FY 2009-2010. These costs were trended forward using a 2.9% inflation rate for the first year of the waiver renewal period. For waiver renewal years 2 through 3 the same inflation factor was used. Factor G values were rounded to the nearest integer. The Factor G calculated was compared to a weighted average of the Factor G in all of the former waivers and found to be comparable.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was derived from the actual State Plan service costs for nursing facility services for residents who were either 65 years of age or older or between the ages of 18 and 64 and eligible for Medicaid by reason of a disability during FY 2009-2010. These costs were trended forward using a 2.9% inflation rate for the first year of the waiver renewal period. For waiver renewal years 2 through 3 the same inflation factor was used. Factor G' values were rounded to the nearest integer. The Factor G' calculated was compared to a weighted average of the Factor G' in all of the former waivers and found to be comparable.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 7)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Adult Day Health Care	
Case Management	
Homemaker	
Respite	
Attendant Care	
Intermittent and Skilled Nursing	

Waiver Services	
Medical Equipment and Supplies	
Occupational Therapy	
Personal Care	
Physical Therapy	
Respiratory Therapy	
Speech Therapy	
Transportation	
Adult Companion	
Assisted Living	
Behavior Management	
Caregiver Training	
Home Accessibility Adaptations	
Home Delivered Meals	
Medication Administration	
Medication Management	
Nutritional Assessment and Risk Reduction	
Personal Emergency Response System (PERS)	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 7)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J -1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**19485663.07**
Adult Day Health Care	☑	15 minute	2716	2499.79	2.87	**19485663.07**	
Case Management Total:							**67196029.82**
Case Management	☐	15 minute	36795	101.91	17.92	**67196029.82**	

GRAND TOTAL:	**417469400.33**
Total: Services included in capitation:	417469400.33
Total: Services not included in capitation:	-
Total Estimated Unduplicated Participants:	**36795**
Factor D (Divide total by number of participants):	**11345.82**
Services included in capitation:	11345.82
Services not included in capitation:	
Average Length of Stay on the Waiver:	265

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker Total:							**32635811.88**
Homemaker	☑	15 minute	13529	529.01	4.56	**32635811.88**	
Respite Total:							**20168192.81**
Respite Facility Based	☐	15 minute	29	1775.24	2.49	**128190.08**	
Respite In Home	☑	15 minute	5019	856.83	4.66	**20040002.73**	
Attendant Care Total:							**9952892.39**
Attendant Care	☑	15 minute	106	9333.52	10.06	**9952892.39**	
Intermittent and Skilled Nursing Total:							**24172.02**
Intermittent and Skilled Nursing	☐	Visit	28	27.83	31.02	**24172.02**	
Medical Equipment and Supplies Total:							**14656029.70**
Medical Equipment and Supplies	☑	Month	20160	33.44	21.74	**14656029.70**	
Occupational Therapy Total:							**18018.35**
Occupational Therapy	☐	15 minute	18	90.59	11.05	**18018.35**	
Personal Care Total:							**63727243.71**
Personal Care	☐	15 minute	17192	888.92	4.17	**63727243.71**	
Physical Therapy Total:							**525291.91**
Physical Therapy	☑	15 minute	2019	22.03	11.81	**525291.91**	
Respiratory Therapy Total:							**23123.98**
Respiratory Therapy	☐	15 minute	89	22.00	11.81	**23123.98**	
Speech Therapy Total:							**94.48**
Speech Therapy	☑	15 minute	2	4.00	11.81	**94.48**	
Transportation Total:							**608850.00**
Transportation	☑					**608850.00**	

GRAND TOTAL:	**417469400.33**
Total: Services included in capitation:	417469400.33
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**36795**
Factor D (Divide total by number of participants):	**11345.82**
Services included in capitation:	11345.82
Services not included in capitation:	
Average Length of Stay on the Waiver:	265

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Mile	2214	500.00	0.55		
Adult Companion Total:							9467837.69
Adult Companion	☑	15 minute	3330	672.15	4.23	9467837.68	
Assisted Living Total:							153022536.66
Assisted Living	☑	Day	22127	242.91	28.47	153022536.66	
Behavior Management Total:							191793.18
Behavior Management	☐	15 minute	235	46.69	17.48	191793.18	
Caregiver Training Total:							67653.81
Caregiver Training	☐	15 minute	1218	5.29	10.50	67653.81	
Home Accessibility Adaptations Total:							1684275.66
Home Accessibility Adaptations	☑	Job	859	2.16	907.75	1684275.66	
Home Delivered Meals Total:							18398341.03
Home Delivered Meals	☑	Meal	14083	223.32	5.85	18398341.03	
Medication Administration Total:							1434834.00
Medication Administration	☑	Administration	8857	50.00	3.24	1434834.00	
Medication Management Total:							987909.78
Medication Management	☑	Evaluation	8857	3.00	37.18	987909.78	
Nutritional Assessment and Risk Reduction Total:							152461.52
Special Drug and Nutritional Assessment Services	☑	15 minute	349	32.97	13.25	152461.52	
Personal Emergency							3040342.88

GRAND TOTAL:	417469400.33
Total: Services included in capitation:	417469400.33
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	36795
Factor D (Divide total by number of participants):	11345.82
Services included in capitation:	11345.82
Services not included in capitation:	
Average Length of Stay on the Waiver:	265

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response System (PERS) Total:							
Personal Emergency Response System Maintenance	☐	Day	9318	216.42	1.50	**3024902.34**	
Personal Emergency Response System Installation	☑	Purchase	288	1.05	51.06	**15440.54**	

GRAND TOTAL:	**417469400.33**
Total: Services included in capitation:	417469400.33
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**36795**
Factor D (Divide total by number of participants):	**11345.82**
Services included in capitation:	11345.82
Services not included in capitation:	
Average Length of Stay on the Waiver:	265

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 7)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J -1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**20096711.73**
Adult Day Health Care	☐	15 minute	2716	2499.79	2.96	**20096711.73**	
Case Management Total:							**69145914.62**
Case Management	☑	15 minute	36795	101.91	18.44	**69145914.62**	
Homemaker Total:							**33637788.56**
Homemaker	☑	15 minute	13529	529.01	4.70	**33637788.56**	
Respite Total:							**20773856.71**

GRAND TOTAL:	**429801046.23**
Total: Services included in capitation:	429801046.23
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**36795**
Factor D (Divide total by number of participants):	**11680.96**
Services included in capitation:	11680.96
Services not included in capitation:	
Average Length of Stay on the Waiver:	265

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Facility Based	☐	15 minute	29	1775.24	2.56	131793.82	
Respite In Home	☑	15 minute	5019	856.83	4.80	20642062.90	
Attendant Care Total:							10239804.79
Attendant Care	☑	Hour	106	9333.52	10.35	10239804.79	
Intermittent and Skilled Nursing Total:							24873.34
Intermittent and Skilled Nursing	☐	Visit	28	27.83	31.92	24873.34	
Medical Equipment and Supplies Total:							15080744.45
Medical Equipment and Supplies	☑	Month	20160	33.44	22.37	15080744.45	
Occupational Therapy Total:							18540.15
Occupational Therapy	☑	15 minute	18	90.59	11.37	18540.15	
Personal Care Total:							65561121.23
Personal Care	☐	15 minute	17192	888.92	4.29	65561121.23	
Physical Therapy Total:							540859.41
Physical Therapy	☐	15 minute	2019	22.03	12.16	540859.41	
Respiratory Therapy Total:							23809.28
Respiratory Therapy	☑	15 minute	89	22.00	12.16	23809.28	
Speech Therapy Total:							97.28
Speech Therapy	☐	15 minute	2	4.00	12.16	97.28	
Transportation Total:							630990.00
Transportation	☑	Mile	2214	500.00	0.57	630990.00	
Adult Companion Total:							9758811.42
Adult Companion	☑	15 minute	3330	672.15	4.36	9758811.42	

GRAND TOTAL:	**429801046.23**
Total: Services included in capitation:	429801046.23
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**36795**
Factor D (Divide total by number of participants):	**11680.96**
Services included in capitation:	11680.96
Services not included in capitation:	
Average Length of Stay on the Waiver:	265

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							**157483678.40**
Assisted Living	☑	Day	22127	242.91	29.30	**157483678.40**	
Behavior Management Total:							**197388.98**
Behavior Management	☑	15 minute	235	46.69	17.99	**197388.98**	
Caregiver Training Total:							**69586.78**
Caregiver Training	☑	15 minute	1218	5.29	10.80	**69586.78**	
Home Accessibility Adaptations Total:							**1733110.84**
Home Accessibility Adaptations	☑	Job	859	2.16	934.07	**1733110.84**	
Home Delivered Meals Total:							**18932993.67**
Home Delivered Meals	☑	Meal	14083	223.32	6.02	**18932993.67**	
Medication Administration Total:							**1474690.50**
Medication Administration	☑	Administration	8857	50.00	3.33	**1474690.50**	
Medication Management Total:							**1016606.46**
Medication Management	☑	Evaluation	8857	3.00	38.26	**1016606.46**	
Nutritional Assessment and Risk Reduction Total:							**156949.07**
Special Drug and Nutritional Assessment Services	☑	15 minute	349	32.97	13.64	**156949.07**	
Personal Emergency Response System (PERS) Total:							**3202118.56**
Personal Emergency Response System Maintenance	☐	Day	9318	216.42	1.58	**3186230.46**	
Personal Emergency	☑	Purchase	288	1.05	52.54	**15888.10**	

GRAND TOTAL:	**429801046.23**
Total: Services included in capitation:	429801046.23
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**36795**
Factor D (Divide total by number of participants):	**11680.96**
Services included in capitation:	11680.96
Services not included in capitation:	
Average Length of Stay on the Waiver:	265

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response System Installation							

GRAND TOTAL:	**429801046.23**
Total: Services included in capitation:	429801046.23
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**36795**
Factor D (Divide total by number of participants):	**11680.96**
Services included in capitation:	11680.96
Services not included in capitation:	
Average Length of Stay on the Waiver:	265

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 7)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J -1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**20639866.11**
Adult Day Health Care	☐	15 minute	2716	2499.79	3.04	**20639866.11**	
Case Management Total:							**71133297.20**
Case Management	☐	15 minute	36795	101.91	18.97	**71133297.20**	
Homemaker Total:							**34568195.48**
Homemaker	☑	15 minute	13529	529.01	4.83	**34568195.48**	
Respite Total:							**21379520.62**
Respite Facility Based	☐	15 minute	29	1775.24	2.63	**135397.55**	
Respite In Home	☐	15 minute	5019	856.83	4.94	**21244123.06**	
Attendant Care Total:							**10536610.73**

GRAND TOTAL:	**442085666.86**
Total: Services included in capitation:	442085666.86
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**36795**
Factor D (Divide total by number of participants):	**12014.83**
Services included in capitation:	12014.83
Services not included in capitation:	
Average Length of Stay on the Waiver:	265

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care	☐	Hour	106	9333.52	10.65	10536610.73	
Intermittent and Skilled Nursing Total:							25598.03
Intermittent and Skilled Nursing	☑	Visit	28	27.83	32.85	25598.03	
Medical Equipment and Supplies Total:							15518942.21
Medical Equipment and Supplies	☑	Month	20160	33.44	23.02	15518942.21	
Occupational Therapy Total:							19078.25
Occupational Therapy	☑	15 minute	18	90.59	11.70	19078.25	
Personal Care Total:							67394998.74
Personal Care	☑	15 minute	17192	888.92	4.41	67394998.74	
Physical Therapy Total:							556426.91
Physical Therapy	☑	15 minute	2019	22.03	12.51	556426.91	
Respiratory Therapy Total:							24494.58
Respiratory Therapy	☑	15 minute	89	22.00	12.51	24494.58	
Speech Therapy Total:							100.08
Speech Therapy	☑	15 minute	2	4.00	12.51	100.08	
Transportation Total:							653130.00
Transportation	☑	Mile	2214	500.00	0.59	653130.00	
Adult Companion Total:							10027402.56
Adult Companion	☑	15 minute	3330	672.15	4.48	10027402.56	
Assisted Living Total:							162052317.54
Assisted Living	☑	Day	22127	242.91	30.15	162052317.54	
Behavior Management Total:							203094.50

GRAND TOTAL:	442085666.86
Total: Services included in capitation:	442085666.86
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	36795
Factor D (Divide total by number of participants):	12014.83
Services included in capitation:	12014.83
Services not included in capitation:	
Average Length of Stay on the Waiver:	265

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavior Management	☐	15 minute	235	46.69	18.51	203094.50	
Caregiver Training Total:							71648.61
Caregiver Training	☑	15 minute	1218	5.29	11.12	71648.61	
Home Accessibility Adaptations Total:							1783374.71
Home Accessibility Adaptations	☑	Job	859	2.16	961.16	1783374.71	
Home Delivered Meals Total:							19467646.32
Home Delivered Meals	☑	Meal	14083	223.32	6.19	19467646.32	
Medication Administration Total:							1518975.50
Medication Administration	☑	Administration	8857	50.00	3.43	1518975.50	
Medication Management Total:							1046100.27
Medication Management	☐	Evaluation	8857	3.00	39.37	1046100.27	
Nutritional Assessment and Risk Reduction Total:							161436.62
Special Drug and Nutritional Assessment Services	☑	15 minute	349	32.97	14.03	161436.62	
Personal Emergency Response System (PERS) Total:							3303411.31
Personal Emergency Response System Maintenance	☐	Day	9318	216.42	1.63	3287060.54	
Personal Emergency Response System Installation	☑	Purchase	288	1.05	54.07	16350.77	

GRAND TOTAL:	**442085666.86**
Total: Services included in capitation:	442085666.86
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**36795**
Factor D (Divide total by number of participants):	**12014.83**
Services included in capitation:	12014.83
Services not included in capitation:	
Average Length of Stay on the Waiver:	265