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 waivers 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.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Definition of Intellectual Disability revised from IQ 60-69 inclusive to IQ 60-70 inclusive, for those with a secondary impairment/limitation [Appendix B]

Participants served/unduplicated number of participants expanded [Appendix B-3a]

Electronic signatures authorized for Level of Care evaluation documents [Appendix B-6f]

Support Coordination service definition updated to change "Transitional Support Coordination" to "Enhanced Support Coordination" [Appendix C and throughout]

"Waitlist" changed to "pre-enrollment" (categories/status) [Throughout]

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*):

Developmental Disabilities Individual Budgeting Waiver

C. Type of Request: renewal

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**

Waiver Number:FL.0867.R03.00
Draft ID: FL.027.03.00

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

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

04/01/24

Approved Effective Date: 04/01/24

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID 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:

  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 Developmental Disabilitiess Individual Budgeting Waiver is a Medicaid home and community-based services waiver for persons with intellectual and developmental disabilities living in their own home, family home, licensed home, or other home-like setting in the community. The waiver is operated by the Florida Agency for Persons with Disabilities (APD) in partnership with the Agency for Health Care Administration (AHCA) as the single state Medicaid Agency. This waiver reflects the use of an individual budgeting model. The flexibility of the model allows recipients more opportunities to participate in determining service choices. Each recipient and their parent or guardian will be involved in the budget process to the extent of choosing their array of services, choosing their providers, and having the flexibility to make changes as their needs change, without additional authorization from the operating agency or from the contracted prior authorization vendor.

The purpose of the waiver is to promote and maintain the health of eligible recipients with developmental disabilities; to minimize the effects of illness and disabilities through the provision of needed supports and services in order to delay or prevent institutionalization; and to foster the principles of self-determination as a foundation for supports and services. The intent of the waiver is to provide an array of services from which eligible recipients may choose, which allow them to live as independently as possible in their own home or in the community and to achieve productive lives as close to normal as possible as opposed to residing in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) or other institutional setting.

The waiver embraces the principles of self-determination, which include for the recipient the freedom to exercise the same rights as all citizens; authority to exercise control over authorized funds allocated for one's own support, including the re-prioritization of these funds when necessary; responsibility for the wise use of public funds; self-advocacy to speak and advocate for oneself and others who cannot do so in order to gain independence; and ensure that all recipients with a developmental disability are treated equally.

Recipients enrolled in the waiver may choose to receive services that assist them to:

• have a safe place to live,
• have a meaningful day activity,
• receive medical and dental services,
• receive supplies and equipment, and
• receive transportation required to access necessary services.

This waiver provides recipients the opportunity for greater choice among services within the limits of an individual budget. To facilitate this, similar services will be grouped in service families. Recipients will have authority to shift funds between services within a service family and certain services between service families, enabling them to respond to their changing needs. Prior service review processes will be tailored to maximize recipient flexibility while assuring health and safety. Recipients and their families will be supported by receiving training about managing their individual budgets and making good choices. This training will be provided by waiver support coordinators, through paid waiver services, and through other means. Recipients and families will also be provided relevant information, such as the variety of waiver and community supports available. An on-line budget tool was developed to help recipients to select waiver services and track waiver service use. This tool will maximize their authority and flexibility while supporting them in responsibly managing their individual budgets.

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/IID.

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:

The State Medicaid Agency provided public notice as specified in 42 CFR 441.304(f) to solicit meaningful input from recipients, providers, tribal organizations, and all stakeholders on waiver amendments or renewals. On December 20, 2023, the State published the 30-day public notice and comment period in the Florida Administrative Register (FAR) for the 1915 (c) Developmental Disabilities Individual Budgeting (iBudget) Waiver renewal. The State emailed the tribal representatives about the 30-day public notice and comment period for the 1915 (c) Developmental Disabilities Individual Budgeting (iBudget) Waiver renewal. The State published a provider alert about the 30-day public notice and comment period for the 1915 (c) Developmental Disabilities Individual Budgeting (iBudget) Waiver renewal by email and on the AHCA website. The 30-day comment period was from December 20, 2023, to January 19, 2024.

The FAR notice gives AHCA staff phone and mail contact information to request more information about the waiver. Included in the public notice is an AHCA staff member's direct phone number and AHCA's Florida Relay Service TDD and voice numbers. If any interested party requests a printed copy of the waiver materials, AHCA will provide them in the manner requested (printed copy sent by US mail or made available for pickup at an AHCA office). The AHCA website was updated with a dedicated waiver page, which included a complete copy of the waiver in PDF form for the entire 30-day public notice and comment period.

The State Medicaid Agency received public comments on a variety of topics including the phrases "Unique Abilities" and "pre-enrollment." No comments were received related to service provision, eligibility, providers, or operational issues.

All comments were thoroughly considered. One update was made to the waiver application as publicly noticed based on comments regarding the phrase "Unique Abilities". The phrase "Unique Abilities" was removed from the Program Title section of the waiver. The State proposes to keep the current Program Title of "Developmental Disabilities Individual Budgeting (iBudget) Waiver".

The State of Florida has one of the most robust government transparency laws in the country, known as Florida's Government in the Sunshine Law, as outlined in Chapter 286 Florida Statutes (F.S.). The Agency utilizes the Florida Administrative Register to notify stakeholders of Medicaid policy actions the Agency takes, including information or actions regarding Medicaid Waiver programs administered by the Agency. This is the established method by which state administrative actions must be noticed to the public in accordance with Chapter 120 F.S. and in alignment with the Sunshine Law. As such, the Agency noticed the intent to submit the iBudget waiver renewal to the public in the Florida Administrative Register. The Agency works closely with its state partner, the Agency for Persons with Disabilities (APD), on the administration of this program, as APD is statutorily named as the primary Agency for services provided to the developmentally disabled population in the State of Florida. Both the Agency and APD attend and participate in stakeholder meetings, including Developmental Disability (DD) Council meetings. Additionally, AHCA and APD participate with Qlarant, the state's quality improvement vendor for the iBudget Waiver, in a Quality Council. DD Council and Quality Council meetings include providers, self-advocates, family members, and staff from other partner agencies; the waiver renewal was discussed at both DD Council (September 21-22, 2023) and Quality Council (October 19, 2023) meetings. They are also open to the public and the public can make comment during these meetings if they wish to. Additionally, there are regular calls between APD, stakeholder groups, and providers. Any individual that requests a non-electronic waiver application at any time will be accommodated.

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: Dalton

First Name: Ann

Title: Bureau Chief

Agency: Agency for Health Care Administration

Address: 2727 Mahan Drive

Address 2: Mail Stop #20

City: Tallahassee

State: **Florida**

Zip: 32308

Phone: (850) 412-4257 **Ext:** ☐ **TTY**

Fax: (850) 414-1721

E-mail: Ann.Dalton@ahca.myflorida.com

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

Last Name: Hinrichs

First Name: Katie

Title: Operations Program Coordinator

Agency: Agency for Persons with Disabilities

Address: 4030 Esplanade Way

Address 2:

City: Tallahassee

State: **Florida**

Zip:

32399

Phone:

(850) 300-6816 **Ext:** ☐ **TTY**

Fax:

(850) 410-0665

E-mail:

katie.hinrichs@apdcares.org

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: Jason Weida

State Medicaid Director or Designee

Submission Date: Jun 14, 2024

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

Last Name:

Weida

First Name:

Jason

Title:

Secretary

Agency:

Agency for Health Care Administration

Address:

2727 Mahan Drive

Address 2:

Mail Stop #8

City:

Tallahassee

State: **Florida**

Zip:

32308

Phone:

(850) 412-4118 **Ext:** ☐ **TTY**

Fax:

(850) 488-2520

E-mail:

Jason.Weida@ahca.myflorida.com

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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:

(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:

The Florida Agency for Persons with Disabilities (APD)

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:

Oversight by the State Medicaid Agency is achieved through an interagency agreement with the Operating Agency (APD). Delegated functions include: determination of eligibility and enrollment for iBudget Waiver recipients; management of the statewide pre-enrollment status of individuals eligible but not enrolled for iBudget Waiver services to operate and administer the waiver in partnership with AHCA; and ensuring qualified providers are enrolled and providing oversight for those providers.

Regular meetings between AHCA and APD are held to discuss operational and policy issues, including recipient issues, waiver requirements, and interagency agreement specifics. The State Medicaid Agency has responsibility for rule-making related to provider reimbursement criteria, which includes the Coverage and Limitations Handbook and provider rates. This is also frequently discussed during the interagency meetings.

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.:*

The State Medicaid Agency utilizes a Contracted Vendor (CV) for statewide quality assurance for the Developmental Disabilities Individual Budgeting Waiver.

○ **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:

The Agency for Health Care Administration is responsible for assessment of performance of the CV for statewide quality assurance for the Developmental Disabilities Individual Budgeting Waiver.

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:

AHCA's contract manager works closely with the CV and APD to monitor operation of the waiver.
The following is a list of required actions specified for monitoring of the contract:
1. The CV is contractually obligated to participate in monthly status meetings, to present CV updates, answer questions and receive feedback from APD and AHCA.
2. The AHCA contract manager meets with the CV's contract manager, weekly, to discuss any immediate concerns and provide updates.
3. Waiver quality assurance is administratively monitored by AHCA, annually, to ensure that the operating structure of the CV is in accordance with the contract. (i.e. Personnel Records, Policies and Procedures, IT Compliance).
4. The CV is required to submit monthly, quarterly, and annual reports to AHCA and APD providing a summary of findings for that period. The reports summarize best practices and provide a comprehensive analysis of the data gathered. Information from review activities is designed to support APD in their efforts at remediation throughout the state.
5. All recipient and provider reports are reviewed and approved by AHCA contract manager prior to distribution to the public, and designed for posting to the CV website.
6. The CV provides training modules (online or face-to-face) for APD, AHCA, recipients, families, and providers, as needed, to increase understanding of the program and its requirements.

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	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☐
Waiver enrollment managed against approved limits	☒	☒	☐
Waiver expenditures managed against approved levels	☒	☒	☐

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
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 States quality improvement strategy, provide information in the following fields to detail the States 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 the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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:
(A-1) Percentage of required Person Centered Reviews (PCR) conducted timely and with all required components. N: Number of PCR conducted timely and with all required components. D: Number of PCR conducted.

Data Source (Select one):
On-site observations, interviews, 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 = 95%+/-5
☒ **Other** Specify: Contracted Vendor	☐ **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: Contracted Vendor	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
(A-2) Percentage of required Provider Discovery Reviews (PDR) conducted timely and with all required components. N: Number of PDR conducted timely and with all required components. D: Number of PDR conducted.

Data Source (Select one):
On-site observations, interviews, 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 = 95%+/-5
☒ **Other** Specify: Contracted Vendor	☐ **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: Contracted Vendor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 Medicaid Agency staff and the Operating Agency staff are in on-going communications via telephone or face to face to identify and address waiver issues.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

(A-1) The Contracted Vendor conducts PCRs on a continuous and ongoing basis. The Contracted Vendor sends them to the State Medicaid Agency for review on a monthly basis. The State Medicaid Agency reviews a representative sample to identify problems or concerns. Any problems or concerns identified are discussed at periodic status meetings between the Medicaid Agency, the Operating Agency, and the Contracted Vendor. Issues that are not able to be resolved are advanced to upper management.

(A-2) The Contracted Vendor conducts PDRs on a continuous and ongoing basis. The Contracted Vendor sends them to the State Medicaid Agency for review on a monthly basis. The State Medicaid Agency reviews a representative sample to identify problems or concerns. Any problems or concerns identified are discussed at periodic status meetings between the Medicaid Agency, the Operating Agency, and the Contracted Vendor. Issues that are not able to be resolved are advanced to upper management.

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **Other** Specify: Contracted Vendor	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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 one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR ï¿½441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) 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**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☒	Autism	3		☒
	☒	Developmental Disability	3		☒
	☒	Intellectual Disability	3		☒
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Individuals must meet one of the following requirements in accordance with Chapter 393, F.S.

*The individual's primary disability is an intellectual disability with an intelligence quotient (IQ) of 59 or less.
*The individual's primary disability is an intellectual disability with an IQ of 60-70 inclusive, and has at least one of the following handicapping conditions:

-Ambulatory Deficits
-Sensory Deficits
-Chronic Health Problems
-Behavior Problems
-Autism
-Cerebral Palsy
-Down Syndrome
-Epilepsy
-Spina Bifida
-Phelan McDermid Syndrome
-Prader-Willi Syndrome

*The individual's primary disability is an intellectual disability with an IQ of 60-70 inclusive and has severe functional limitations in at least three of the major life activities specified below.

*The individual has a diagnosis of Autism, Cerebral Palsy, Down Syndrome, Spina Bifida, Phelan McDermid Syndrome, or Prader-Willi Syndrome, and has severe functional limitations in at least three of the major life activities specified below.

Major Life Activities:
-Self care
-Understanding and use of language
-Learning
-Mobility
-Self direction
-Capacity for independent living

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:

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	40742
Year 2	41637
Year 3	43137
Year 4	44637
Year 5	46137

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	
Year 2	
Year 3	
Year 4	
Year 5	

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).**

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:

Eligibility for waiver services is identified in Florida Statutes, Chapter 393. Once eligibility is established under Florida Statutes, an individual must meet the waiver level of care criteria to enroll in the waiver. The initial statutory criteria is as follows:

"Developmental disability" means a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.

"Autism" means a pervasive, neurologically based developmental disability of extended duration which causes severe learning, communication, and behavior disorders with age of onset during infancy or childhood. Individuals with autism exhibit impairment in reciprocal social interaction, impairment in verbal and nonverbal communication and imaginative ability, and a markedly restricted repertoire of activities and interests.

"Cerebral palsy" means a group of disabling symptoms of extended duration which results from damage to the developing brain that may occur before, during, or after birth and that results in the loss or impairment of control over voluntary muscles. For the purposes of this definition, cerebral palsy does not include those symptoms or impairments resulting solely from a stroke.

"Down syndrome" means a disorder caused by the presence of an extra chromosome 21.

"Intellectual disability" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior which manifests before the age of 18 and can reasonably be expected to continue indefinitely. For the purposes of this definition, the term: (a)"Adaptive behavior" means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age, cultural group, and community. (b)"Significantly subaverage general intellectual functioning" means performance that is two or more standard deviations from the mean score on a standardized intelligence test specified in the rules of the agency.

"Prader-Willi syndrome" means an inherited condition typified by neonatal hypotonia with failure to thrive, hyperphagia or an excessive drive to eat which leads to obesity usually at 18 to 36 months of age, mild to moderate mental retardation, hypogonadism, short stature, mild facial dysmorphism, and a characteristic neurobehavior.

"Spina bifida" means a person with a medical diagnosis of spina bifida cystica or myelomeningocele.

"Phelan-McDermid syndrome" means a disorder caused by the loss of the terminal segment of the long arm of chromosome 22, which occurs near the end of the chromosome at a location designated q13.3, typically leading to developmental delay, intellectual disability, dolicocephaly, hypotonia, or absent or delayed speech.

The criteria for waiver level of care can be found in the waiver application in Appendix B: Participant Access and Eligibility, B-6: Evaluation/Reevaluation of Level of Care.

APD maintains the statewide pre-enrollment status of individuals eligible but not enrolled for iBudget Waiver services. Enrollment in the iBudget Waiver is available only when APD has determined it has sufficient funding appropriate to offer enrollment to an individual, when a review of the individual's diagnosis and related characteristics indicate that the ICF/IDD level of criteria has been met, and when determination of Medicaid eligibility has been made.

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

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:

  Parents and other caretaker relatives specified at 435.110,
  Pregnant women specified at 435.116, and
  Children specified at 435.118

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 spend down 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 7)

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. 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:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by

law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **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 uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (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 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

The state uses the post-eligibility rules at 42 CFR 435.726. 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:

○ **Other**

Specify:

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

○ **Not Applicable (see instructions)**
◉ **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 third party payer for the same or similar item. Other waiver participant health insurance policies will be treated as first payer and the beneficiary will have to demonstrate that the 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. Not be a Medicaid compensable expense; and
c. 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 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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).

Answers provided in Appendix B-5-a 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 (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

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:

○ **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 third party payer for the same or similar item. Other waiver participant health insurance policies will be treated as first payer and the beneficiary will have to demonstrate that the 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. Not be a Medicaid compensable expense; and
c. Not be covered by the facility or provider per diem.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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 (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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. 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:

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 a government agency 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:

Support Coordinators or APD staff employed by the state shall meet the following minimum qualifications: two years of professional experience in developmental disabilities, special education, mental health, counseling, guidance, social work or health and rehabilitative services. A degree can substitute for one year of the required experience.

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 following level of care criteria are used to evaluate and reevaluate whether an individual needs services through the waiver and is a component of the level of care instrument/tool. This tool is located on the Medicaid Waiver Eligibility Worksheet.

These eligibility requirements are set in Chapter 393, Florida Statute, per the Florida Legislature.

I. Level of Care Eligibility: An individual who has applied for developmental disability Medicaid waiver services who meets one of the following criteria and is eligible to receive the services provided in an ICF/DD. Check all criteria that are met.
Option A. ____The individual's primary disability is intellectual disability with an intelligence quotient (IQ) of 59 or less.
Option B. ____The individual's primary disability is intellectual disability with an IQ of 60-70 inclusive and the individual has at least one of the following handicapping conditions OR individual's primary disability is intellectual disability with an IQ of 60-70 inclusive and the individual has severe functional limitations in at least three of the Major Life Activities. Please check all handicapping conditions and major life activities that apply.
Option C. ____The individual is eligible under the category of autism, cerebral palsy, Down syndrome, spina bifida, Phelan McDermid syndrome or Prader-Willi syndrome and the individual has severe functional limitations in at least three of the major life activities. Please check all handicapping conditions and major life activities that apply.

Handicapping Conditions
____Ambulatory Deficits
____Sensory Deficits
____Chronic Health Problems
____Behavior Problems
____Autism
____Cerebral Palsy
____Down syndrome
____Epilepsy
____Spina Bifida
____Phelan McDermid syndrome
____Prader-Willi syndrome

Major Life Activities
____Self Care
____Understanding and use of language
____Learning
____Mobility
____Self Direction
____Capacity for independent living

* The State Medicaid Agency periodically monitors client status and pre-enrollment status to prevent any restriction of access to care for applicants.

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:

APD staff or support coordinators will evaluate an individual's level of care on an annual basis as a part of the support planning process. During that process, the individual is presented with options for maximum community integration according to their needs in addition to a reevaluation of the level of care.

Required documents, including the support plan, may utilize an electronic method of signature.

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:

The level of care is updated and reevaluated at least every twelve months. Individuals or their families may request a reevaluation of level of care at any time. A level of care reevaluation is also conducted upon changed needs of the recipient.

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):*

The Quality Assurance contractor monitors the timeliness of level of care reevaluations during records reviews. Additionally, the operating agency implemented an electronic system that allows for the input and tracking of the annual level of care reevaluations.

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:

Records of evaluations and reevaluations of level of care are maintained in the recipient's central file.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for

evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
(B-1) Percentage of new waiver enrollees receiving a level of care determination prior to enrollment. N: Number of new waiver enrollees receiving a level of care determination prior to enrollment. D: Number of new waiver enrollees.

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

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:

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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.

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
(B-2) Percentage of initial level of care determinations that were accurately completed in accordance with state policies and procedures. N: Number of initial level of care determinations that were accurately completed in accordance with state policies and procedures. D: Number of initial level of care determinations.

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

APD has adopted a quality assurance strategy that mirrors the CMS Quality Framework. The Discovery function is a universal responsibility, but the majority of the work is done by the CV utilizing a statistically valid sampling methodology for individual single case analysis and a traditional provider compliance process which engages service providers annually. The Remediation function is handled by APD which receives discovery material from the CV. The CV issues alerts to APD upon discovery of health and safety violations and concerns. APD responds immediately to all alerts. Plans of Remediation are required of cited providers that identifies specifc actions and timeframes to address deficiency.

APD utilizes the quality team approach to review data trend from the CV and other data sources such as incident and abuse reports. The function of this group is to identify and prioritize appropriate actions to make ongoing improvements.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

(B-1) The Operating Agency ensures that the level of care determination, including the iBudget Eligibility Worksheet, is completed prior to Waiver enrollment on a continuous and ongoing basis. Systematically, the waiver enrollment process disallows enrollment prior to a completed level of care determination. In the event a level of care determination is not completed, the operating agency will work with the regional office and the recipient to make sure that it is completed prior to waiver enrollment.

(B-2) The Operating Agency ensures that the level of care determination, including the iBudget Eligibility Worksheet, is completed accurately prior to Waiver enrollment on a continuous and ongoing basis. Systematically, the waiver enrollment process disallows enrollment prior to a completed level of care determination. In the event a level of care determination is not completed accurately, the operating agency will work with the regional office and the recipient to make sure that it is completed accurately prior to waiver enrollment.

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:

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).

The Operating Agency provides information about the services that are available through the waiver to interested individuals. Once enrolled, Waiver Support Coordinators are required to inform applicants of their freedom of choice of institutional, waiver services, and choice of provider. Waiver Support Coordinators document this choice on an annual basis using a standardized form that requires signature of the recipient or legal representative. The form specifying freedom of choice is the Medicaid Eligibility Worksheet.

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.

The Medicaid Eligibility Worksheet, specifying Freedom of Choice, is retained in the individual's central file maintained by their support coordinator.

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):

In accordance with Florida Statute, the State is required to provide notice to recipients in their language of record. Documents including applications, intake forms, notices of denial, loss, or decrease in benefits or services, and notices of rights are translated into recipients' non-English language of record for convenience. Additionally, the State offers several brochures in English, Spanish, and Haitian Creole, as well as bilingual staff available via telephone.

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	**Life Skills Development Level 3 - Adult Day Training**		
Statutory Service	**Life Skills Development Level 4 - Prevocational Services**		
Statutory Service	**Residential Habilitation**		
Statutory Service	**Respite**		
Statutory Service	**Support Coordination**		
Extended State Plan Service	**Adult Dental Services**		
Extended State Plan Service	**Occupational Therapy**		
Extended State Plan Service	**Physical Therapy**		
Extended State Plan Service	**Respiratory Therapy**		
Extended State Plan Service	**Skilled Nursing**		
Extended State Plan Service	**Specialized Medical Equipment and Supplies**		
Extended State Plan Service	**Specialized Mental Health Counseling**		
Extended State Plan Service	**Speech Therapy**		

Service Type	Service		
Extended State Plan Service	Transportation		
Other Service	Behavior Analysis Services		
Other Service	Behavior Assistant Services		
Other Service	Dietitian Services		
Other Service	Environmental Accessibility Adaptations		
Other Service	Life Skills Development Level 1 - Companion		
Other Service	Life Skills Development Level 2 - Supported Employment		
Other Service	Personal Emergency Response System		
Other Service	Personal Supports		
Other Service	Private Duty Nursing		
Other Service	Residential Nursing		
Other Service	Specialized Medical Home Care		
Other Service	Supported Living Coaching		

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):

Life Skills Development Level 3 - Adult Day Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Adult Day Training (ADT) services support the participation of recipients in valued routines of the community, in settings that are appropriate. The training, activities, and routine established by the ADT provider must be meaningful to the recipient and provide an appropriate level of variation and interest. This includes the provision of regularly scheduled activities in a non-residential setting, separate from the participant's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living. Meals are not included in this service.

Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice. Services are furnished consistent with the participant's person-centered service plan.

Non-emergency transportation is a covered waiver 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 services must be authorized in the enrollee's person-centered support plan.

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

Life Skills Development Level 3 – Adult Day Training services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

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	Adult Day Training Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Life Skills Development Level 3 - Adult Day Training

Provider Category:

Agency

Provider Type:

Adult Day Training Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The provider must meet the following minimum qualifications for staff and staffing ratio:
• The agency manager or director will not have full-time responsibility for providing direct services and will not be included in determining the staffing ratios.
• The program director must possess at a minimum an associate's degree from an accredited college or university and two years, hands-on, related experience.
• Supervisors of direct care staff will have a high school diploma or GED and one year of direct, care-related experience.
• Related experience will substitute on a year-for-year basis for the required college education.
• Direct service staff will work under appropriate supervision.
• The staffing ratio will not exceed 10 recipients per direct service staff for ADT facility-based programs (supervisory and other management staff can be included in determining the direct care staff ratio. Administrative staff and those not providing direct service to the recipient are not considered direct service staff).
• Direct service staff must be age 18 years or older at the time they are hired.Providers of ADT services must be designated by the APD regional office as ADT providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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:

Prevocational Services

Alternate Service Title (if any):

Life Skills Development Level 4 - Prevocational Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Prevocational services are services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are time-limited and with specific outcomes to be achieved, as determined by the individual and his/her service and supports planning team through an ongoing person-centered planning process, to be reviewed not less than annually or more frequently as requested by the individual.
Individuals receiving prevocational services must have employment-related goals in their person-centered service plan; the general habilitation activities must be designed to support such employment goals. The successful outcome of prevocational services is competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational services should enable everyone to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills that lead to competitive and integrated employment including: the ability to communicate effectively with supervisors, co-workers and customers; adhere to generally accepted community workplace conduct and dress; follow directions; attend to tasks; employ workplace problem solving skills and strategies; adhere to general workplace safety and mobility training.
Documentation is maintained in the file of everyone receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Non-emergency transportation is a covered waiver 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 services must be authorized in the enrollee's person-centered support plan. Additionally, prevocational providers are paid separately for transportation services only when the service is authorized in the cost plan, the provider is enrolled as a transportation provider, and transportation is provided between a recipient's place of residence and the training site. Transportation between prevocational sites, if the activities provided are a part of the respective services, will be included as a component and in the rate paid to the provider of prevocational services.

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

Life Skills Development Level 4 – Prevocational services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

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	Adult Day Training Center
Agency	Prevocational Services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Life Skills Development Level 4 - Prevocational Services

Provider Category:

Agency

Provider Type:

Adult Day Training Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency manager or director will not have full-time responsibility for providing direct services and will not be included in determining the staffing ratios. • The program director must possess at a minimum an associate's degree from an accredited college or university and two years, hands-on, related experience. • Supervisors of direct care staff will have a high school diploma or GED and one year of direct, care-related experience. • Related experience will substitute on a year-for-year basis for the required college education. • Direct service staff will work under appropriate supervision. • The staffing ratio will not exceed 10 recipients per direct service staff (supervisory and other management staff can be included in determining the direct care staff ratio. Administrative staff and those not providing direct service to the recipient are not considered direct service staff). • Direct service staff must be age 18 years or older at the time they are hired. Providers of Prevocational services must be designated by the APD regional office as Life Skills Development 4 providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency

Frequency of Verification:

Upon initial enrollment and upon reenrollment requested of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Life Skills Development Level 4 - Prevocational Services

Provider Category:

Agency

Provider Type:

Prevocational Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency manager or director will not have full-time responsibility for providing direct services and will not be included in determining the staffing ratios. The program director must possess at a minimum an associate's degree from an accredited college or university and two years, hands-on, related experience. Supervisors of direct care staff will have a high school diploma or GED and one year of direct, care-related experience. Related experience will substitute on a year-for-year basis for the required college education. Direct service staff will work under appropriate supervision. The staffing ratio will not exceed 10 recipients per direct service staff (supervisory and other management staff can be included in determining the direct care staff ratio. Administrative staff and those not providing direct service to the recipient are not considered direct service staff). Direct service staff must be age 18 years or older at the time they are hired. Providers of Prevocational services must be designated by the APD regional office as Life Skills Development Level 4 providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency

Frequency of Verification:

Upon initial enrollment and upon reenrollment of the Medicaid Agency

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:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirement of the applicable life safety code. Payments will not be made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Residential habilitation services can be provided in an adult family care home, assisted living facility, foster home, or group home setting, as identified under “Provider Specifications”.

Residential Habilitation (Standard) provides supervision and specific training activities that assist the recipient to acquire, maintain, or improve skills related to activities of daily living. The service focuses on personal hygiene skills, such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming, and laundry; and social and adaptive skills that enable the recipient to reside in the community. This training is provided in accordance with a formal implementation plan, developed by the provider with direction from the recipient, and reflects the recipient’s goals from the current support plan.

Residential Habilitation (Behavior Focused): This level of service must be approved for a recipient only when it has been determined through use of the APD approved instrument by the APD regional behavior analyst or designee, and through the support planning process, that a recipient requires residential habilitation services with a behavioral focus. The goal of behavior focused residential habilitation service is to prepare the recipient for full or partial re-integration into the community, with established behavioral repertoires, such as developing a healthy lifestyle, filled with engaging and productive activities. Residential habilitation services with a behavior focus are appropriate for recipients exhibiting at least one of the following behavioral characteristics, within the past twelve months, as documented in their central record:

- Exhibits self-inflicted, detectable, external, or internal damage requiring medical attention or the behavior is expected to increase in frequency, duration, or intensity resulting in self-inflicted, external, or internal damage requiring medical attention. These types of behaviors include head banging, hand biting, and regurgitation.
- Exhibits external or internal damage to other persons that requires medical attention or the behavior is expected to increase in frequency, duration, or intensity resulting in external or internal damage to other persons that requires medical attention. These types of behaviors include hitting others, biting others, and throwing dangerous objects at others.
- Arrest and confinement by law enforcement personnel.
- Causes major property damage or destruction in excess of $500 for any one intentional incident.
- Engages in behavior that creates a life threatening situation, including excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, and severe insomnia.
- Behavior has led to the use of restraint or emergency medications or Baker Act within the past twelve months.
- Engaged in public displays of inappropriate sexual behavior.
- Engaged in threats of inappropriate sexual behavior or sexually provocative behavior towards another person, or is vulnerable to exploitation due to being sexually active.

Residential Habilitation (Intensive Behavioral): Intensive behavior (IB) residential habilitation is for recipients who present issues with behavior that are exceptional in intensity, duration, and frequency, whose needs cannot be met in a behavior focus or standard residential habilitation setting, and who meet one or more of the following conditions. The goal of IB residential habilitation service is to prepare the recipient for full or partial reintegration into the community, with an expanded array of skills and behaviors, with a focus on independent adaptive functioning, and developing a healthy lifestyle, while participating in engaging and productive activities. Treatment within IB residential habilitation also includes medical oversight by psychiatric and nursing services when recipients routinely use psychotropic medications or emergency medications for the management of behavior, mood, or thought processes. Intensive behavioral services for a recipient must be approved and authorized by APD through the characteristics that identify the service requirements. The APD regional behavioral analyst or designee will determine individual characteristics have been met for intensive behavioral residential habilitation. IB residential habilitation services are appropriate for recipients exhibiting at least one of the following behavioral characteristics, within the past six months, as documented in their central record:

- Engaged in behavior that caused injury to self or others that required emergency room or other inpatient care from a physician or other health care professional.
- Engaged in a behavior that creates a life-threatening situation, such as, excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, and severe

insomnia.
- Engaged in unauthorized fire setting.
- Attempted suicide.
- Intentionally caused damage to property in excess of $1,000 in value for one incident.
- Engaged in behavior that was unable to be controlled via less restrictive means and necessitated the use of restraints, either mechanically, manually or by commitment to a crisis stabilization unit, three or more times in a 30-day period, or six times across the applicable six-month period.
- Engaged in behavior that resulted in the recipient's arrest and confinement.
- Engaged in sexual behavior with any person who did not consent or is considered unable to consent to such behavior, or engaged in sexual behavior that caused injury to self or others requiring emergency room or other in-patient care from a physician or other health care professional.
- If the supervision and environment is such that the recipient lacks opportunity for engaging in these serious behaviors, the behavior analyst providing services must provide data, probes or other documented evidence to the regional behavior analyst providing oversight for services, showing that the behavior would likely occur at least every six months if the recipient were without the supervision or environment provided.

Residential Habilitation (Enhanced Intensive Behavior): There are two types of enhanced intensive behavior (EIB) residential habilitation. This includes EIB Residential Habilitation and EIB Medical. Both types of EIB services are for recipients who present behavioral challenges that are exceptional in intensity, duration, and frequency, whose needs cannot be met in an intensive, behavior focus, or standard residential habilitation setting. Enhanced intensive behavior medical (EIB Medical) services are for recipients who also require nursing services for 24-hours per day, seven days a week. The goal of all EIB residential habilitation services is to prepare the recipient for full or partial reintegration into less restrictive community settings by teaching an expanded array of skills and behaviors. The focus is on independent adaptive functioning and developing a healthy lifestyle, while participating in engaging and productive activities. EIB residential habilitation services must be authorized by the APD State Office and may be appropriate for recipients who meet all of the following criteria: 1. Transitioning from a comprehensive transitional education program 2. A score of 4, 5, or 6 on the Global Behavioral Service Need Matrix 3. Have met at least one of the following behavioral characteristics within the past six months:
- Engaged in behavior that caused injury to self or others that required emergency room or other inpatient care from a physician or other health care professional.
- Engaged in a behavior that creates a life-threatening situation, such as, excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, or severe insomnia.
- Engaged in unauthorized fire setting.
- Attempted suicide.
- Intentionally caused damage to property in excess of $1,000 in value for one incident.
- Engaged in behavior that was unable to be controlled via less restrictive means and necessitated the use of restraints, either mechanically, manually or by commitment to a crisis stabilization unit, three or more times in a 30-day period, or six times across the applicable six-month period.
- Engaged in behavior that resulted in the recipient's arrest and confinement.
- Engaged in sexual behavior with any person who did not consent or is considered unable to consent to such behavior, or engaged in sexual behavior that caused injury to self or others requiring emergency room or other in-patient care from a physician or other health care professional.

In addition, to be eligible for EIB Medical services, recipients must meet the behavioral characteristics above and have significant and complex medical needs requiring nursing services 24-hours per day. Recipients must meet at least one of the following characteristics as determined by the regional APD behavior analyst and medical case manager: 1. Has a medical condition that, in conjunction with their behavioral issues, clearly indicated the need for 24-hour nursing availability. 2. Has a medical condition that may not have required continuous nursing services, but may have been caused or exacerbated by the behavior exhibited by the individual, that is frequent enough to warrant the availability of nursing services to deal with medical issues or conditions. 3. Experiences a medical condition, independent of their behavior. However, the target behavior(s) made the medical issue or condition difficult or impossible to treat in a less specialized environment. 4. Has a medical condition that required specialized equipment and/or procedures that could only be provided by licensed staff. If this care is not available, the risk is such that there are consequences that could cause the individual to experience a decrease in function, acute illness, or a decline in health status. EIB services must be approved and authorized by APD through verification that the criteria for eligibility for this service have been met. The APD regional behavioral analyst or designee will make the determination that an individual meets all criteria for EIB residential habilitation with final authority through the APD state office. The regional behavioral analyst and medical case manager will make the determination that an

individual meets all criteria for EIB Medical with final authority through the APD state office.

Non-emergency transportation is a covered waiver 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 services must be authorized in the enrollee's person-centered support plan.

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

Residential habilitation services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

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	Group Home
Agency	Adult Family Care Home
Agency	Foster Home
Agency	Assisted Living Facility

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License *(specify):*

In accordance with Chapter 393, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Providers of standard residential habilitation must hire direct care providers who are age 18 years and older, and have one year experience working in a medical, psychiatric, nursing, or child-care setting, or experience working with recipients with developmental disabilities, or have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Direct service providers hired by the licensee prior to July 1, 2014, shall be exempt from these requirements, as provided for in Rule 65G-2.008(1)(f), F.A.C.

Providers of group homes including standard, behavior focus, intensive behavior focus, and enhanced intensive behavior focus residential habilitation must be designated by the APD regional office and must consult with APD for the expressed purpose of ensuring adequate provider capacity before placing an enrollee of the in a group home licensed by APD. Agencies must hire direct care providers who are age 18 years and older, have at least a high school or GED diploma, have one year of experience working in a medical, psychiatric, nursing, or child-care setting, or experience working with recipients with developmental disabilities. In lieu of the required work experience, the employee may have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Additional qualifications for behavior focus, intensive behavior, and enhanced intensive behavior providers are included in the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, Rule 59G-13.070, F.A.C.

All service providers must be in good standing with the Florida Medicaid program and APD. 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 AHCA authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Adult Family Care Home

Provider Qualifications

License *(specify):*

In accordance with Chapters 408 and 429, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Providers of standard residential habilitation must hire direct care providers who are age 18 years and older, and have one year experience working in a medical, psychiatric, nursing, or child-care setting, or experience working with recipients with developmental disabilities, or have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Direct service providers hired by the licensee prior to July 1, 2014, shall be exempt from these requirements, as provided for in Rule 65G-2.008(1)(f), F.A.C.

Providers of group homes including standard, behavior focus, intensive behavior focus, and enhanced intensive behavior focus residential habilitation must be designated by the APD regional office and must consult with APD for the expressed purpose of ensuring adequate provider capacity before placing an enrollee of the in a group home licensed by APD. Agencies must hire direct care providers who are age 18 years and older, have at least a high school or GED diploma, have one year of experience working in a medical, psychiatric, nursing, or child-care setting, or experience working with recipients with developmental disabilities. In lieu of the required work experience, the employee may have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Additional qualifications for behavior focus, intensive behavior, and enhanced intensive behavior providers are included in the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, Rule 59G-13.070, F.A.C.

All service providers must be in good standing with the Florida Medicaid program and APD. 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 AHCA authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Foster Home

Provider Qualifications

License *(specify):*

In accordance with Chapter 393, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Providers of standard residential habilitation must hire direct care providers who are age 18 years and older, and have one year experience working in a medical, psychiatric, nursing, or child-care setting, or experience working with recipients with developmental disabilities, or have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Direct service providers hired by the licensee prior to July 1, 2014, shall be exempt from these requirements, as provided for in Rule 65G-2.008(1)(f), F.A.C.

Providers of group homes including standard, behavior focus, intensive behavior focus, and enhanced intensive behavior focus residential habilitation must be designated by the APD regional office and must consult with APD for the expressed purpose of ensuring adequate provider capacity before placing an enrollee of the in a group home licensed by APD. Agencies must hire direct care providers who are age 18 years and older, have at least a high school or GED diploma, have one year of experience working in a medical, psychiatric, nursing, or child-care setting, or experience working with recipients with developmental disabilities. In lieu of the required work experience, the employee may have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Additional qualifications for behavior focus, intensive behavior, and enhanced intensive behavior providers are included in the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, Rule 59G-13.070, F.A.C.

All service providers must be in good standing with the Florida Medicaid program and APD. 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 AHCA authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

In accordance with Chapter 408 and 429, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Providers of standard residential habilitation must hire direct care providers who are age 18 years and older, and have one year experience working in a medical, psychiatric, nursing, or child-care setting, or experience working with recipients with developmental disabilities, or have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Direct service providers hired by the licensee prior to July 1, 2014, shall be exempt from these requirements, as provided for in Rule 65G-2.008(1)(f), F.A.C.

Providers of group homes including standard, behavior focus, intensive behavior focus, and enhanced intensive behavior focus residential habilitation must be designated by the APD regional office and must consult with APD for the expressed purpose of ensuring adequate provider capacity before placing an enrollee of the in a group home licensed by APD. Agencies must hire direct care providers who are age 18 years and older, have at least a high school or GED diploma, have one year of experience working in a medical, psychiatric, nursing, or child-care setting, or experience working with recipients with developmental disabilities. In lieu of the required work experience, the employee may have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Additional qualifications for behavior focus, intensive behavior, and enhanced intensive behavior providers are included in the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, Rule 59G-13.070, F.A.C.

All service providers must be in good standing with the Florida Medicaid program and APD. 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 AHCA authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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):

HCBS Taxonomy:

Category 1: 09 Caregiver Support

Sub-Category 1: 09012 respite, in-home

Category 2: 09 Caregiver Support

Sub-Category 2: 09011 respite, out-of-home

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Services provided to individuals unable to care for themselves, furnished on a short-term basis for a planned absence or need for relief of those persons normally providing their care. Respite care will be provided in the following locations: individual's home, foster home, group home, or Assisted Living Facility.

If a nurse is needed to provide respite services, then a prescription from a physician, ARNP, or physician assistant is required.

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

Respite services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient. Recipients living in licensed group homes or who are in supported or independent living are not eligible to receive respite care services.

This waiver service is limited to individuals under age 21. Respite care for individuals age 21 years or older is available as a part of Personal Supports.

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	Group Home
Agency	Assisted Living Facility

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Registered Nurse
Agency	Homemaker/sitter/companion
Individual	Licensed Practical Nurse
Agency	Hospice Agency
Individual	Nurse Registry
Individual	Independent Vendors

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License *(specify):*

In accordance with Chapter 393, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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/sitter/companion

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must be age 18 years or older, have a high school diploma or GED, and have at least one year of hands-on, verifiable experience working in a medical, psychiatric, nursing, or childcare setting or working with recipients who have a developmental disability. In lieu of the required work experience, the providers and their employees may have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Hospice Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Nurse Registry

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Independent Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must be age 18 years or older, have a high school diploma or GED, and have at least one year of hands-on, verifiable experience working in a medical, psychiatric, nursing, or childcare setting or working with recipients who have a developmental disability. In lieu of the required work experience, the providers and their employees may have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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):

Support Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Support coordination assists individuals who receive waiver services in gaining access to needed waiver and State plan services, including needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Support Coordinators shall be responsible for ongoing monitoring of the provision of services included in the individuals plan of care.

Full Support Coordination: Full Support Coordination provides significant support to a recipient to ensure the recipient's health, safety, and well-being. The WSC can share tasks with the recipient and the recipient's family, or other support persons as they desire, but ultimately the WSC must be responsible for performing all tasks required to locate, select, and coordinate services and supports, whether paid with waiver funds or through other resources. Full Support Coordination includes a 24/7 on-call system; providing basic information to recipient about the waiver and iBudget system; completing annual support plan and cost plan and updates; assisting with locating, interviewing, selecting, and coordinating providers; determining if the services being provided meet the recipient's expectations; and attending medical appointments, recipient education plan meetings, social security meetings, and similar appointments at the recipient's request. Full Support Coordination requires at least two contacts monthly with the recipient or on the behalf of the recipient. When the recipient resides in supported living, assisted living, or licensed residential facility settings, one of the monthly contacts must be face-to-face with the recipient. For recipients who live in the family home, a face-to-face contact is required every 3 months.

Limited Support Coordination: Limited support coordination services are services that are intended to be less intense than full support coordination. Limited support coordination services are billed at a reduced rate and have reduced contact requirements. Limited support coordinators are not on-call 24 hours per day, 7 days per week. Limited support coordination occurs during times and dates prearranged by the recipient and the WSC. In the event that the recipient experiences emergencies that require a more intensive level of support coordination, a change to full support coordination is initiated. Limited Support Coordination includes providing basic information about the iBudget Waiver system; completing the annual support and cost plan and updates; providing information and referrals on locating, selecting, and coordinating providers; and providing guidance in evaluating the quality of services. Limited Support Coordination requires at least one contact monthly with the recipient or on the behalf of the recipient. For individuals in the family home, the WSC must conduct two face-to-face visits annually. For individuals in independent living, the face-to-face visit must be every three months. Limited Support Coordination is only available to individuals in the family home or independent living situations.

Enhanced Support Coordination: Enhanced Support Coordination consists of activities that assist the recipient in transitioning from a nursing facility, Developmental Disabilities Defendant Program, or an ICF/IDD to the community, or assisting recipients who need a more intensive level of support coordination. Enhanced Support Coordination must meet all the same requirements as Full Support Coordination, and the WSC must have, at a minimum, weekly face-to-face contact with the recipient. If a recipient is moving from an institutional placement into the community, the WSC providing enhanced support coordination will work directly with the recipient, institutional staff, and the selected waiver providers prior to the move to ensure a smooth transition to community services, including those funded through the waiver and other services and supports necessary to ensure the health and safety of the recipient. The WSC will coordinate these activities with the facility's discharge planning processer. The WSC must develop an initial support plan for the recipient, taking into account information from the provider's summary of the recipient's development, behavioral, social, health, and nutritional status and a discharge plan designed to assist the recipient in adjusting to their new living environment. The WSC must have, at a minimum, weekly face-to-face contact with the recipient for the first 30 days following discharge from the facility. WSC providing enhanced support coordination is on call 24 hours per day, 7 days per week for the recipient. The WSC must update the recipient's support plan at the end of 30 consecutive calendar days to identify progress made with the transition to community services and possible changes needed in supports and services, and follow-up on unresolved issues. Enhanced support coordination is intended to be time limited for three months prior to discharge from the facility, and for three months after the move occurs, or for a total of no more than six consecutive months for situations that are related to a change in the recipient's situation as described above.

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

Support coordination services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

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	Support Coordination Agencies

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:

Agency

Provider Type:

Support Coordination Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Support Coordination Agencies are qualified organizations as specified in Chapter 393.0663, Florida Statutes. Support Coordination Agency employees must meet the following minimum qualifications: have a bachelor’s degree from an accredited college or university and two years of professional experience in developmental disabilities, special education, mental health, counseling, guidance, social welfare, or health and rehabilitative services. A master's degree in a related field can substitute for one year of the required experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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:

Adult Dental Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11070 dental services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Adult dental services include diagnostic, preventive and restorative treatment, extractions; and endodontics, periodontal and surgical procedures. The services strive to prevent or remedy dental problems that, if left untreated, could compromise a recipient's health, by increasing the risk of infection or disease, or reducing food options, resulting in restrictive nutritional intake.

Dental services for children are provided through Medicaid State Plan services.

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

Adult dental services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

All medically necessary dental services for children under the age of 21 are covered State Plan benefits. As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1915(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. Adult dental services covered by the waiver must not duplicate services provided by Medicaid State Plan dental services. A recipient must not receive more than ten quarter-hour units daily of medically necessary waiver services that exceed the amount, duration, and scope available from the dental plan.

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	Independent Denists
Agency	Dental Agencies

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adult Dental Services

Provider Category:

Individual

Provider Type:

Independent Denists

Provider Qualifications

License *(specify):*

In accordance with Chapter 466, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Unlicensed dental interns and dental students of university based dental programs may provide services under the general supervision of a licensed dentist but cannot act as a treating provider or bill Medicaid for covered services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adult Dental Services

Provider Category:

Agency

Provider Type:

Dental Agencies

Provider Qualifications

License *(specify):*

In accordance with Chapter 466, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Unlicensed dental interns and dental students of university based dental programs may provide services under the general supervision of a licensed dentist but cannot act as a treating provider or bill Medicaid for covered services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Occupational therapy services are services prescribed by a physician, ARNP, or physician assistant that produce specific functional outcomes in self-help, adaptive, and sensory motor skill areas, and assist the recipient to control and maneuver within the environment. The services may also include an occupational therapy assessment, which does not require a physician's prescription. In addition, this service may include training direct care staff and caregivers and monitoring those individuals to ensure they are carrying out therapy goals correctly.

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

Occupational therapy services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is limited to individuals over age 21.

All medically necessary Occupational Therapy services for children under the age of 21 are covered State Plan benefits. As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1915(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. Occupational Therapy services covered by the waiver must not duplicate services provided by Medicaid State Plan Occupational Therapy services.

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	Occupational Therapy Assistant
Individual	Occupational Therapist
Agency	Occupational Therapist
Agency	Occupational Therapy Assistant

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):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

In accordance with 42 CFR 484.

Other Standard *(specify):*

Enrolled in the Medicaid Home Health Program.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid 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 Therapy Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In accordance with Chapter 468, F.S.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid 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):*

In accordance with Chapter 468, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid 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:

Agency

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

In accordance with Chapter 468, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid 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:

Agency

Provider Type:

Occupational Therapy Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In accordance with Chapter 468, F.S.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11090 physical therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Physical therapy is a service prescribed by a physician, ARNP, or physician assistant that produces specific functional outcomes in ambulation, muscle control, and postural development, and to prevent or reduce further physical disability. The service may also include a physical therapy assessment, which does not require a physician's prescription. In addition, this service may include training and monitoring direct care staff and caregivers to ensure they are carrying out therapy goals correctly.

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

Physical therapy services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is limited to individuals over age 21.

All medically necessary Physical Therapy services for children under the age of 21 are covered State Plan benefits. As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1915(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. Physical Therapy services covered by the waiver must not duplicate services provided by Medicaid State Plan Physical Therapy services.

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 Therapy Assistant
Agency	Physical Therapy Assistant
Agency	Physical Therapist
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):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

In accordance with 42 CFR 484.

Other Standard *(specify):*

Enrolled in the Medicaid Home Health Program.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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 Therapy Assistant

Provider Qualifications

License *(specify):*

In accordance with Chapter 486, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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:

Physical Therapy Assistant

Provider Qualifications

License *(specify):*

In accordance with Chapter 486, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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:

Physical Therapist

Provider Qualifications

License *(specify):*

In accordance with Chapter 486, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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):*

In accordance with Chapter 486, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11110 respitory therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Respiratory therapy is a service prescribed by a physician, ARNP, or physician assistant and relates to impairment of respiratory function and other deficiencies of the cardiopulmonary system. Treatment activities include ventilator support, therapeutic and diagnostic use of medical gases, respiratory rehabilitation, management of life support systems, bronchopulmonary drainage, breathing exercises and chest physiotherapy. The provider determines and monitors the appropriate respiratory regimen and maintains sufficient supplies to implement the regimen. The provider may also provide training to direct care staff to ensure adequate and consistent care is provided. Respiratory therapy services may also include a respiratory assessment.

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

Respiratory therapy services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is limited to individuals over age 21.

All medically necessary Respiratory Therapy services for children under the age of 21 are covered State Plan benefits. As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1915(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. Respiratory Therapy services covered by the waiver must not duplicate services provided by Medicaid State Plan Respiratory Therapy services.

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
Agency	Respiratory Therapist
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):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

In accordance with 42 CFR 484.

Other Standard *(specify):*

Enrolled in the Medical Home Health Program.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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:

Respiratory Therapist

Provider Qualifications

License *(specify):*

In accordance with Chapter 468, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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):*

In accordance with Chapter 468, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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:

Skilled Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Services listed in the plan of care which are within the scope of the States 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 is a service prescribed by a physician, ARNP, or physician assistant and consists of part-time or intermittent nursing care visits provided by registered or licensed practical nurses for recipients who require a skilled nursing visit.

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

Skilled nursing services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is limited to individuals over age 21.

All medically necessary Skilled Nursing services for children under the age of 21 are covered State Plan benefits. As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1915(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. Skilled Nursing services covered by the waiver must not duplicate services provided by Medicaid State Plan Skilled Nursing services.

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	Nurse Registry
Agency	Hospice Agency
Individual	Registered Nurse
Agency	Licensed Practical Nurse Agency
Individual	Licensed Practical Nurse
Agency	Home Health Agency
Agency	Registered Nurse Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Nurse Registry

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Hospice Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Licensed Practical Nurse Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

In accordance with 42 CFR 484.

Other Standard *(specify):*

Enrolled in the Medicaid Home Health Program.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Registered Nurse Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

This service includes devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment for the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items, which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

This service is defined in Florida as two services: 1) Durable Medical Equipment and Supplies, and 2) Consumable Medical Supplies. Both Durable Medical Equipment and Supplies and Consumable Medical Supplies Services are prescribed by a physician, ARNP, or physician's assistant.

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

Consumable medical supplies and durable medical equipment are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is limited to individuals over age 21.

All medically necessary Specialized Medical Equipment and Supplies services for children under the age of 21 are covered State Plan benefits. As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1915(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. Specialized Medical Equipment and Supplies services covered by the waiver must not duplicate services provided by Medicaid State Plan Specialized Medical Equipment and Supplies services.

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
Agency	Retail Stores
Agency	Assistive Technology Suppliers and Practitioners
Agency	Pharmacy
Agency	Medical supply companies and durable medical equipment suppliers

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Must provide a bond, letter of credit, or other collateral.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Retail Stores

Provider Qualifications

License *(specify):*

In accordance with Chapter 205, F.S.

Certificate *(specify):*

Other Standard *(specify):*

If county does not require a permit or license, evidence must be provided and FEID number made available.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Assistive Technology Suppliers and Practitioners

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Pharmacy

Provider Qualifications

License *(specify):*

In accordance with Chapter 465, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Medical supply companies and durable medical equipment suppliers

Provider Qualifications

License *(specify):*

In accordance with Chapter 205, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Must provide a bond, letter of credit, or other collateral.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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:

Specialized Mental Health Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10010 mental health assessment
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10060 counseling
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialized mental health counseling for persons with developmental disabilities are services provided to maximize the reduction of a recipients mental illness and restoration to the best possible functional level. Specialized mental health services focus on the unique treatment of psychiatric disorders and rehabilitation for impairments for persons with developmental disabilities and mental illness. These services include specialized individual, group and family therapy provided to recipients using techniques appropriate to this population.

Specialized Mental Health Counseling services are provided in the provider’s office, the recipient’s place of residence, or anywhere in the community.

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

Specialized mental health counseling services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is limited to individuals over age 21.

All medically necessary Specialized Mental Health Counseling services for children under the age of 21 are covered State Plan benefits. As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1915(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. Specialized Mental Health Counseling services covered by the waiver must not duplicate services provided by Medicaid State Plan Specialized Mental Health Counseling services.

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	Mental Health Counselor
Individual	Clinical Social Worker
Individual	Marriage and Family Therapist
Agency	Marriage and Family Therapist
Agency	Clinical Social Worker
Agency	Mental Health Counselor
Agency	Psychiatrist
Individual	Psychologist
Individual	Psychiatrist
Agency	Psychologist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Mental Health Counseling

Provider Category:

Individual

Provider Type:

Mental Health Counselor

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Two years experience with individuals who have mental illness and developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Mental Health Counseling

Provider Category:

Individual

Provider Type:

Clinical Social Worker

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Two years experience with individuals who have mental illness and developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Mental Health Counseling

Provider Category:

Individual

Provider Type:

Marriage and Family Therapist

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Two years experience with individuals who have mental illness and developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Mental Health Counseling

Provider Category:

Agency

Provider Type:

Marriage and Family Therapist

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Two years experience with individuals who have mental illness and developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Mental Health Counseling

Provider Category:

Agency

Provider Type:

Clinical Social Worker

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Two years experience with individuals who have mental illness and developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Mental Health Counseling

Provider Category:

Agency

Provider Type:

Mental Health Counselor

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Two years experience with individuals who have mental illness and developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Mental Health Counseling

Provider Category:

Agency

Provider Type:

Psychiatrist

Provider Qualifications

License *(specify):*

In accordance with Chapters 458 and 459, F.S.

Certificate *(specify):*

In accordance with rule 59G-1.010, F.A.C.

Other Standard *(specify):*

Two years experience with individuals who have mental illness and developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Specialized Mental Health Counseling

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

In accordance with Chapter 490, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Two years experience with individuals who have mental illness and developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Mental Health Counseling

Provider Category:

Individual

Provider Type:

Psychiatrist

Provider Qualifications

License *(specify):*

In accordance with Chapters 458 and 459, F.S.

Certificate *(specify):*

In accordance with rule 59G-1.010, F.A.C.

Other Standard *(specify):*

Two years experience with individuals who have mental illness and developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Mental Health Counseling

Provider Category:

Agency

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

In accordance with Chapter 490, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Two years experience with individuals who have mental illness and developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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

HCBS Taxonomy:

Category 1: 11 Other Health and Therapeutic Services

Sub-Category 1: 11100 speech, hearing, and language therapy

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Speech therapy is a service prescribed by a physician, ARNP, or physician assistant and produces specific functional outcomes in the communication skills of a recipient with a speech, hearing or language disability. The service may also include a speech therapy assessment, which does not require a physicians prescription. In addition, this service may include training and monitoring of direct care staff and caregivers, to ensure they are carrying out therapy goals correctly.

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

Speech Therapy services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is limited to individuals over age 21.

All medically necessary Speech Therapy services for children under the age of 21 are covered State Plan benefits. As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1915(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. Speech Therapy services covered by the waiver must not duplicate services provided by Medicaid State Plan Speech Therapy services.

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 Pathology Assistant
Agency	Audiologist
Individual	Speech-Language Pathologist
Agency	Home Health Agency
Individual	Audiology Assistant
Individual	Audiologist
Agency	Audiology Assistant
Agency	Speech-Language Pathologist
Agency	Speech-Language Pathology Assistant

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 Pathology Assistant

Provider Qualifications

License *(specify):*

In accordance with Chapter 468, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid 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:

Agency

Provider Type:

Audiologist

Provider Qualifications

License *(specify):*

In accordance with Chapter 455, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid 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):*

In accordance with Chapter 468, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid 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:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid 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:

Audiology Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In accordance with Chapter 468, F.S.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid 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:

Audiologist

Provider Qualifications

License *(specify):*

In accordance with Chapter 455, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid 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:

Agency

Provider Type:

Audiology Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In accordance with Chapter 468, F.S.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid 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:

Agency

Provider Type:

Speech-Language Pathologist

Provider Qualifications

License *(specify):*

In accordance with Chapter 468, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid 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:

Agency

Provider Type:

Speech-Language Pathology Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In accordance with Chapter 468, F.S.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Services are offered only to gain access to waiver services. 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 individual's plan of care. Whenever possible family, neighbors, friends, or community agencies, which can provide this service without charge, will be utilized.

Transportation services are provided to Waiver covered services and to Extended State Plan services covered in this waiver and authorized by the plan of care. Providers may not charge a copay under this waiver. The scope and nature of these services do not differ from services furnished under the state plan. The provider qualifications specified under the state plan apply. The additional amounts of services that may be provided through the waiver are determined by the enrollee's approved plan of care and prior authorizations received.

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

Transportation services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is limited to individuals over age 21.

All medically necessary Transportation services for children under the age of 21 are covered State Plan benefits. As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1915(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. Transportation services covered by the waiver must not duplicate services provided by Medicaid State Plan Transportation services.

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 automobile, 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):*

In accordance with Chapters 316 and 322, F.S.

Certificate *(specify):*

Other Standard *(specify):*

In accordance with Chapter 41-2, F.A.C.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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 automobile, wheelchair van, bus, taxi)

Provider Qualifications

License *(specify):*

In accordance with Chapter 322, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Group homes, residential facility or adult day training providers must comply with Chapter 427, F.S.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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 Analysis Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

These services are provided to assist a person to learn a new behavior, to increase an existing behavior, to reduce an existing behavior, or to emit behavior under precise environmental conditions. Behavior analysis includes the design, implementation and evaluation of systematic environmental modifications for the purpose of producing socially significant improvements and understanding of human behavior based on the principles of behavior identified through the experimental analysis of behavior. It includes the identification of functional relationships between behavior and environment. Contextual factors, establishing operations, antecedent stimuli, positive re-enforcers and other consequences are used based on identified functional relationships between behavior and environment in order to produce practical behavior change. Behavior analysis does not rely on cognitive therapies and expressly excludes psychological testing, neuro-psychology, psycho-therapy, sex therapy, psycho-analysis, hypnotherapy, and long-term counseling as treatment modalities. Training for parents, caregivers, and staff is also part of behavior analysis services when these persons are integral to the implementation or monitoring of a behavior analysis services plan. These services may be provided in the provider's office, the recipient's place of residence or anywhere in the community. However, in all cases, behavior analysis services must also be provided in the setting(s) relevant to the behavior problems being addressed.

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

Behavior Analysis Services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

Waiver services are limited to individuals over age 21.

All medically necessary Behavior Analysis services for children under the age of 21 are covered State Plan benefits. As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1915(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. Behavior Analysis services covered by the waiver must not duplicate services provided by Medicaid State Plan Behavior Analysis services.

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	Mental Health Counselor
Individual	Clinical Social Worker
Agency	Marriage and Family Therapist
Individual	Psychologist
Agency	Behavior Analyst
Agency	Psychologist
Individual	Marriage and Family Therapist
Agency	Clinical Social Worker
Individual	Behavior Analyst
Agency	Mental Health Counselor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Individual

Provider Type:

Mental Health Counselor

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Individual

Provider Type:

Clinical Social Worker

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Agency

Provider Type:

Marriage and Family Therapist

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

In accordance with Chapter 490, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Agency

Provider Type:

Behavior Analyst

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In accordance with Chapter 393, F.S.

Other Standard *(specify):*

Level 1: Board Certified Behavior Analyst; Florida Certified Behavior Analyst with expanded privileges; or a person licensed under Chapter 490 or 491, F.S., (Psychologist, School Psychologist, Clinical Social Worker, Marriage and Family Therapist or Mental Health Counselor) with more than three years of experience post certification or licensure.
Level 2: Board Certified Behavior Analyst; Florida Certified Behavior Analyst with expanded privileges; or a person licensed under Chapter 490 or 491, F.S., (Psychologist, School Psychologist, Clinical Social Worker, Marriage and Family Therapist or Mental Health Counselor), with less than three years of experience; or a Florida Certified Behavior Analyst with a Masters or Doctorate, regardless of experience.
Level 3: Board or Florida Certified Associate Behavior Analyst or a Florida Certified Behavior Analyst with bachelors or high school diploma, regardless of experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Agency

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

In accordance with Chapter 490, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Individual

Provider Type:

Marriage and Family Therapist

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Agency

Provider Type:

Clinical Social Worker

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Individual

Provider Type:

Behavior Analyst

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In accordance with Chapter 393, F.S.

Other Standard *(specify):*

Level 1: Board Certified Behavior Analyst; Florida Certified Behavior Analyst with expanded privileges; or a person licensed under Chapter 490 or 491, F.S., (Psychologist, School Psychologist, Clinical Social Worker, Marriage and Family Therapist or Mental Health Counselor) with more than three years of experience post certification or licensure.
Level 2: Board Certified Behavior Analyst; Florida Certified Behavior Analyst with expanded privileges; or a person licensed under Chapter 490 or 491, F.S., (Psychologist, School Psychologist, Clinical Social Worker, Marriage and Family Therapist or Mental Health Counselor), with less than three years of experience; or a Florida Certified Behavior Analyst with a Masters or Doctorate, regardless of experience.
Level 3: Board or Florida Certified Associate Behavior Analyst or a Florida Certified Behavior Analyst with bachelors or high school diploma, regardless of experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Agency

Provider Type:

Mental Health Counselor

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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 Assistant Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

These services are one-on-one activities related to the delivery of behavior analysis services and are designated in and required by a behavior analysis service plan. Activities include monitoring of behavior analysis services, the implementation of behavioral procedures, data collection and display as authorized by the consumer's behavior analysis service plan, and training for caregivers. Behavior assistant services are designed for recipients for whom traditional residential habilitation services have been documented as unsuccessful or are considered inappropriate for health or safety reasons. These services may be provided in the provider's office, the recipient's place of residence, or anywhere in the community. However, in all cases, behavior assistant services must also be provided in the setting(s) relevant to the behavior problems being addressed.

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

Behavior Assistant services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

Waiver services are limited to individuals over age 21.

All medically necessary Behavior Assistant services for children under the age of 21 are covered State Plan benefits. As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1915(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. Behavior Assistant services covered by the waiver must not duplicate services provided by Medicaid State Plan Behavior Assistant services.

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	Behavior Assistant
Individual	Behavior Assistant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Assistant Services

Provider Category:

Agency

Provider Type:

Behavior Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of this service must be age 18 and older, have a high school diploma or a GED and have at least:

1) Two years of experience providing direct services to recipients with developmental disabilities, or at least 120 hours of direct services to recipients with complex behavior problems and 90 classroom hours of instruction in applied behavior analysis; and 20 contact hours of instruction in a curriculum meeting the requirements specified by the APD central office and approved by the APD-designated behavior analyst. Instruction must include real-time visual and auditory contact with an individual having behavior problems (face-to-face or via electronic means) for initial certification. Certification by the Behavior Analyst Certification Board (BACB) as a Registered Behavior Technician may substitute for the requirements above.

2) At least eight hours of supplemental training in general behavior analysis skills for annual recertification, determined by the local regional office behavior analyst.

3) Training in an APD approved emergency procedure curriculum where providers will be working with recipients with significant behavioral challenges.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Assistant Services

Provider Category:

Individual

Provider Type:

Behavior Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of this service must be age 18 and older, have a high school diploma or a GED and have at least:

1) Two years of experience providing direct services to recipients with developmental disabilities, or at least 120 hours of direct services to recipients with complex behavior problems and 90 classroom hours of instruction in applied behavior analysis; and 20 contact hours of instruction in a curriculum meeting the requirements specified by the APD central office and approved by the APD-designated behavior analyst. For initial certification, role play, videotaped feedback or instructional videos demonstrating the skill being taught, must be included. Certification by the Behavior Analyst Certification Board (BACB) as a Registered Behavior Technician may substitute for the requirements above.

2) At least eight hours of supplemental training in general behavior analysis skills for annual recertification, determined by the local regional office behavior analyst.

3) Training in an APD approved emergency procedure curriculum where providers will be working with recipients with significant behavioral challenges.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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:

Dietitian Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11040 nutrition consultation
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Dietitian services are those services prescribed by a physician, ARNP, or physician assistant that maintain or improve the overall physical health of a recipient. The services include assessing the nutritional status and needs of a recipient; recommending an appropriate dietary regimen, nutrition support and nutrient intake; and providing counseling and education to the recipient, family, direct service staff and food service staff. The services may also include the development and oversight of nutritional care systems that promote a persons optimal health.

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

Dietitian services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is only provided to individuals aged 21 and over. All medically necessary services for children under the age of 21 are covered in the Early and Periodic Screening, Diagnostic, and Treatment State Plan benefits, under Section 383.011(1)(e)1, F.S.

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	Dietitian/Nutritionist Agency
Individual	Dietitian/Nutritionist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietitian Services

Provider Category:

Agency

Provider Type:

Dietitian/Nutritionist Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 468, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietitian Services

Provider Category:

Individual

Provider Type:

Dietitian/Nutritionist

Provider Qualifications

License *(specify):*

In accordance with Chapter 468, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Physical adaptations to the home, required by the individuals plan of care, which ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual 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 electronic and plumbing systems which are necessary to accommodate the medical equipment and supplies, which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home, which are of general utility, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

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

Environmental Accessibility Adaptations services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

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	Engineer
Individual	Contractor/Electrician
Agency	Plumbers
Agency	Architects
Agency	Engineers
Individual	Carpenters/other Independent Vendors
Individual	Architect
Individual	Plumber

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Engineer

Provider Qualifications

License *(specify):*

In accordance with Chapter 471, F.S.

Certificate *(specify):*

Other Standard *(specify):*

One year experience in Rehabilitation Engineering or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Contractor/Electrician

Provider Qualifications

License *(specify):*

In accordance with Chapter 489, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Plumbers

Provider Qualifications

License *(specify):*

In accordance with Chapter 553, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Architects

Provider Qualifications

License *(specify):*

In accordance with Chapter 481, F.S.

Certificate *(specify):*

Other Standard *(specify):*

One year experience in Rehabilitation Engineering or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Engineers

Provider Qualifications

License *(specify):*

In accordance with Chapter 471, F.S.

Certificate *(specify):*

Other Standard *(specify):*

One year experience in Rehabilitation Engineering or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Carpenters/other Independent Vendors

Provider Qualifications

License *(specify):*

In accordance with Chapter 205, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Architect

Provider Qualifications

License *(specify):*

In accordance with Chapter 481, F.S.

Certificate *(specify):*

Other Standard *(specify):*

One year experience in Rehabilitation Engineering or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Plumber

Provider Qualifications

License *(specify):*

In accordance with Chapter 553, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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:

Life Skills Development Level 1 - Companion

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

08 Home-Based Services | 08040 companion

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Life Skills Development Level 1 – Companion services consist of non-medical care, supervision, and socialization activities provided to recipients age 21 years or older. This service must be provided in direct relation to the achievement of the recipient's goals as specified in the recipient's support plan. The service provides access to community-based activities that cannot be provided by natural or other unpaid supports, and should be defined as activities most likely to result in increased ability to access community resources without paid support. These services can be scheduled on a regular, long-term basis.

Activities that a companion provider may support/assist an enrollee with can be volunteer activities performed by the recipient as a pre-work activity or activities that connect a recipient to the community.

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

Life Skills Development Level 1 – Companion services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is limited to individuals over age 21.

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	Agency Vendors

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Independent Vendors
Agency	Adult Day Training Center

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Development Level 1 - Companion

Provider Category:

Agency

Provider Type:

Agency Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Life Skills I: Providers and employees of agencies must be age 18 years or older, have a high school diploma or GED, and have at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing, or childcare setting or working with recipients who have a developmental disability. In lieu of the required work experience, providers and employees may have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Development Level 1 - Companion

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Life Skills I: Providers and employees of agencies must be age 18 years or older, have a high school diploma or GED, and have at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing, or childcare setting or working with recipients who have a developmental disability. In lieu of the required work experience, providers and employees may have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Development Level 1 - Companion

Provider Category:

Individual

Provider Type:

Independent Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Life Skills I: Providers and employees of agencies must be age 18 years or older, have a high school diploma or GED, and have at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing, or childcare setting or working with recipients who have a developmental disability. In lieu of the required work experience, providers and employees may have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Development Level 1 - Companion

Provider Category:

Agency

Provider Type:

Adult Day Training Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Director: Associates degree and two years of experience working with individuals with developmental disabilities.
Instructor/supervisor: High school or equivalent diploma and one year of experience in a related field.
Direct service: age 18 and older

Life Skills I: Providers and employees of agencies must be age 18 years or older, have a high school diploma or GED, and have at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing, or childcare setting or working with recipients who have a developmental disability. In lieu of the required work experience, providers and employees may have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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:

Life Skills Development Level 2 - Supported Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
03 Supported Employment	03022 ongoing supported employment, group
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supported employment services provide training and assistance to help support recipients in job development and sustaining paid employment at or above minimum wage unless the recipient is operating a small business. This service can be performed on a full or part-time basis and at a level of benefits paid by the employer for the same or similar work performed by trained non-disabled recipients. The provider assists with the acquisition, retention, or improvement of skills related to accessing and maintaining such employment, or developing and operating a small business. With the assistance of the provider, the recipient receives help in securing employment according to the recipient's knowledge, skills, abilities, supports needed, desired goals, and planned outcomes. This service is conducted in a variety of settings, including work sites in which individuals without disabilities are employed. This service should include assisting a recipient to learn job tasks needed to be employed, and the recipient should be included in all aspects of job development, interviewing, and job seeking activities.

Supported employment services include three models: Individual, Group, and Supported Self-Employment.

Supported Employment is provided to support, obtain and maintain competitive or customized employment in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

The enrollee's person-centered support plan and authorization records must include documentation related to Supported Employment and document if the service is not available through a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.)

Federal financial participation may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

Transportation is not a component of this service. Non-emergency transportation is a covered waiver 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 services must be authorized in the enrollee's person-centered support plan.

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

Life Skills Development Level 2 - Supported Employment services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

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	Agency Providers
Individual	Individual Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Development Level 2 - Supported Employment

Provider Category:

Agency

Provider Type:

Agency Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Level 2: completion of required pre-service training.

Other Standard *(specify):*

Providers of supported employment services must meet one or more of the following requirements:
* Have a bachelor's degree from an accredited college or university with a major in education, rehabilitative science, business or a related degree.
* Have an associate's degree or two years of college from an accredited college or university and have two years of documented direct experience with recipients with developmental disabilities.
* Have one year of college from an accredited college or university and three years of documented direct experience in working with recipients with developmental disabilities.
* Four years of direct professional experience in working with recipients with developmental disabilities may substitute for college on a year for year basis.

The provider must hold a valid high school diploma or GED diploma.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Development Level 2 - Supported Employment

Provider Category:

Individual

Provider Type:

Individual Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Level 2: completion of required pre-service training.

Other Standard *(specify):*

Providers of supported employment services must meet one or more of the following requirements:
* Have a bachelor's degree from an accredited college or university with a major in education, rehabilitative science, business or a related degree.
* Have an associate's degree or two years of college from an accredited college or university and have two years of documented direct experience with recipients with developmental disabilities.
* Have one year of college from an accredited college or university and three years of documented direct experience in working with recipients with developmental disabilities.
* Four years of direct professional experience in working with recipients with developmental disabilities may substitute for college on a year for year basis.

The provider must hold a valid high school diploma or GED diploma.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

An electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the persons phone and programmed to signal a response center once a help button is activated. The response center is staffed by trained professionals.

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

Personal Emergency Response System services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

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	Electrical or alarm system contractors
Individual	Independent vendor (discount or home improvement stores)
Agency	Contract agencies for Community Care for the Elderly Program
Agency	Hospitals
Agency	Contract agencies for the Community Care for Disabled Adults Program

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Electrical or alarm system contractors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In accordance with Chapter 489, F.S.

Other Standard *(specify):*

Must provide a bond, letter of credit, or other collateral.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Individual

Provider Type:

Independent vendor (discount or home improvement stores)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In accordance with Chapter 205, F.S.

Other Standard *(specify):*

Freestanding equipment may also be purchased from independent vendors, such as discount or home improvement stores, but these vendors may not provide monitoring.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Contract agencies for Community Care for the Elderly Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Authorized by Chapter 430, F.S.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Hospitals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In accordance with Chapter 395, F.S.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Contract agencies for the Community Care for Disabled Adults Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Authorized by Chapter 410, F.S.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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 Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08020 home health aide
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Personal Supports services provides assistance and/or training to the recipient in activities of daily living to include the areas of eating, bathing, dressing, personal hygiene, and preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include housekeeping chores such as bed making, dusting and vacuuming and assistance to do laundry, shopping, and cooking which are incidental to the care furnished, or which are essential to the health and welfare of the recipient. Services include non-medical care, supervision and socialization activities provided to an adult on an one-to-one basis or in groups not to exceed three recipients.

Personal supports for individuals in the family home are limited to adults 21 years or older. Personal supports can be provided to recipients age 18 years or older who are in a supported living situation or living in their own home.

Training and continuing education requirements for Personal Supports providers are governed by the Developmental Disabilities Individual Budgeting (iBudget) Waiver Handbook, Rule 59G-13.070, F.A.C. A listing of qualified Personal Supports providers is available to all stakeholders on the APD website. The Contracted Vendor regularly monitors Personal Supports providers for compliance with state policies, as detailed in this waiver.

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

Personal supports services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

All medically necessary Personal Supports services for children under the age of 21 are covered State Plan benefits. As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1915(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. Personal Supports services covered by the waiver must not duplicate services provided by Medicaid State Plan Personal Supports services.

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	Hospice Agency
Individual	Independent Vendor
Individual	Registered Nurse
Agency	Foster Home
Agency	Licensed Practical Nurse Agency
Individual	Licensed Practical Nurse
Agency	Registered Nurse Agency
Agency	Group Home
Individual	Nurse Registry
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Providers and employees of agencies must be age 18 years or older, have a high school diploma or GED, and have at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing, or childcare setting or working with recipients who have a developmental disability. In lieu of the required work experience, providers and employees may have or have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Solo providers must have a high school diploma or a GED and at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing or child care setting or working with recipients who have a developmental disability In lieu of the required work experience, providers and employees may have or have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Hospice Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Providers and employees of agencies must be age 18 years or older, have a high school diploma or GED, and have at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing, or childcare setting or working with recipients who have a developmental disability. In lieu of the required work experience, providers and employees may have or have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Solo providers must have a high school diploma or a GED and at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing or child care setting or working with recipients who have a developmental disability In lieu of the required work experience, providers and employees may have or have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Independent Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers and employees of agencies must be age 18 years or older, have a high school diploma or GED, and have at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing, or childcare setting or working with recipients who have a developmental disability. In lieu of the required work experience, providers and employees may have or have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Solo providers must have a high school diploma or a GED and at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing or child care setting or working with recipients who have a developmental disability In lieu of the required work experience, providers and employees may have or have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Foster Home

Provider Qualifications

License *(specify):*

In accordance with Chapter 393, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Providers and employees of agencies must be age 18 years or older, have a high school diploma or GED, and have at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing, or childcare setting or working with recipients who have a developmental disability. In lieu of the required work experience, providers and employees may have or have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Solo providers must have a high school diploma or a GED and at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing or child care setting or working with recipients who have a developmental disability In lieu of the required work experience, providers and employees may have or have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Licensed Practical Nurse Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Registered Nurse Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License *(specify):*

In accordance with Chapter 393, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Providers and employees of agencies must be age 18 years or older, have a high school diploma or GED, and have at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing, or childcare setting or working with recipients who have a developmental disability. In lieu of the required work experience, providers and employees may have or have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Solo providers must have a high school diploma or a GED and at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing or child care setting or working with recipients who have a developmental disability In lieu of the required work experience, providers and employees may have or have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Nurse Registry

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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:

Private Duty Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Individual and continuous care (in contrast to part time or intermitted care) provided by licensed nurses within the scope of State law. These services are provided to an individual in their own home or family home or while the individual is in the community.

Private duty nursing services are prescribed by a physician, ARNP, or physician assistant and consist of individual, continuous nursing care provided by registered or licensed practical nurses.

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

Private duty nursing services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is limited to individuals over age 21.

All medically necessary Private Duty Nursing services for children under the age of 21 are covered State Plan benefits. As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1915(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. Private Duty Nursing services covered by the waiver must not duplicate services provided by Medicaid State Plan Private Duty Nursing services.

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	Licensed Practical Nurse Agency
Agency	Home Health Agency
Individual	Nurse Registry
Individual	Registered Nurse
Agency	Registered Nurse Agency
Individual	Licensed Practical Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Licensed Practical Nurse Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

In accordance with 42 CFR 484.

Other Standard *(specify):*

Enrolled in the Medical Home Health Program.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Individual

Provider Type:

Nurse Registry

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Registered Nurse Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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:

Residential Nursing

HCBS Taxonomy:

Category 1: 05 Nursing

Sub-Category 1: 05010 private duty nursing

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Residential nursing services are services prescribed by a physician ARNP, or physician assistant and consist of continuous nursing care provided by registered or licensed practical nurses, in accordance with Chapter 464, F.S., and within the scope of Florida's Nurse Practice Act, for recipients who require ongoing nursing intervention in a licensed residential facility, group or foster home.

This waiver service is only provided to individuals aged 21 and over. All medically necessary services for children under the age of 21 are covered in the Early and Periodic Screening, Diagnostic, and Treatment State Plan benefits, under Section 383.011(1)(e)1, F.S.

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

Residential nursing services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

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
Agency	Group Home
Individual	Licensed Practical Nurse
Agency	Assisted Living Facility

Provider Category	Provider Type Title
Agency	Licensed Practical Nurse Agency
Agency	Registered Nurse Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License *(specify):*

In accordance with Chapter 393, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:

Agency

Provider Type:

Licensed Practical Nurse Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:

Agency

Provider Type:

Registered Nurse Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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:

Specialized Medical Home Care

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialized medical home care services are for a period of up to 24-hours-a-day and include nursing services and medical supervision provided to residents of a licensed foster or group home that serves recipients with complex medical conditions. The group home must maintain a staffing ratio of one nurse to every three recipients in the home who require close nursing supervision.

This waiver service is only provided to individuals aged 21 and over. All medically necessary services for children under the age of 21 are covered in the Early and Periodic Screening, Diagnostic, and Treatment State Plan benefits, under Section 383.011(1)(e)1, F.S.

Specialized Medical Home Care services are provided to enrollees with complex medical conditions requiring an intensive level of nursing care residing in a foster or group home. This can include recipients who are ventilator dependent, require tracheostomy care, or have a need for deep suctioning to maintain optimal health.

The service is provided for up to 24 hours per day and includes nursing services and medical supervision for all individuals residing in the home. The foster or group home must have APD state office authorization and must maintain appropriate and sufficient staffing at all times to meet the intensive needs of all recipients residing in the home. The rate for Specialized Medical Home Care is considered to be an inclusive rate for nursing, medical supervision, and residential habilitation. These services cannot be billed independently when billing for Specialized Medical Home Care. The rate for Specialized Medical Home Care does not include other wellness and therapeutic support services.

All direct service professionals providing iBudget 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:

Specialized Medical Home Care services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

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	Registered Nurse Agency
Agency	Group Home
Agency	Licensed Practical Nurse Agency
Individual	Licensed Practical Nurse
Agency	Certified Nurses Aide
Individual	Registered Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Home Care

Provider Category:

Agency

Provider Type:

Registered Nurse Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Home Care

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License *(specify):*

In accordance with Chapter 393, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Home Care

Provider Category:

Agency

Provider Type:

Licensed Practical Nurse Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Home Care

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Home Care

Provider Category:

Agency

Provider Type:

Certified Nurses Aide

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In accordance with Chapter 464, F.S.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Home Care

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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:

Supported Living Coaching

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08010 home-based habilitation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supported living coaching services provide training and assistance, in a variety of activities, to support recipients who live in their own homes or apartments. These services may include assistance with locating appropriate housing; the acquisition, retention or improvement of skills related to activities of daily living such as personal hygiene and grooming; household chores; meal preparation; shopping; personal finances and the social and adaptive skills necessary to enable recipients to reside on their own.

Supported living coaching services, including the housing procurement component, are not to be provided during the same period of time as residential habilitation services or when the recipient is living in the family home, except for the 90 days prior to the recipient moving into the supported living setting.

Transportation is not a component of this service. Non-emergency transportation is a covered waiver 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 services must be authorized in the enrollee's person-centered support plan.

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

Supported Living Coaching services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

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	Agency Vendors
Individual	Independent Vendors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living Coaching

Provider Category:

Agency

Provider Type:

Agency Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must be age 18 and older and shall have one of the following:
• A bachelor's degree from an accredited college or university with a major in education, rehabilitative science, business or a related degree.
• An associate's degree or two years of college from an accredited college or university and have two years of documented direct experience with recipients with developmental disabilities.
• One year of college from an accredited college or university and three years of documented direct experience in working with recipients with developmental disabilities.
• Four years of direct professional experience in working with recipients with developmental disabilities may substitute for college on a year for year basis. The provider must hold a high school or GED diploma.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living Coaching

Provider Category:

Individual

Provider Type:

Independent Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must be age 18 and shall have one of the following:
• A bachelor's degree from an accredited college or university with a major in education, rehabilitative science, business or a related degree.
• An associate's degree or two years of college from an accredited college or university and have two years of documented direct experience with recipients with developmental disabilities.
• One year of college from an accredited college or university and three years of documented direct experience in working with recipients with developmental disabilities.
• Four years of direct professional experience in working with recipients with developmental disabilities may substitute for college on a year for year basis. The provider must hold a high school or GED diploma.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

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.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *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:

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):

Staff of all waiver provider types must undergo a criminal history and/or background investigation prior to becoming a Medicaid provider. These applications are sent from APD to AHCA for processing through the Florida Department of Law Enforcement. Processing with the Florida Department of Law Enforcement includes a national background investigation.

The following State of Florida rules apply:
Florida Statute 393.0655 - Screening of direct service providers.
MINIMUM STANDARDS. The agency shall require level 2 employment screening pursuant to chapter 435 for direct service providers who are unrelated to their clients, including support coordinators, and managers and supervisors of residential facilities or adult day training programs licensed under this chapter and any other person, including volunteers, who provide care or services, who have access to a client's living areas, or who have access to a client's funds or personal property. Background screening shall include employment history checks as provided in s. 435.03(1) and local criminal records checks through local law enforcement agencies.

a. A volunteer who assists on an intermittent basis for less than 10 hours per month does not have to be screened if a person who meets the screening requirement of this section is always present and has the volunteer within his or her line of sight.

b. Licensed physicians, nurses, or other professionals licensed and regulated by the Florida Department of Health are not subject to background screening pursuant to this section if they are providing a service that is within their scope of licensed practice.

c. A person selected by the family or the individual with developmental disabilities and paid by the family or the individual to provide supports or services is not required to have a background screening under this section.

d. Persons 12 years of age or older, including family members, residing with a direct services provider who provides services to clients in his or her own place of residence are subject to background screening; however, such persons who are 12 to 18 years of age shall be screened for delinquency records only.

All providers are mandated to maintain current background investigation evidence in each personnel file pursuant to Section 393.0655 & Section 435.04 Florida Statutes. This evidence is required to show appropriate clearance according to the Florida law screening requirements and the Medicaid Provider Handbooks.

The evidence of screening is reviewed by the operating agency for all providers at least annually, with any discrepancies being required to be remediated within seven business days, and staff without appropriate clearance removed from participant contact immediately until clearance is obtained. The regional offices of the operating agency retain copies of clearance documentation submitted during the application process as provided by the Florida Department of Children and Families.

Additionally, the CV, as described in Appendix G-3-b-ii; State Oversight and Follow-up, reviews all screening information for staff as part of the Provider Discovery Review process.

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)

Note: Required information from this page is contained in response to C-5.

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.*

☐ **Self-directed**

☐ **Agency-operated**

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:

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:

APD will operate two open enrollment periods each year for qualified provider applicants of services furnished under the iBudget waiver. However, if critical needs exist for a specific provider type, APD will offer enrollment outside of the established periods.

Information pertinent to provider enrollment will be available online continuously to facilitate the recruitment of qualified providers. The information will detail provider requirements, required training, instructions on how to apply for enrollment, and the enrollment forms. APD Regional Office contact information will be available online for potential providers needing additional assistance regarding provider enrollment. Providers will apply directly to the State Operating Agency who verifies initial provider qualifications prior to the applicant submitting an application directly to the State Medicaid Agency.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by 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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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:
(C-2) Percentage of DOH licensed providers continually determined to meet minimum licensure and/or certification requirements as detailed in F.A.C. N: Number of DOH licensed providers continually determined to meet minimum licensure and/or certification requirements as detailed in F.A.C. D: Number of DOH-licensed and/or certified providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Florida DOH Licensing and Regulation website

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

		100% during the Medicaid Waiver Provider Agreement renewal process, which occurs every five years
	☒ **Other** Specify: During the Medicaid Waiver Provider Agreement renewal process	

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: During the Medicaid Waiver Provider Agreement renewal process

Performance Measure:
(C-1)Percentage of Florida Department of Health (DOH) licensed providers initially determined to meet minimum licensure and/or certification requirements as detailed in F.A.C. N: # of DOH licensed providers initially determined to meet minimum licensure and/or certification requirements as detailed in F.A.C. D: # of new DOH-licensed and/or certified provider applicants in the iBudget Waiver.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Florida DOH Licensing and Regulation website

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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:
(C-4) Percentage of non-licensed and non-certified (enrolled) providers who continually meet state enrollment requirements as detailed in the F.A.C. N: Total number of non-licensed and non-certified providers who continually meet state enrollment requirements. D: Number of non-licensed and non-certified provider applicants reviewed.

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

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:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: 100% during the Medicaid Waiver Provider Agreement renewal process, which occurs every five years
	☒ **Other** Specify: During the Medicaid Waiver Provider Agreement renewal process	

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Other** Specify: During the Medicaid Waiver Provider Agreement renewal process

Performance Measure:
(C-3) Percentage of non-licensed and non-certified (enrolled) providers initially determined to meet state enrollment requirements as detailed in F.A.C. N: Number of non-licensed/non-certified providers who initially meet state enrollment requirements. D: Total number of new non-licensed/non-certified providers.

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

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: During initial enrollment process	

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:

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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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:
(C-5) % of providers whose staff received training in an agency approved curriculum for behavioral emergency procedures consistent with the requirements of the Reactive Strategies rule. N: # of providers whose staff received training in an agency approved curriculum for behavioral emergency procedures consistent with the requirements of the Reactive Strategies rule. D: Total # of providers.

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: Contracted Vendor	☐ **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**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify: Contracted Vendor	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(C-6) Percentage of providers with service specific staff training requirements met. N: Total number of providers with service specific staff training requirements met. D: Total number of providers 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: Contracted Vendor	☐ **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: Contracted Vendor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 has adopted a quality assurance strategy that mirrors the CMS Quality Framework. The Discovery function is a universal responsibility, but the bulk of the work is done by the CV, utilizing a statistically valid sampling methodology for individual single case bore analysis and a traditional provider compliance process which engages service providers annually. The Remediation function is handled by APD, which receives discovery material from the CV in near real time. The CV issues immediate alerts upon discovery of health and safety violations or concerns to APD. APD responds with immediacy to alerts; they primarily respond to less urgent matters using a universal Remediation Plan, which is a detailed action plan specifying the corrective action required of the provider and the timeframes for completion. APD utilizes the quality team approach to review a variety of data including that supplied in trend form from the CV and other data sources such as incident and abuse reports. The function of this group is to analyze the data and identify and prioritize appropriate improvements to make ongoing systemic changes.

APD also uses the National Core Indicators to gather additional information concerning recipients' ability to choose services and providers. This allows for longitudinal trend analysis.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

(C-1) On an initial basis, the Operating Agency validates provider applications have been submitted with documented proof of meeting the licensure and/or certification requirements stipulated in F.A.C. for services (dental, nursing, and therapies) the applicant wishes to render through the iBudget Waiver. The provider enrollment process does not allow an application to be processed unless all required documents are present. If an applicant fails to provide proof of having a current licensure and/or certification, the application is denied or closed.

(C-2) On a continuous and ongoing basis, the Operating Agency validates providers have submitted documented proof of meeting the licensure and/or certification requirements stipulated in F.A.C. for services (dental, nursing, and therapies) the providers render through the iBudget Waiver. During the provider renewal process, all required documents must be present to process the renewal application. If a provider fails to provide proof of all required documents, the provider application is not renewed.

(C-3) On an initial basis, the Operating Agency validates provider applications have been submitted with documented proof of meeting the provider requirements stipulated in the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook prior to rendering services through the iBudget Waiver.

(C-4) On a continuous and ongoing basis, the Operating Agency validates the provider continues to meet the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook for services the applicant wishes to render through the iBudget Waiver. During the provider renewal process, all required documents must be present to process the renewal application. If a provider fails to provide proof of meeting the minimum requirements (i.e., education, background screening, training, experience), the application is not renewed.

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:

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.

These discovery activities are a component of the current CV. Alerts on issues for remediation are being generated by the CV and sent to APD. APD responds as appropriate given the nature of the issue. APD is in the process of competitively procuring its centralized database for collecting remediation data; all remediation activities will be entered, tracked, and trended to ensure that all issues requiring remediation are brought into compliance within state required time frames. Until that time, APD will be required to track remediation activities using standardized Excel templates and submit data on remediation to the State Medicaid Agency for remediation data aggregation purposes.

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.

This waiver provides each recipient a prospective individual budget amount. Additional funding will be provided for recipients whose needs are so extraordinary that the use of this approach is inappropriate or who experience one-time needs or changes in needs that cannot be accommodated within the individual budget. The algorithm and methodology will determine the budget for all of a recipient's waiver services. The recipient may not exceed this budget amount for paid waiver services.

The algorithm was developed by a Ph.D.-level statistician with stakeholder input using multiple regression techniques to equitably distribute available funds based on historical funding patterns. The algorithm considers individual recipient characteristics, which are statistically proven to correlate with costs, and generates a budget amount for each person prior to the support planning process. The data used in the algorithm is reliable and valid, and its sources include the client database and the agency-approved needs assessment instrument. Factors considered by the algorithm include age, living setting, and results from APD's needs assessment instrument. The weight of these factors in the algorithm is based on the nature of their relationship with the historical costs for individuals enrolled in the Developmental Disabilities Individual Budgeting Waiver; those with the greatest relationship to costs have the most weight in the algorithm.

The methodology for determining an individual budget is open for public inspection in several ways. Prior to finalizing the methodology for determining an individual budget, APD convened a formal workgroup comprised of representatives from key stakeholder groups, including self-advocates, families with loved ones receiving waiver services, those in pre-enrollment, waiver support coordinators, independent waiver support coordinators, and other members from the public. In addition, the specific criteria for determining the individual budget amount is provided in Florida Administrative Code. All state rules are published online and subject to public input during the rule promulgation process.

APD determines each recipient's budget amount using the funding formula and algorithm. Some recipients have extraordinary needs that do not fit a formula. Also, all recipients are subject to unplanned, temporary service needs and changes in their personal circumstances that require reexamination of their budget. A change may be temporary or permanent. It may require a one-time expenditure or a permanent budget adjustment. Accordingly, this waiver makes provision for these needs through reserving a portion of APD's overall budget to meet them. The APD may approve an increase to the amount determined by the funding formula prior to notifying the recipient of their budget amount, or recipients may apply to access these additional funds.

If service needs increase beyond the maximum annual dollar amount assigned to a recipient or if there is a documented change in circumstance, the recipient will be evaluated using the APD approved assessment and other processes for a potential increase in the budget amount.

Recipients will receive an evaluation using the APD approved assessment. The results of the assessment, along with other information required by the algorithm, will be used to determine the recipient's budget amount. All recipients will receive written notification of the maximum annual dollar amount assigned to that recipient. Recipients will also receive written notice with instructions should they wish to request a fair hearing regarding the determination.

The algorithm is set forth in Rule 65G-4.0214, F.A.C. It does not reference geographic differences, nor does it build in cost-of-living increases or an inflation factor. Changes in circumstances specified in the algorithm would impact an individual's budget amount, in addition to criteria specified as significant additional needs, referenced 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 C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Agency and APD (operating agency) worked together to review the HCBS Settings Rule (rule) and develop the process, procedures, and tools for determining compliance with the rule's requirements. The partner agencies conducted an assessment of Florida's laws, rules, regulations, standards, and policies to determine whether the State's requirements are consistent with the HCB Settings Rule. The State selected the following HCB Settings Rule criteria to determine whether the statutes and regulations were in compliance.

1. The setting is integrated in and supports full access of the individual receiving Medicaid HCBS to the greater community to the same degree of access as individuals not receiving Medicaid HCBS.
2. Opportunities to seek employment and work in competitive integrated settings.
3. Opportunities to engage in community life.
4. Opportunities to control personal resources.
5. The right to select from among various setting options, including non-disability specific settings.
6. The individual's personal rights of privacy, dignity and respect and freedom from coercion and restraint.
7. The optimization of autonomy and independence in making life choices, including daily activities, physical environment and with whom to interact.
8. Choice regarding services and supports and who provides them.
9. A legally enforceable written agreement between the provider and the consumer that allows the consumer to own, rent or occupy the residence and provides protections that address eviction processes, comparable to those provided under the jurisdiction's landlord-tenant law.
10. Privacy in the sleeping or living units that includes the entrance having lockable doors, with only appropriate staff having keys to doors.
11. An option for a private unit and a choice of roommates in semi-private units.
12. Freedom to furnish and decorate sleeping or living units.
13. Freedom and support to control schedules and activities, including access to food at any time.
14. Access to visitors at any time.
15. A physically accessible setting.
16. Locations that have qualities of institutional settings, including: settings that are located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment; settings that are in a building located on the grounds of, or immediately adjacent to, a public institution; and any other settings that have the effect of isolating individuals receiving Medicaid home and community-based services (HCBS) from the broader community of individuals not receiving Medicaid HCBS.
17. Home and community-based settings do not include the following: a nursing facility, institution for mental diseases; an intermediate care facility for individuals with intellectual disabilities; a hospital.
18. The settings options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and for residential settings, resources available for room and board.
19. Any modifications of the additional conditions under 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan (including the 8 requirements that must be documented in the PCSP).

The HCBS settings' tools were designed to allow providers and State assessors to review each setting for the standards set forth by CMS. The tools were made available for public comment prior to implementation. Tools are divided into the following sections; each section contains a number of standards settings must meet:

- Residential
  - Section 1: Setting
  - Section 2: Room/Privacy
  - Section 3: Meals
  - Section 4: Activities/Community Integration
  - Section 5: Respect/Rights/Choices
  - Section 6: Other
- Non-Residential
  - Section 1: Community Integration
  - Section 2: Respect/Rights/Choices
  - Section 3: Employment

Trainings have been posted on the Agency's website, and updated Residential and Non-Residential tools will be posted on the Agency's website. The Agency will use the HCB Characteristics sections within the assessment tools to address each aspect of the HCB Settings Rule to ensure ongoing compliance. The tools will continue to be reviewed and amended based on direct guidance from CMS as well as lessons learned and monitoring outcomes to ensure their ongoing efficacy, and applicability to the rule. The State ensures compliance via onsite reviews.

- The following are all the residential settings in the waiver: Assisted Living Facilities, Adult Family Care Homes, and Group Homes/Foster Care Homes.
- The following are all the non-residential settings in the waiver: Adult Day Training Centers and Prevocational Centers.

All settings receiving Florida Medicaid reimbursement for HCBS are required to adhere to the requirements established in the State's HCB settings Rule, Rule 59G-13.075, Florida Administrative Code (F.A.C.) in order to continue to receive reimbursement for HCBS provided after March 17, 2023. The rule became effective on December 25, 2018. The State's HCBS rule is available at https://www.flrules.org/gateway/ruleno.asp?id=59G-13.075

Based on the assessment, HCB settings are categorized as one of the following: fully compliant with the HCB Settings Rule; will be compliant with remediation; will not comply with the HCB Settings Rule; or presumptively institutional. If the HCB setting is non-compliant with the rule, APD must impose remediations and track the HCB setting provider's activities until completion. Settings must be compliant with the rule before providing services to any iBudget enrollee and receiving any Medicaid funding. If the HCB setting is determined to be presumptively institutional, APD must visit those settings in-person or virtually to gather additional information to determine whether the setting is compliant with the HCBS Settings rule. APD must submit the evidentiary package, including the full provider compliance assessment package with supporting documentation to the Agency. The Agency reviews the evidentiary packets submitted by APD to determine if the setting is presumptively institutional. The Agency assures that all HCBS settings have been assessed and are compliant with the HCBS settings rules before they serve the waiver recipients. APD assesses settings to determine if they have the effect of isolating recipients from the broader community. If the State determines these settings to be presumptively institutional, then the State will submit a request to CMS for a Heightened Scrutiny review.

The State also monitors changes to state laws, rules, regulations, standards, and policy each year. The Agency will update any rules, tools, trainings, and communications based on CMS direction and HCB setting rule updates. APD will continue ongoing monitoring of all settings for compliance through the recredentialing process. APD confirms that reassessments will be completed on a three-year basis from the previous determination. APD will ensure reassessments are conducted for those assessments that have exceeded the three-year time period within the next 12 months. The Agency ensures that the settings are not being isolated from the community and encourage not only community involvement but also afford access to receive Medicaid services in the community, and access to community activities such as shopping, restaurants, religious institutions, senior centers, etc. The iBudget recipients have designated waiver support coordinators to review all services that are requested and approved according to their specific waiver process and documented in each waiver recipient's person-centered service plan. Any modifications of the additional conditions, under 42 C.F.R. 443.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan and will include the requirements outlined at ss 443.301(c)(4)(VI)(F)(1) through (8). APD also conducts on-going monitoring to ensure the recipient has the continued opportunity to be active in the community, reside in a home-like environment, and make personal choices.

The State has determined the waiver recipients who live in private homes of their own or the home of their family member are in compliance with the HCB setting Final Rule, per SMD 19-001. Individual, privately-owned homes (privately owned or rented home and apartments in which the individual receiving Medicaid-funded HCBS lives independently or with family member, friends, or roommates) are presumed to be in compliance with the regulatory criteria of the HCB setting Final Rule. Each waiver recipient has a Waiver Support Coordinator (WSC) to ensure services are being provided and each waiver recipient has access to the community at large. APD is responsible for ongoing monitoring for HCB settings compliance. APD requires waiver support coordinators to make face-to-face visits with each enrollee periodically. At these meetings, the WSC reviews the person-centered service plan and reviews for community isolation. The person-centered service plan occurs at least annually and ongoing as needed in accordance with 42 CFR 441.301. For recipients living in their own home receiving Supported Living Coaching services or Personal Supports, there must be a face-to-face visit monthly, with the contact occurring in the recipient's home quarterly. For recipients living in the family home (Full Support Coordination), there must be a face-to-face visit quarterly, with the contact occurring at the residence semiannually. For recipients living in the family home (Limited Support Coordination), there must be a face-to-face visit semi-annually, with the contact occurring at the residence annually. WSCs must be available and accessible to the recipients receiving services on a 24-hour-per-day, 7-day-per-week basis for Full Support Coordination, and for emergencies in the case of Limited Support Coordination. Additionally, the State's contracted vendor conducts person-centered reviews for a sample of the iBudget population, where recipients are asked questions about various topics, including community integration.

The State will address any areas of non-compliance identified as of March 17, 2023, through a corrective action plan with CMS.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Waiver Support Plan

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:*

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.

The support coordinator conducts activities that assist the recipient in determining his or her own future. At least one time annually during the support planning meeting, the support coordinator assists the recipient, family or guardian, or primary caregiver, to:

-Identify the recipient's desired outcomes, personal goals and needs, and the supports necessary to achieve or meet them.
-Complete the support plan and cost plan, including signatures of those present during the meeting, and recipient/guardian signature.
-Complete the Waiver Eligibility Worksheet, which documents the individual's categorical and functional eligibility for the waiver and documents their choice between the waiver and an institutional placement.

Before the initial support plan meeting, the support coordinator is required to have a face-to-face visit with the recipient and his or her family or guardian to discuss all areas of the waiver, including who will participate in the decision-making process for supports and services. The support coordinator provides a written summary of the waiver program and services prior to the initial face-to-face visit. The support coordinator also shares with the recipient and his or her family other resources useful in identifying and selecting services and supports, such as the internet Web site of the CV and other listings of community supports. A person-centered planning process is utilized in helping the consumer to identify and develop their support plan.

The support plan is valid for one year. Prior to the expiration of the plan, the support coordinator discusses with the recipient the purpose of the planning process and provides a summary of the past year's plan and services. The recipient is asked to identify changes to the goals or services received and a discussion of changes of providers if needed. The meeting is planned based on the recipient's preferences for the dates and times of the meeting. In addition, the support coordinator discusses who the recipient would like to invite to the meeting, including providers, family members, and friends. The support coordinator notifies invitees of the recipient's choice of the time, place, and date of the meeting.

It is the responsibility of the support coordinator to, at least annually, and more frequently if indicated, provide recipients receiving adult day training or prevocational services information about competitive employment opportunities available in their community. Further, the support coordinator provides appropriate referral of the recipient to other sources of employment support such as vocational rehabilitation. The purpose of this requirement is to ensure that the recipient can make an informed, meaningful decision about the type of day activity or employment opportunity of his or her choice.

On a regular and ongoing basis, the support coordinator will provide necessary technical assistance and oversight of the recipient's individual budget to assure there is adequate funding remaining in the budget to meet needs for the cost plan year and to assist the recipient in making adjustments to frequency, intensity, and duration of services.

The support coordinator must be available to meet the recipient's needs and to perform the responsibilities for support coordination services. The support coordinator must have an on-call system approved by the APD so that recipients can reach their support coordinators when needed. For those individuals who receive limited support coordination, the on-call system will be defined by the recipient and their family. Any time a back-up support coordinator is used during the provider's absence, the back-up support coordinator must be a certified and enrolled support coordinator. The name and contact information for the back-up support coordinator must be clearly communicated to the individual receiving services and to the APD office. Telephone access to the provider or back up support coordinator must be toll-free.

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):

Prior to the support plan development, the Questionaire for Situational Information (QSI) assessment instrument is completed by APD staff that are trained and certified in its administration. The assessment includes items in the areas of functional, behavioral, and physical status. The assessment instrument is updated as needed and is re-administered every three years. The support plan development process includes a wide range of information from the recipient, family, other loved ones, and service providers. The QSI identifies needs in the areas of functional, behavioral, and physical (health). This needs assessment provides information to the waiver support coordinator regarding the health care needs of the recipient. Additionally, the waiver support coordinator gathers information from the recipient and from providers, including physicians, to ensure the health needs of the recipient are addressed.

For new enrollees to the waiver, once the recipient's individual budget has been established, the recipient and the support coordinator begin the support planning process approximately thirty (30) days before the beginning of the support plan year. The cost plan is developed on a fiscal year basis. The support plan will be developed every 12 months using the current individual budget. The support coordinator reviews the assessment instrument for valuable information about the person's need for support and may also review assessments from other sources such as the school system, Vocational Rehabilitation, or a certified behavior analyst to assure that the plan will address any emerging needs not previously addressed. The support coordinator also reviews annual reports of progress, needs and preferences, and activities from all providers who served the recipient in the previous year. Once these documents have been reviewed, the recipient is consulted about his or her preferences regarding who will participate in the support planning meeting and when and where it will be held.

The support plan process is intended to be person-centered in that it is directed and controlled by the recipient. Prior to the meeting, the support coordinator will, through conversations with the recipient, determine who the recipient wants to invite to the meeting, and determine a date, time, and location. During the meeting, the support coordinator records the information gathered in the recipient's own words for development of the plan. The recipient, with input from those invited to participate, discusses the recipient's needs, personally-determined goals and preferences, and potential services that are desired to help meet needs and achieve goals. The recipient will know the amount of funding available to meet his or her needs based on his or her previously-established individual budget. Prior to or during the support plan meeting, the support coordinator will assist the recipient and his or her family in identifying family, neighborhood, and community supports funded by private, city, and county resources prior to seeking services available through federal and state resources. The support coordinator will also assist the recipient in accessing Medicaid State Plan services prior to seeking services funded by the waiver. When non-waiver services must be purchased by either APD or the recipient or his or her family, the support coordinator will work cooperatively with APD to locate service providers who meet the needs of the recipient in the most cost-effective manner possible. So that the recipient has the information necessary to make decisions about services needed, the support coordinator will thoroughly discuss the service families that contain the specific services he has selected for the coming year. The party or entity responsible for each goal and need are identified and documented for inclusion on the support plan form. The support plan and the cost plan will identify the services to be provided and the responsibility for the tasks associated with each goal implementation. The support coordinator, through regular contacts with the recipient and services providers, monitors the implementation and progress toward achieving the recipient's individually determined goals.

This waiver allows recipients the opportunity to choose among services within the limits of their individual budgets. To facilitate this, similar services will be grouped in service families. Recipients will often have authority to shift funds between services within a service family and between service families, enabling them to respond to their changing needs. Prior service review processes will be tailored to maximize recipient flexibility while assuring health and safety.

Once the support plan has been completed, a cost plan will be prepared by the support coordinator. The cost plan identifies the specific service families and services selected and their intensity, frequency, and duration and the unit rate for that service. For an initial cost plan developed upon the recipient's transition to this waiver, there will be a service review by the APD or a qualified entity under contract to the APD. The purpose of the review is to verify that the services requested using waiver funding are not available from any other source. APD will also review to ensure the cost plan complies with the prospective individual budget limit and other polices regarding budgeting for a recipient. For subsequent cost plan years, this review may not be required for recipients who have not had a change in their service families, have not had a change in their circumstances that may necessitate an increase in their individual budget, who comply with budgeting policies, or who do not meet other criteria which indicate a higher risk to health or safety. Should specific services be denied or reduced, the individual will be provided with information about the opportunity to request a fair hearing, in accordance with applicable state and federal law.

Once the services on the cost plan have been approved, the waiver support coordinator will ensure the recipient has a copy of the cost plan and will issue a service authorization to the selected approved providers. If there is a need to change services, the recipient will work with the waiver support coordinator to review the service authorization. The service authorization is the document that authorizes the provider to bill Medicaid for services rendered.

Throughout the year, a recipient's service and support needs may change, necessitating an update in his or her cost plan. While it may not be necessary to update the support plan, a comprehensive description of these changes and sufficient information concerning the change in service needs should be thoroughly documented in the support coordinator's progress notes. An amendment to the plan may be submitted during the year if there is a documented significant change in the recipient's condition or circumstance that impacts on health, safety, or welfare, or when a change in the plan is required to avoid institutionalization.

Recipients and their families will be supported in exercising greater choice by being offered training though waiver support coordinators, paid waiver services, and other means. Recipients and families will also be provided relevant information, such as about what waiver and community supports are available. An on-line budget tool will help recipients in selecting waiver service and managing their individual budgets.

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.

During the scheduled support plan meeting and throughout the year, the support coordinator must remain aware of possible risks to the health, safety, and welfare of the recipient. The support coordinator will counsel recipients on the selection of supports and services that best mitigate risks to the recipient. The support coordinator will engage in continuous monitoring, including use of the individual budget and through face-to-face meetings held by the support coordinator with the recipient that will identify possible risk factors to address and thereby reduce or eliminate those factors from the recipient's daily life. The service plan, developed with the participation of the recipient and his or her family and guardian, in accordance with their preferences, identifies critical services that affect the recipient's health, safety, and welfare with backup supports identified, including paid or unpaid supports. With every contact with or on behalf of the recipient, the provision of those identified critical services should be specifically reviewed and addressed if necessary. When a recipient seeks to make choices that place him or herself at unacceptable risk, the support coordinator will work with the area office to implement strategies to address the situation.

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.

A list of qualified providers is available at each AHCA and APD office and is also available on the Internet. Support coordinators provide this information to recipients and train families to interview potential providers. Choice of providers is documented in case notes.

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 Florida Medicaid Agency reviews the frequency, amount, and duration of recipient support plans through the use of a Federally Designated Contracted Vendor. The Operating Agency (APD) is required through an interagency agreement with the State Medicaid Agency (AHCA) to approve client plans of care to ensure the services on the plan are those without which the client would require the services of an intermediate care facility for the developmentally disabled. Support plans are submitted to area APD offices and are updated at least annually, or when there is a change in recipient circumstance. The Operating Agency does not use a sample size, but rather reviews 100% of the plans of care.

The interagency agreement between AHCA and APD states that Florida Medicaid has the authority to monitor and approve all APD waiver related policies and operating procedures, including the service plan format and instructions. Waiver policies are discussed and reviewed at periodic meetings between the State Medicaid Agency and the Operating Agency, and via topic-specific workgroups if extensive changes to the format, procedures, or instructions are needed.

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:

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.

The Florida State Medicaid Agency monitors the service providers and outcomes of recipients through the use of a Federally Designated CV. The CV is responsible for conducting person-centered reviews, provider performance reviews, special studies, report development, report delivery, and education and training of recipients, family members, caregivers, provider organizations, and staff members of APD and AHCA.

Recipients are interviewed as part of a Person Centered Review using the National Core Indicator (NCI) survey tool, an Individual Interview Instrument, a Health/Behavioral Assessment, Medical Peer Review, and service specific record reviews. Quality Assurance Reviewers of the CV are required to contact the APD Area Office to report of any observations that need immediate attention and contact the Abuse Registry hotline to report any alert of abuse, neglect, or exploitation.

Annually, service providers are reviewed using a Provider Performance Discovery Review tool. Administrative records and service records are reviewed for compliance with the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook.

The CV is contractually required to provide monthly, quarterly, and annual reports on provider reviews and aggregate outcomes. Individual and Provider reports are available on a secured web site for review by designated AHCA and APD staff. The findings of the CV are also discussed at monthly status meetings.

Waiver support coordinators conduct face-to-face visits with each participant to discuss progress toward their goals and satisfaction with current supports received. Face-to-face visits are scheduled every three months for recipients living in their family home, monthly for recipients living in a licensed facility or their own home, and every six months for those receiving limited support coordination.

The waiver support coordinator is required to receive and approve provider implementation plans and review provider's documentation of service delivery and information to ensure the services are provided at the frequency, intensity, and duration specified in the support (service) plan and authorized in the cost plan. Waiver support coordinators also correspond routinely with waiver recipients or their legal representative to ensure services are provided to their satisfaction and in accordance with the service plan.

Waiver support coordinators are directed by policy and regulation to secure services sufficient to meet the needs of the recipient. The Operating Agency conducts periodic formal surveys to ensure adequate providers of services in different parts of the state, and uses local office staff to help recruit and train providers where indicated. Additionally the Operating Agency uses informal data gathered through monthly provider forums to assess adequacy of various provider types to ensure service availability.

Participants' services are assured of meeting their needs by the waiver support coordinator through written records of services delivery, and verbal communication with participants and vendors. Participants may select new providers if the services do not meet their needs.

Provider back up plans are developed by the waiver support coordinator with the recipient input and reviewed and validated by the Operating Agency to be safe for the participant and to ensure effective delivery of services.

The health and safety of the participants is assured through standards contained in administrative rule, the constant observation and monitoring of the support coordinators, and the periodic monitoring of the waiver standards by the Operating Agency and the CV.

Participants are supported in their choice of provider selection by the design of support coordination in this waiver being an exclusive service, which prevents self-referrals and promotes freedom of choice. The participant is supported in the selection and changing of services providers informally on a monthly basis, with a required formal opportunity to continue the selection of waiver services at least annually at the re-certification of the eligibility worksheet.

Florida Medicaid offers a variety of options in health services delivery to include the selection of traditional fee-for-services models and various managed care options including HMOs and PPO arrangements. Additionally, services are required to be pursued by other payers or natural supports in the community whenever these supports are offered to meet the needs of the participant. The Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook and state law support this important component of choice.

Designated APD staff is tasked with the responsibility of ensuring that all follow-up actions are completed in a prompt manner. Incidents that involve violations on the part of waiver providers are tracked via the APD's Remediation Tracking System. The APD is also contracting with a vendor to design an electronic database that will further enhance the State's ability to track and report on follow-up actions.

To ensure the ongoing provision of quality services to APD clients, it is required that all identified deficiencies, regardless of the discovery source, shall be sufficiently addressed in a timely manner. Critical deficiencies related to health, safety, and welfare must have a Plan of Remediation (POR) completed within seven calendar days or less. For all other deficiencies, the completion for the POR deadline is no greater than 90 calendar days from the APD letter/email notification date.

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:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
(D-2) Percentage of recipients whose service plans reflect supports and services necessary to address assessed risks. N: Number of recipients whose support plans reflect supports and services necessary to address assessed risks. D: All service plans 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: Contracted Vendor	☐ **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):*
Contracted Vendor	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(D-1) Percentage of recipients whose service plans include supports and services consistent with assessed needs. N: Number of recipients whose support plans include supports and services consistent with assessed needs. D: All service plans 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: Contracted Vendor	☐ **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: Contracted Vendor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(D-3) Percentage of recipients whose service plans address the recipients' personal goals. N: Number of recipients whose support plans address the recipient's personal goals. D: All service plans 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: Contracted Vendor	☐ **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: Contracted Vendor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and***

procedures.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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.

c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
(D-5) Percentage of recipients whose needs have changed and service plans were reviewed and updated, as warranted, to address those changed needs. N: Number of recipients whose needs have changed whose support plans were reviewed and updated, as warranted, to address those changed needs. D: The number of recipients reviewed whose needs have changed.

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: Contracted Vendor	☐ **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: Contracted Vendor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(D-4) Percentage of recipients whose service plans are updated within 12 months of the last service plan. N: Number of recipients whose support plans are updated within 12 months of their last service plan. D: All service plans 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: Contracted Vendor	☐ **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: Contracted Vendor	☒ **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:

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
(D-6) Percentage of recipients who receive the services by type, scope, amount, duration, and frequency identified in their service plans. N: Number of recipients who receive the services by type, scope, amount, duration, and frequency identified in their service plans. D: All service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Reviews, Support Coordinator Reviews

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: Contracted Vendor	☐ **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: Contracted Vendor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
(D-7) Percentage of recipients afforded a choice between waiver services and institutional care. N: Number of recipients afforded a choice between waiver services and institutional care. D: All service plans reviewed.

Data Source (Select one):
On-site observations, interviews, 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 = 95% +-5
☒ **Other** Specify: Contracted Vendor	☐ **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: Contracted Vendor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(D-8) Percentage of recipients afforded choice of services and service providers. N: Number of recipients afforded choice of services and service providers. D: All service plans reviewed.

Data Source (Select one):
On-site observations, interviews, 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 = 95% +/-5
☒ **Other** Specify: Contracted Vendor	☐ **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: Contracted Vendor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 has adopted a quality assurance strategy that mirrors the CMS Quality Framework. The Discovery function is a universal responsibility, but the bulk of the work is done by the CV, utilizing a statistically valid sampling methodology for individual single case bore analysis and a traditional provider compliance process which engages service providers annually. The Remediation function is handled by APD, which receives discovery material from the CV in near real time. The CV issues immediate alerts upon discovery of health and safety violations or concerns to APD. APD responds with immediacy to alerts; they primarily respond to less urgent matters using a universal Remediation Plan, which is a detailed action plan specifying the corrective action required of the provider and the timeframes for completion. APD utilizes the quality team approach to review a variety of data including that supplied in trend form from the CV and other data sources such as incident and abuse reports. The function of this group is to analyze the data and identify and prioritize appropriate improvements to make ongoing systemic changes.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

(D-1) On a continuous and ongoing basis, providers are required to ensure service plans include supports and services consistent with assessed needs. For all deficiencies cited on a Provider Discovery Review, providers are required to prepare, submit for approval, and then execute approved Remediation Plans. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

(D-2) On a continuous and ongoing basis, providers are required to ensure service plans reflect supports and services necessary to address assessed risks. For all deficiencies cited on a Provider Discovery Review, providers are required to prepare, submit for approval, and then execute approved Remediation Plans. This will be reviewed quarterly by the Contracted Vendor. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

(D-3) On a continuous and ongoing basis, providers are required to ensure service plans address the recipients' personal goals. For all deficiencies cited on a Provider Discovery Review, providers are required to prepare, submit for approval, and then execute approved Remediation Plans. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

(D-4) On a continuous and ongoing basis, providers are required to ensure recipients' service plans are updated within 12 months of their last service plan. For all deficiencies cited on a Provider Discovery Review, providers are required to prepare, submit for approval, and then execute approved Remediation Plans. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

(D-5) On a continuous and ongoing basis, providers are required to ensure service plans are reviewed and updated, as warranted, for recipients whose needs have changed. For all deficiencies cited on a Provider Discovery Review, providers are required to prepare, submit for approval, and then execute approved Remediation Plans. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

(D-6) On a continuous and ongoing basis, providers are required to ensure recipients receive the services by type, scope, amount, duration, and frequency identified in their service plans. For all deficiencies cited on a Provider Discovery Review, providers are required to prepare, submit for approval, and then execute approved Remediation Plans. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

(D-7) The provider (Waiver Support Coordinator) is responsible to meet with the recipient on an annual basis to complete and sign an eligibility worksheet where the recipient specifies choice of either receiving waiver services or institutional care. Providers who fail to provide choice counseling are required to prepare, submit for approval, and then execute approved corrective action plans. The implementation and outcomes of the correction action plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

(D-8) On a continuous and ongoing basis, providers are required to ensure recipients are afforded choice of services and service providers. For all deficiencies cited on a Provider Discovery Review, providers are required to prepare, submit for approval, and then execute approved Remediation Plans. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

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**

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

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.

These discovery activities are a component of the current CV. Alerts on issues for remediation are being generated by the CV and sent to APD. APD responds as appropriate given the nature of the issue. APD is in the process of including remediation activities within its centralized data system; all remediation activities will be entered, tracked, and trended to ensure that all issues requiring remediation are brought into compliance within state required time frames. Until that time, APD will continue to track remediation activities using standardized Excel templates and submit data on remediation to the State Medicaid Agency for aggregation purposes.

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.

The United States Deficit Reduction Act (DRA) of 2005, Section 6087, was enacted into law on February 8, 2006 (Pub.L.109-171); amending section 1915 of the Social Security Act to add a new paragraph (j), the State Plan Amendment Option, for self-direction of certain Medicaid services. Section 1915(j) of the Medicaid State Plan Amendment enables states to offer a self-directed service delivery model for personal assistance services as a State Plan option. The 1915(j) Medicaid State Plan Amendment authorized programs enable beneficiaries to pay legally liable relatives directly for personal assistance services identified in the service plan and budget. The State of Florida refers to its 1915(j) Medicaid State Plan Amendment as the Consumer-Directed Care Plus (CDC+) program.

CDC+ Consumers may purchase all services available in the 1915(c) Developmental Disabilities iBudget Waiver except for residential habilitation services provided in a residential setting.

Individuals eligible to participate in the CDC+ program must:
• Be enrolled in the Individual Budgeting Waiver.
• Reside in their own or family home, in accordance with 42 USC 1396n(j)(1); which states, “Self-directed personal assistance services may not be provided under this subsection to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.”
• Not have been previously disenrolled from the CDC+ program due to their mismanagement or inappropriate use of Medicaid funds. Additionally, any CDC+ Representative who has been previously disenrolled from the CDC+ program for mismanagement or inappropriate use of Medicaid funds will not be permitted to participate in the CDC+ program in any capacity.

CDC+ consultants are specifically trained in consumer self-direction to assist consumers enrolled in CDC+ and their families or representatives in identifying and choosing supports and services through the CDC+ program. A consultant provides technical assistance to consumers or their representatives in meeting their responsibilities under the CDC+ program, as defined in section 409.221(4)(c)2, F.S.

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 participant's 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

Participant direction of services is not available to all waiver enrollees, but only to waiver enrollees who additionally enroll in the 1915(j) CDC+ program. Like the waiver, the 1915(j) CDC+ program is available to all waiver enrollees ages 3 and older.

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.

Waiver Support Coordinators are required to inform recipients of all the options available to them, including participant self direction opportunities, at least annually. In addition to the Waiver Support Coordinators and CDC+ Consultants informing participants of all available options, APD provides information on its public facing website which includes a printable welcome packet, steps to onboard including roles and responsibilities, and a video which explains the programs available for interested individuals.

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:

A representative is an uncompensated individual designated by the consumer to assist in managing the consumer's budget allowance and needed services [s. 409.221(4)(c)(6), F.S.] and must meet qualifications outlined within the CDC+ Coverage, Limitations, and Reimbursement Handbook, Rule 59G-13.088, F.A.C. The CDC+ representative advocates for and acts on behalf of the consumer in his or her CDC+ matters. The representative will be trained and provided with materials to assist the consumer in implementing self-direction of budget allowance and approved CDC+ services. CDC+ consultants oversee consumer and representatives by providing on-going assistance to manage program requirements, ensure the consumer is informed of all program updates, and assess the consumers health and safety.

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.

Waiver Service	Employer Authority	Budget Authority
Life Skills Development Level 2 - Supported Employment	☒	☒
Adult Dental Services	☒	☒
Speech Therapy	☒	☒
Supported Living Coaching	☒	☒
Specialized Mental Health Counseling	☒	☒
Environmental Accessibility Adaptations	☒	☒
Life Skills Development Level 3 - Adult Day Training	☒	☒
Behavior Assistant Services	☒	☒
Dietitian Services	☒	☒
Life Skills Development Level 1 - Companion	☒	☒
Respite	☒	☒
Skilled Nursing	☒	☒
Personal Supports	☒	☒
Physical Therapy	☒	☒
Personal Emergency Response System	☒	☒
Support Coordination	☒	☒
Private Duty Nursing	☒	☒

Waiver Service	Employer Authority	Budget Authority
Respiratory Therapy	☒	☒
Occupational Therapy	☒	☒
Residential Nursing	☒	☒
Behavior Analysis Services	☒	☒
Specialized Medical Equipment and Supplies	☒	☒
Transportation	☒	☒
Specialized Medical Home 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 C-1/C-3**

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 APD, as the CDC+ program operating agency for the iBudget Waiver, serves as the fiscal agent/employer (F/EA) for the CDC+ waiver.

The F/EA operates under Section 3504 of the Internal Revenue Service Code and Revenue Procedure 70-6. The F/EA may further utilize the services of a subagent to perform certain required duties of the F/EA. The Consumer gives the F/EA legal authority to process payroll to withhold and pay employment related taxes. The F/EA collects and reviews documents included in employee and Agency or Vendor packets, and verifies tax information for Consumers, employees, Agency or Vendors, and CDC+ Representatives.

Specifically, CDC+ consultants must perform and document the following tasks for each monthly contact:

– Review the Consumer's monthly statement with the Consumer or Representative and determine whether the Consumer or Representative has complied with the Purchasing Plan;

– Document the monthly contact and review the monthly statement.

This must include, but is not limited to:
• Verification that the Consumer or Representative has submitted all provider timesheets and invoices in a timely manner;
• Identification of any budget management problems; and
• Identification of any circumstances that require a Corrective Action Plan or disenrollment from CDC+.
• Review all provider materials to assure that the items are complete whenever there is a change to the Consumer's Purchasing Plan.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

As financial management services are included in the roles and responsibilities of CDC+ consultants, they are not reimbursed separately or these services.

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:

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☐ **Other**

  Specify:

Supports furnished when the participant exercises budget authority:

- ☐ **Maintain a separate account for each participant's participant-directed budget**
- ☐ **Track and report participant funds, disbursements and the balance of participant funds**
- ☐ **Process and pay 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:

☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide 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 operating agency conducts monitoring reviews to evaluate the extent to which consumer goals and needs are being met as well as to determine compliance and accountability with Medicaid, AHCA and APD standards, and occur as part of quality assurance monitoring.

Reviews conducted by APD or the Contracted Quality Assurance entity consists of a review of the following:
• Support Plan/Cost Plan;
• Purchasing Plan;
• Representative Agreement;
• Monthly Statements;
• Timesheets (Appendix G);
• Invoices;
• Employee Files including Background Screening documentation;
• Agency or Vendor files;
• Emergency Back-up Plan; and
• Corrective Action Plan.

APD will monitor and report to AHCA whether consumer goals have been reached and the status of program compliance. The monitoring must also incorporate information from consumers concerning health, safety, and welfare, and their service needs. The APD area offices must follow up on pertinent consumer issues noted in monitoring.

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:

☒ **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
Life Skills Development Level 2 - Supported Employment	☐
Adult Dental Services	☐
Speech Therapy	☐
Supported Living Coaching	☐
Specialized Mental Health Counseling	☐
Environmental Accessibility Adaptations	☐
Life Skills Development Level 3 - Adult Day Training	☐
Behavior Assistant Services	☐
Dietitian Services	☐
Life Skills Development Level 1 - Companion	☐
Respite	☐
Residential Habilitation	☐
Skilled Nursing	☐
Personal Supports	☐
Life Skills Development Level 4 - Prevocational Services	☐
Physical Therapy	☐
Personal Emergency Response System	☐
Support Coordination	☒
Private Duty Nursing	☐
Respiratory Therapy	☐
Occupational Therapy	☐
Residential Nursing	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Behavior Analysis Services	☐
Specialized Medical Equipment and Supplies	☐
Transportation	☐
Specialized Medical Home Care	☐

☐ **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:

The concept of self-determination within Medicaid acknowledges the rights of people with disabilities to take charge of and responsibility for their own lives. In the CDC+ program, there are five principles of self-determination:
• Freedom: People have the freedom to decide where and with whom they will live;
• Authority: People have the authority to decide how they will live their lives;
• Support: People have the support they need to make decisions;
• Control: People have control over the resources needed for their support; and
• Responsibility: People have responsibility for their decisions and actions.

“Self-determination” exemplifies an individual's freedom to exercise the same rights as all other citizens, authority to exercise control over funds needed for one's own support, including prioritizing these funds when necessary, responsibility for the wise use of public funds, and self-advocacy to speak and advocate for oneself in order to gain independence and ensure that individuals with a developmental disability are treated equally. [s.393.063, F.S.]

The person-centered review process assists a Consumer to: (1) identify person-centered supports and services; (2) enhance service delivery in a manner that supports the achievement of individually determined outcomes; and (3) make improvements in the provider’s service delivery system.

Every participant on the iBudget Waiver is required to select a Waiver Support Coordinator or CDC+ Consultant of their choosing. In accordance with Rule 59G-13.070, Florida Administrative Code, Waiver Support Coordinators and CDC+ Consultants duties include “advocating for the recipient and identifying, developing, coordinating, and accessing supports and services on the recipient’s behalf, regardless of the funding source."

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:

A consumer may elect to discontinue participation in the CDC+ program at any time.

In the event disenrollment is requested by the consumer or the representative, the consumer's consultant completes documentation to disenroll the consumer, specifying that the disenrollment was initiated by the consumer or representative, and forwards the documentation to APD program staff. All disenrollments are effective the first day of the month following receipt of the disenrollment form. Upon disenrollment from CDC+, the consumer may still access waiver services through traditional means. The consultant is responsible for ensuring the consumer's traditional iBudget Waiver services are set to begin on the first of the month after disenrollment from CDC+.

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 provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The circumstances under which a consumer may be involuntarily disenrolled from self-directing personal assistance services, and returned to the traditional service delivery model are as follows:
• Consumer moved out of state;
• Temporary or permanent long-term care facility admission;
• Hospitalization for more than 30 consecutive days;
• Loss of Medicaid eligibility;
• Loss of waiver eligibility;
• Representative not available if necessary for participation;
• Death of Consumer;
• Mismanagement of budget or services or for failure to follow the provisions of this handbook;
• Consumer health or safety at risk;
• Consumer can no longer be served safely in the community; or
• Admission to a licensed facility (group home, ALF, etc.).

Consumers who are disenrolled from CDC+ remain eligible for the iBudget Waiver and shall continue to receive services through the iBudget Waiver service and programs after disenrollment.

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		3200

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 2		3300
Year 3		3400
Year 4		3500
Year 5		3600

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:

☐ **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.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **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**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **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:*

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**

☒ **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

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.

The budget is discounted by eight percent to ensure the program is cost-neutral. The consumer becomes a home-based employer as defined by the IRS and appoints APD to help collect, process, and report employer-related activities. To perform these activities on behalf of the consumer, APD charges a fee, currently four percent up to a max of $160 monthly, to handle the payroll responsibilities such as provider enrollment, accounting, check writing, and tax withholding. Consumers can use the monthly budget to pay for services and supports they choose, including:

- Purchasing services from a provider at a rate they negotiate.
- Hiring an individual to work for them (Medicaid and non-Medicaid enrolled providers).
- Purchasing consumable medical supplies from a vendor or store of their choice.
- Modifying their home to increase independence, such as adding a chair lift or ramp.
- Purchasing accessible equipment, appliances, or other assistive technology.

Funds for One-Time Expenditures (OTE) and Short-Term Expenditures (STE) are not included in the calculation of the consumer's monthly budget nor is the waiver support coordination fees, as these are billed through the waiver while the STE/OTE is provided as one lump sum and is included with the monthly budget in which the STE/OTE is requested.

The CDC+ monthly budget may continue unchanged:

- If there are not any changes in the consumer’s support plan and/or cost plan.
- If the Florida Legislature has not required any changes in the way the Medicaid waiver operates, which could impact program funding.

The CDC+ monthly budget may change if:

- There are changes in the consumer’s health or living situation that result in a cost plan increase or decrease or redistribution of funds.
- There are changes in the consumer’s Personal Care Assistance (PCA) for consumers under age 21 funded through Medicaid State Plan (MSP).

By design, consumers enrolled on the CDC+ program are able to take advantage of greater flexibility for provider selection, rate setting, and modifications to increase independence. As such, APD utilizes program funding to ensure the program is cost neutral and provides greater administrative supports for participants. APD regularly evaluates all aspects of the programs and services that are available, as we continue to enhance service delivery and maximize flexibility, APD maintains current methodology.

Per 59G-13.088 Florida Administrative Code, a CDC+ Consumer’s monthly budget is based on the cost of services that a Consumer has been approved to receive under the iBudget Waiver. A Consumer’s monthly budget is calculated from the current approved Cost Plan. Using only the services that the Consumer receives annually, services are divided by the number of months authorized. Those amounts are totaled to determine the total monthly Cost Plan amount. The CDC+ payment methodology is applied to the monthly Cost Plan amount. Based on this methodology, the CDC+ Consumer exchanges the total budget of their current approved Medicaid cost plan for a smaller budget that has greater flexibility, in accordance with the self-direction model established in section 1915(j) State Plan Amendment.

Per 59G-13.088 Florida Administrative Code, APD drafts a Budget Calculation Worksheet which indicates the consumer’s monthly budget. This worksheet is sent to the Waiver Support Coordinator/CDC+ Consultant, who is then responsible for ensuring the consumer and their representative receive a copy. This process is the same whenever any change in the monthly budget occurs. If additional funds are needed, a Significant Additional Needs (SAN) request must be submitted. Anytime an iBudget amount is determined (including approvals, partially approvals, reductions, denials, and terminations), hearing rights are provided in writing in a formal notice to the legal representative.

Information on how the CDC+ Monthly Budget Allowance is determined is in the promulgated Consumer Directed Care Plus Coverage, Limitations and Reimbursements Handbook. Specifics regarding the methodology are provided in the CDC+ How-to Guide. This document is available to the public on the APD website.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

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.

The APD drafts a Budget Calculation Worksheet which indicates the consumer's monthly budget. The worksheet details the current services that are listed on the Cost Plan and shows the 8% reduction as well as the 4% admin fee, which will not exceed $160. This worksheet is sent to the regional liaisons and the support coordinator, who is then responsible for ensuring the consumer and their representative receive a copy. If a consumer representative's email is on file, the agency will also copy the representative when sending this worksheet out. This process is the same whenever any change in the monthly budget occurs.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

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:

CDC+ consumers have the authority to request changes in services. Purchasing plans must be effective on the first of the month and can be updated at any time. However, when completing a purchasing plan update the purchasing plan update/change must be submitted to the WSC/consultant no later than the 5th of the month prior to the effective date. The WSC has five days to submit the request to the regional office. After the regional office reviews the request, the state office has 10 days to review and issue a final determination.

If a change in services is required immediately, consumers have the option of submitting a Quick Update Form. This form allows consumers to add or replace a service or provider on a temporary basis in order to provide the WSC enough time to get the purchasing plan update/change submitted.

In terms of needing additional funding, the CDC+ participant would follow the SAN (significant additional needs) procedure.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

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:

Consumers' representative and WSCs are required to provide oversight of services and supports as well as reviewing and managing spending.

The state office also has a “pend process” which will hold payments to a provider/employee in the event that account has insufficient funds. This will result in the initiation of a CAP (Corrective Action Plan) which identifies the debt and describes how the consumer will pay these funds back and get the account back in good standing. If the consumer is unable to abide by the CAP, disenrollment from CDC+ can be initiated.

the APD reinvests any funds that have not been earmarked for any certain service or need. This is done periodically, but no longer than annually.

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 individual is informed of his/her right to a Fair Hearing when action has been taken regarding his/her Medicaid waiver services. A Fair Hearing may be requested at any time should the individual feel that he/she has not been given the choice of home and community-based services as an alternative to institutional care, has been denied the service or provider of their choice, has had his/her services denied, suspended, reduced, or terminated, or feels that other rules, regulations, or laws have not been followed in the determination of his/her eligibility or the delivery of his/her services. The individual receives a notice from the operating agency or contracted entity every time an eligibility determination is made. This notice includes information regarding how the individual can request a redetermination regarding the decision and/or a Fair Hearing.

Any individual, or his/her parent, guardian, guardian advocate, if a minor, or authorized representative may request a Fair Hearing. No specific form is required. Fair Hearings for Medicaid programs administered by the operating agency are conducted by the Department of Children and Family Services pursuant to Sections 393.125 and 409.285, Florida Statutes, and follow procedures consistent with federal law and rules applicable to Medicaid cases. Procedural steps for requesting a Medicaid Fair Hearing will be clearly specified in the waiver's Coverage and Limitations handbook made available to providers and will be shared with participants of the waiver.

Notice of all service decisions is provided to the individual through the prior authorization entity and support coordinator, both orally and in writing. These notices provide clear instructions on how to request a Fair Hearing and inform the individual of continuation of services through the appeal process. Support coordinators are trained on how to assist individuals in requesting a Fair Hearing. State employees involved in providing services to individuals are also trained on how to assist individuals in requesting a Fair Hearing. When issuing notices of agency action, the State provides the notices to the recipient, legal representative, and waiver support coordinator. The State retains copies of notices issued in accordance with records retention requirements. Waiver Support Coordinators are required to maintain a copy of the notice in the recipient’s central record.

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 following are considered critical incidents under the APD's Operating Procedure for Incident Reporting and Risk Prevention for recipients living in the community and are required to be reported to the APD Regional/Field Office by the recipient, representative, support coordinator, or service provider within one hour of becoming aware of the incident. An APD Incident Reporting Form must be submitted to the APD Regional/Field Area Office no later than the next business day.

The APD Regional/Field Office will immediately inform the APD Central Office in Tallahassee of the critical incident. The incident reporter must also provide immediate notification to the recipient's support coordinator, and to the child's or incompetent adult's parent or guardian.

Critical Incidents include:
1. Unexpected Client Death
2. Life Threatening Injury or Illness
3. Sexual Misconduct
4. Missing Child or Adult Who Has Been Adjudicated Incompetent
5. Media attention
6. Client Arrest for Violent Crime
7. Verified Abuse, Neglect or Exploitation Investigations
8. Staff Arrest for Disqualifying Offense

The following are considered reportable incidents under rule 65G-2, F.A.C. and the APD's Operating Procedure for Incident Reporting and Risk Prevention for clients living in the community and are required to be reported to the APD Regional/Field Office by the recipient, representative, support coordinator, or service provider within one business day of becoming aware of the incident by submitting a complete Incident Reporting form.

Reportable Incidents include:
1. Client Deaths
2. Altercations
3. Client Injury
3. Client Arrest
4. Missing Competent Adult
5. Suicide Attempted
6. Baker Act
7. Hospitalization for illness or injury
8. Client Arrest from Non-Violent Crime

This does not replace the abuse, neglect, and exploitation reporting required by state law and rule. Allegations of abuse, neglect, or exploitation must always be reported immediately to the Florida Abuse Hotline.

Unauthorized use of restraint, seclusion, and restrictive interventions must be documented and reported to AHCA and to the APD Local Review Committee for behavioral review and intervention. If the use of restraint, seclusion, or restrictive intervention reaches a level of one of the incident categories, the provider will need to report the incident to APD in accordance with the required timeframes. If the use of restraint, seclusion, and restrictive intervention is suspected to be abuse, neglect, or exploitation, a report to the DCF Abuse Hotline is required.

Financial exploitation is reported to the DCF Abuse Hotline for investigation. If the investigation is verified for exploitation, this incident will be captured in the Critical category of Verified Abuse, Neglect, or Exploitation Investigation.

Medication Errors must be documented and reported to APD/AHCA in accordance with the requirements set in Rule 65G-7.006, F.A.C. If the medication error reaches a level of one of the incident categories, the provider will need to report the incident to APD in accordance with the required timeframes. If the medication error is suspected to be abuse, neglect, or exploitation, a report to the DCF Abuse Hotline is required.

There are no differences in reporting requirements for critical events for children or adults on this waiver.

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.

Support coordinators are required to educate recipients on topics relative to protections from abuse, neglect, and exploitation, including how recipients can notify appropriate authorities in events of such. Support coordinators are required to share this information on an annual and "as needed" basis. Similarly, provider settings are required to post notices relative to protections from abuse, neglect, and exploitation in prominent places in each facility, and read or explain these notices to recipients who cannot read.

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.

It is the responsibility of the operating agency (APD) to train providers to report incidents to the APD in accordance with the operating procedure and licensing rule 65G-2, F.A.C.

Critical incidents are required to be reported to APD Regional/Field Offices by the support coordinator, or service provider within one hour of becoming aware of the incident. The initial report must be followed by an APD Incident Reporting Form no later than the next business day. The APD Regional/Field Office will immediately notify APD Central Office of the critical incident or event.

Service providers will have primary responsibility for reporting critical incidents occurring at their place of business. There may be instances where parallel investigations are conducted by the APD Area Office and/or the APD Central Office in Tallahassee.

The APD Field Office will notify the service provider if further follow up is required or referral to an outside agency is recommended.

The APD relies on DCF or law enforcement to complete allegation of abuse, neglect, and exploitation investigations. The investigators have the legal authority of notifying the alleged victims/legal representative of the outcome of the investigation. APD collaborates with the enrollees, service providers, and legal representative if applicable to ensure waiver resources and services are available to meet the recipients' needs.

Follow up investigation of each incident commences immediately to ensure clients involved in an incident are healthy and safe. The length of the internal investigation varies from case to case. Investigations of incidents which are conducted by the APD may take up to 90 days to complete. Investigations conducted are for internal use only and may result in disciplinary actions upon providers, changes in providers, etc. The Florida Department of Children and Families (DCF) and local law enforcement officials are the authorized agencies in Florida to investigate allegations of abuse, neglect, and exploitation involving children or vulnerable adults. Florida law authorizes only the DCF and law enforcement agencies to conduct investigations into allegations of abuse, neglect, or exploitation involving children or adults with developmental disabilities. The APD provides information and assistance as requested and necessary to those entities during the investigatory process. The APD also takes action following the closure of such investigations, which may include disciplinary actions against providers, assisting recipients in choosing alternative waiver providers, and the provision of additional services and supports as required to ensure health and safety needs are met. Protective services investigations are typically completed within 90 days of initiation.

Section 39.301, F.S., and Chapter 415, F.S., designate DCF as the primary investigative agency.

The specific process (by incident severity level) is as follows:

a) A Class I (Low Risk) incident would be minor in nature and not create a serious consequence or investigation by DCF or local law enforcement. This type of incident must be documented in the participant's case record by the case management agency, staffed by the case manager and the case management supervisor, and any corrective action taken documented in the participant's case record.

b) A Class II (Intermediate Risk) incident is considered serious in nature and requires a report to the local Medicaid area office and a report of abuse, neglect or exploitation to the DCF, if applicable, within 24 hours of knowledge of the incident, or a report to local law enforcement, if applicable, within 24 hours. The case management agency provides oral notice of the event, followed by a written management agency will provide weekly updates on the progress of the investigations and any actions required or taken on the participant's behalf until the participants risk level is back to normal and the investigation has been completed.

c) A Class III (High Risk) is considered grave in nature and must be reported immediately to the DCF for investigation by local law enforcement.

Depending upon the result of an investigation conducted by DCF, law enforcement, or APD, the APD may impose a variety of disciplinary actions against providers. There are no established timeframes for informing a provider or relevant parties of the investigation results. The APD's investigations are primarily for internal use. As a result of an investigation a Plan of Remediation, Administrative action, or corrective action will be taken by the agency. The provider will be notified immediately of Agency action. The following individuals/entities may be notified of the results

of the investigation as necessary:
a) The alleged victim and legal representative
b) Law Enforcement
c) Emergency Medical Services
d) Courts
e) State Attorney's Office
f) Long Term Care Ombudsman
g) Medicaid Fraud Control Unit
h) APD/AHCA
i) Department of Health's Division of Medical Quality Assurance
j) County medical Examiner

Impacted enrollees are sent a Notice of Conclusion when the investigation is finalized.

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.

The operating agency is responsible for the monitoring and oversight of responses to critical incidents or events. Agency senior management at APD central office, in coordination with the APD regional/field offices, conduct these reviews weekly. All critical incidents are subsequently addressed as appropriate with the nature of the incident.

Aggregate data is compiled by APD. APD conducts trending and analysis of this data to help prevent and/or reduce the occurrence of incidents in the future.

The operating agency submits quarterly aggregated incident data to the Medicaid agency. The Medicaid agency analyzes the data to provide oversight of the incidents.

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.

AHCA and APD collaborate with the Department of Children and Families – Adult Protective Services and other State agencies. AHCA and APD foster increased oversight of providers regarding critical incidents and other health, safety and welfare sub-assurances required for the successful operation of the waiver. 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.

Enrollees will be monitored for service provision and health and safety issues. Providers and Support Coordinators must assist with services necessary to address health, safety and welfare needs as well as plan of care services.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints 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. 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). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Chapter 393, Florida Statutes, requires emergency procedures to be used only for imminent danger. APD has promulgated Rule 65G-8, F.A.C., “Reactive Strategies" to establish Agency approved emergency procedure curricula, for staff training to assure competent implementation of these procedures when preventative or less restrictive procedures have failed. Providers must maintain a reactive strategy policy and procedure, conduct assessments to determine history of trauma and pre-existing medical conditions that may preclude specific techniques or procedures, and specify who can authorize the use of these procedures. This rule also identifies limits for use of reactive strategies, prohibits selected procedures, and requires documentation and reporting of these procedures when used.

Rule 65G-4, F.A.C., “Behavioral Practice and Procedure,” includes the monitoring and oversight of these procedures by the Local Review Committee, as well as a requirement to develop a behavior program when criteria for frequent use of seclusion and restraints are met.

Types of permitted restraint or containment include:
a. Manual restraint
b. Mechanical restraint
c. Chemical restraint
d. Behavioral protective devices
e. Medical protective devices
f. Time-out (< 20 minutes)
g. Time-out (> 20 minutes), reported as Seclusion (door cannot be locked).

Alternative methods to avoid the use of restraint and seclusion are a required component within the emergency procedure curricula reviewed and approved by the Agency. Provider agencies that use emergency procedures are required to ensure staff are trained in one of these curricula. These curricula are required to include common preventative or diffusionary approaches such as:
a. Prompting and redirection
b. Varied verbal and nonverbal methods of defusing behavior problems, such as
1. Environmental modifications;
2. Body posture and movement;
3. Facial expression;
4. Empathic listening;
5. Increasing space between the individual and staff;
6. Things to say and how to say them/tone of voice;
7. Taking a walk.

c. Preventative measures, such as
1. Behavioral programs, including a required component for training and reinforcing replacement or alternative behavior;
2. Environmental modifications;
3. Rich, meaningful and diversionary activities;
4. Reinforcement procedures for demonstrating appropriate behavior;
5. Skill training, such as: social skills, problem solving, relaxation training, anger management training;
6. Medication for diagnosed mental health conditions;
7. Medical and dental exams to rule out any underlying physical conditions;
8. Other traditional therapies.

All emergency procedures (including seclusion and restraint) must be documented and reported monthly to the local APD Field Office. Submitted reports are reviewed by the Area Behavior Analyst and/or their designee. Reporting is reviewed monthly at the Local Review Committee and feedback is provided to individual providers. Excessive frequency and duration of use as well as cases with injury will result in provider-specific feedback for correction or additional review of the person’s behavioral data and behavior program. Individuals who have received an emergency procedure at a frequency of more than two times in any thirty-day period, or six times in any twelve-month period, will result in a request for behavioral services and typically a behavioral assessment and behavior program development.

In an emergency, when continuous and ongoing behavior poses a threat to self, others or property, and all

other interventions to diffuse the problem behavior have failed, then with the proper number of direct care staff, they may implement reactive strategies that they have been trained and certified to implement. At the onset of seclusion or restraint implementation, staff will notify the appropriate authorizing agent of the conditions leading up to the use of the emergency procedure. The authorizing agent is then responsible for assuring that the procedure is in compliance with policy and rule or terminate the procedure. These procedures are monitored continuously during their application. When the emergency has ended the procedures are to be terminated. As soon as possible after the procedures have been terminated staff must document the use of the reactive strategy.

All personnel that use reactive strategies must be trained in an emergency procedure protocol. The emergency procedure training curriculum includes the following:
- non-physical crisis (preventative) intervention techniques;
- history of applied use to persons with developmental disabilities;
- criteria for use of reactive strategies, and methods for reducing physical interventions
- instruction in reactive strategy precautions and potential hazards; and
- it also includes a “release” criterion (e.g., a stated period of calm behavior) that is of short duration and that is client-driven or initiated.

The state employs the following practices to ensure the health and safety of individuals. Annually, the person’s medical condition must be assessed to determine whether or not he or she might be placed at risk of physical injury during restraint or seclusion, or otherwise precludes the use of one or more emergency procedures. An emergency procedure must provide for the least possible restriction consistent with its purpose. The requirements of rule require reactive strategies to be implemented in a manner that permits the greatest possible amount of comfort and protection from injury to the individual. Staff must continuously observe the client during restraint procedures, monitor respiration rate, and determine when release criteria have been met. Before initiating a seclusion or restraint procedure, staff must inspect the environment and the individual in order to ensure that any foreign objects that might present a hazard to the individual’s safety are removed. Any room in which the individual is held must have sufficient lighting and ventilation to permit the individual to be seen, to maintain a comfortable temperature, and must have enough space to permit him or her to lie down comfortably. The door to any room in which an individual is secluded without an attending staff person must not be locked; however, the door can be held shut by a staff person using a spring bolt, magnetic hold, or other mechanism that permits the individual in seclusion to leave the room if the caregiver leaves the vicinity.

Monthly reactive strategy reporting is monitored by the ABAs and ASBA for unusual patterns of use and procedures with adverse outcomes. Providers who have exhibited a pattern in reporting the use of reactive strategies are noted by ABAs and required to report monthly even if no procedures were implemented during the month. In addition, ABAs are also required to note gaps in reporting when they occur, prompting formal action against the provider.
Additionally, ABAs are required to complete an investigative follow-up for every reported incident involving the use of restraint, seclusion, restrictive intervention or a significant behavioral episode. Results from the investigation are documented and may require the provider to develop a corrective action plan by the Region’s Quality Assurance unit. More severe action may be taken depending on the history of deficiencies. The Local Review Committee must review behavior analysis providers’ behavior programs before they are implemented. The review ensures technical integrity, appropriateness of interventions, use of the least restrictive methods, and that an individual’s rights are protected.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Chapter 393, Florida Statutes, requires emergency procedures to be used only for imminent danger and APD has promulgated Rule 65G-8, F.A.C., "Reactive Strategies," and amended Rule 65G-4, F.A.C., "Behavioral Practice and Procedure," to establish limitations and requirements when these procedures are used on waiver enrolled recipients.

These rules call for use of restraints or seclusion as a last resort, with efforts implemented to use preventative or less restrictive interventions first. All use of restraints and seclusion must be logged by providers, with reports submitted to APD monthly. In addition, behavioral services are monitored by the behavior analyst assigned to provide services either as an independent provider or as part of a residential program. This level of monitoring, as well as monitoring of incident reports provides additional opportunities to assure that reactive strategies are documented and used appropriately.

All waiver providers serving individuals with significant inappropriate behavior that may require use of physical management techniques are required to train their staff in an APD approved curriculum for emergency procedures. Minimum standards for curriculum content are outlined in Rule 65G-8, F.A.C., "Reactive Strategies." The providers are obligated to notify the APD of the curriculum they have elected to use and maintain records of certification of all staff for review by APD.

Reports of Reactive Strategy use will be reviewed at least monthly during the regular meeting of the APD Local Review Committee (LRC) to assure that individuals meeting limiting criteria for emergency procedure use have a behavior analysis support plan developed and reviewed to monitor the effectiveness of programs when they are in place. Behavior programs for individuals receiving use of reactive strategies will be reviewed at a frequency determined by the LRC chairperson, or at least annually.

Data related to reactive strategies is monitored for trends and patterns at three levels:

Clinician Level: For those individuals with behavior programs, the behavior analyst providing services is watching the reactive strategy data in conjunction with data for targeted behavior that are the focus of the behavior program. This data is used to evaluate the effectiveness of the program written, along with fidelity data to show how well staff are implementing the plan. These data help to guide the need for revisions to the plan or additional training and monitoring of staff.

Local Field Office Level: The second level of review is conducted by the Area Behavior Analyst who sees data from all providers reporting use of reactive strategies locally. Providers appearing to use higher frequency and duration of procedures are given feedback by the Area Behavior Analyst to make corrections, or closer scrutiny of individualized behavior programs for their residents may be undertaken at the Local Review Committee conducted by the Area Behavior Analyst. This allows peers to offer suggestions for improvements to behavior programs.

State Office Level: The third level of review occurs at the State Office level where all Field Office reports are submitted monthly. Data is reviewed and trended to determine the average frequency, average duration, and numbers of procedures used on average across the state and within each area served by a Field Office. These trends are generated for each local area to allow feedback to be provided to the Area Behavior Analysts for follow-up with providers and/or the individuals they serve.

On a monthly basis, APD aggregates and analyzes data regarding follow-up on use of reactive strategies with injuries or durations greater than 60 minutes. Reports are submitted to the Medicaid agency on a quarterly basis and reviewed jointly with the Medicaid agency and APD. On a continuous and ongoing basis, the contracted QIO vendor reviews and reports residential provider compliance with required reactive strategy training to APD and the Medicaid agency. APD submits an annual report on the health and welfare of iBudget participants to the Medicaid agency. This report includes information regarding reactive strategies (seclusion and restraint). Ad hoc reports regarding reactive strategies are generated by APD and provided to the Medicaid agency upon request.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of

3)

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:

◉ **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.

Chapter 393.13, Florida Statutes, outlines the rights of clients receiving treatment from the APD and its providers, within the least restrictive conditions necessary to achieve the purpose of treatment. Treatment programs involving use of noxious or painful stimuli are prohibited. As set forth in ch. 393 the rights of clients include, unrestricted right to communication, the possession and use of one's own clothing and personal effects, prompt and appropriate medical treatment, space for storage of possessions, opportunities for physical exercise, humane discipline, medical examination prior to behavioral treatment, be free from unnecessary use of restraint and seclusion, have a central record, and have the ability to vote. Unless there is reason to believe that unrestricted exercise of these provisions may be harmful to the client or others, then the individual's support plan must identify those circumstances and a plan of treatment must be developed to provide temporary limitation and active remediation that will lead to full restoration.

Initially, the Support Coordinator takes lead on identifying service needs and discussing proposed treatment options with the consumer, their legal guardian and the person's circle of supports. The support plan identifies services, level of supervision or supports, as well as formalized services found in a behavior analysis support plan, in a safety plan or a combination of the two. When behavioral interventions are appropriate, standards of practice outlined in Rule Chapter 65G-4,F.A.C. Behavioral Service Practice and Procedure call for the "least restrictive most effective intervention."

The procedures to be used in the behavior plan are determined on a case-by-case basis depending on the results of a comprehensive functional assessment to identify the behaviors to be addressed, as well as the causes or functions of the behavior and to rule out other appropriate alternative treatments, including medical, physical or occupational interventions. Also evaluated are the risks presented to self, others and property. It is often the case that there are multiple known treatments found in the behavioral literature for a particular problem behavior. However, individual circumstances and the environment within which the treatment will be implemented will dictate the choice of procedures in an intervention package. In all cases a reinforcement component is required, at least to reinforce appropriate alternative replacement behavior for the targeted inappropriate or undesirable behavior.

Behavior plans addressing behaviors dangerous to self and others or those containing restrictive procedures must be submitted to the Local Review Committee (LRC), a peer review committee. The behavior plan is reviewed to ensure protection of client's rights, clinical integrity and compliance with the requirements of Rule Chapter 65G-4, F.A.C. In addition, the LRC renders a decision to approve the program or not, and establishes the frequency of periodic review of the program. Reviews are intended to evaluate the continued appropriateness of the procedures and their effectiveness. Behavior programs are updated and reviewed as needed, and reviewed at least annually by the LRC. When the data does not show the anticipated change or progress, then the behavior analyst needs to determine whether there is a problem with the procedures written or a problem with implementation. If there is a problem within the program, then modification will be made and resubmitted to the LRC.

Use of unauthorized restrictive interventions (abridgement of rights) may be detected when facilities are monitored monthly for compliance with client behavior management rules, Rule 65G-8, F.A.C., and by the ABA and ASBA for unusual patterns of use and procedures with adverse outcomes, such as a client death, client injury or procedures lasting over 60 minutes. The QIO and CMS Compliance Analysts also monitor these facilities on an annual basis. More specifically, every use of a reactive strategy (seclusion and restraint) is reviewed at the Local Review Committees of Behavior Analysts and may be reported to protective services.

Monthly reactive strategy reporting is monitored by the ABAs and ASBA for unusual patterns of use and procedures with adverse outcomes. Providers who have exhibited a pattern in reporting the use of reactive strategies are noted by ABAs and required to report monthly even if no procedures were implemented during the month. In addition, ABAs are also required to note gaps in reporting when they occur, prompting formal action against the provider.
Additionally, ABAs are required to complete an investigative follow-up for every reported incident involving the use of restraint, seclusion, restrictive intervention or a significant behavioral episode. Results from the investigation are documented and may require the provider to develop a corrective action plan by the Region's Quality Assurance unit. More severe action may be taken depending on the history of deficiencies. The Local Review Committee must review behavior analysis providers' behavior programs before they are

implemented. The review ensures technical integrity, appropriateness of interventions, use of the least restrictive methods, and that an individual's rights are protected.

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:

The APD is primarily responsible for monitoring and providing oversight for the use of restrictive procedures implemented with the recipients it serves, as outlined in Chapter 393, Florida Statutes, and specified in Rule 65G-4, F.A.C. (Behavioral) Service Delivery Practice and Procedure.

Chapter 393.13, F.S., calls for the adoption of a system for the oversight of the plans or behavioral programs. The system was intended to establish guidelines and procedures governing the design, approval, implementation, and monitoring of all behavior programs involving clients. This establishing language authorized the development of rule chapter 65G-4,F.A.C. Behavioral Service Practice and Procedure. This rule identifies the qualifications and credentials required for individuals who provide behavioral services. Furthermore, it identifies a senior clinician to oversee, maintain and give direction to standards of behavioral practice statewide. Under this rule Area Behavior Analysts are established and out-posted throughout the state to reinforce standards of practice through the Local Review Committees (LRC) that provide peer review for new and ongoing behavior programs developed and implemented by behavioral service providers. The LRC reviews and approves behavior programs to assure that they comply with Ch. 393, F.S., Rule 65G-4 and 65G-8,F.A.C. Reactive Strategies, F.A.C., and is consistent with contemporary behavior analysis practices. Behavior programs are reviewed regularly based on a schedule of review determined by the LRC, as often as monthly depending on the severity of behaviors or restrictiveness of procedures, but at least on an annual basis.

In addition, the QIO conducts monitoring of behavioral services to assure that they are implemented consistent with the requirements under the Medicaid Waiver and the requirements for behavioral programing specified in Rule 65G-4, F.A.C., "(Behavioral) Service Delivery Practice and Procedure." During a QIO review, if a "rights" violation or concern is identified an "Alert" notice is provided to the Agency. "Alerts" related to behavioral services require follow-up and documentation of remediation by the Area Behavior Analyst.

Monthly, the licensing staff within each local Field Office, across the state, monitor all residential providers. During these visits they view the home and the individuals residing there and the direct care staff. While conversing with the residents or staff, reviewing consumer records, log books for cross-shift communication or behavioral data collection sheets, evidence may emerge that leads to the discovery of inappropriate use of "restrictive interventions" that abridge the rights of individuals.

If any of these events rise to the level of an "incident" or a call to the abuse hot line, the use or misuse of "restrictive interventions" may be identified. Those events that result in investigations of abuse, neglect or exploitation, incident reporting or use of reactive strategies are reported in the Evidentiary (372) Reports submitted annually, with monthly assurance indicators reviewed and reported to the state Medicaid agency on a quarterly basis.

Use of unauthorized restrictive interventions (abridgement of rights) may be detected when facilities are monitored monthly for compliance with client behavior management rules, Rule 65G-8, F.A.C., and by the ABA and ASBA for unusual patterns of use and procedures with adverse outcomes, such as a client death, client injury or procedures lasting over 60 minutes. The QIO and CMS Compliance Analysts also monitor these facilities on an annual basis. More specifically, every use of a reactive strategy (seclusion and restraint) is reviewed at the Local Review Committees of Behavior Analysts and may be reported to protective services.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of 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).

Chapter 393, Florida Statutes, requires restrictive procedures to be used only for imminent danger. The APD has promulgated Rule 65G-8, F.A.C., “Reactive Strategies" to establish Agency-approved emergency procedure curricula, for staff training to assure competent implementation of these procedures when preventative or less restrictive procedures have failed. Providers must maintain a reactive strategy policy and procedure, conduct assessments annually to determine history of trauma and pre-existing medical conditions that may preclude use of specific techniques or procedures, and specify who can authorize the use of these procedures. This rule also identifies limits for use of reactive strategies, prohibits selected procedures, and requires documentation and reporting of these procedures when used.

Under this rule, “seclusion” is defined as, enforced confinement to a room or area, and is not a “time out”. However, if a time-out procedure exceeds 20 minutes in duration it must be reported as “seclusion”. Any room or space that is used for seclusion must have sufficient lighting and ventilation in accordance with normal standards of comfort, and allow for sufficient dimensions for the person to stand or to lie down comfortably. The door to the room may be held by staff, or by means of a mechanical device requiring constant staff pressure, but cannot be locked. Staff must monitor the individual in seclusion continuously.

All reactive strategies require an “authorizing agent” to approve the use of the procedure. A procedure is limited to one hour. If additional time in the procedure is necessary, then reauthorization is required. As soon as the procedure is terminated staff must document its use. A monthly summary of all reactive strategies must be submitted to the local APD Field Office, with all provider reports compiled and submitted to the State Office for review.

Rule 65G-8, F.A.C., Reactive Strategies and rule 65G-4, F.A.C., Behavioral Practice and Procedure, requires the monitoring and oversight of these procedures by the assigned behavioral services provider, the Area Behavior Analyst, the Local Review Committee, and the Agency Senior Behavior Analyst. If an individual receives a reactive strategy as an emergency procedure more than two times in a 30 day period or more than six times in any twelve-month period then the provider or facility must request behavior analysis services for the individual. In most cases this leads to completion of a behavioral assessment and development of a behavior plan in the interest of devising less restrictive procedures to intervene leading to the development of more adaptive alternative behaviors and reduction of the challenging behaviors for which reactive strategies have been necessary.

The use of seclusion is identified through self-report by providers. There are varied requirements established in statute and rule, including that staff using reactive strategies must be trained in an Agency approved curriculum, that there must be designated “authorizing agents” within a providing agency, as well as prohibitions and limitations on the use of selected procedures, and requirements for documentation and monthly reporting to the Agency. Facilities are monitored monthly for compliance with client behavior management rules, Rule 65G-8, F.A.C., and by the ABA and ASBA for unusual patterns of use and procedures with adverse outcomes, such as a client death, client injury or procedures lasting over 60 minutes. The QIO and CMS Compliance Analysts also monitor these facilities on an annual basis. More specifically, every use of a reactive strategy (seclusion and restraint) is reviewed at the Local Review Committees of Behavior Analysts and may be reported to protective services.

Monthly reactive strategy reporting is monitored by the ABAs and ASBA for unusual patterns of use and procedures with adverse outcomes. Providers who have exhibited a pattern in reporting the use of reactive strategies are noted by ABAs and required to report monthly even if no procedures were implemented during the month. In addition, ABAs are also required to note gaps in reporting when they occur, prompting formal action against the provider.
Additionally, ABAs are required to complete an investigative follow-up for every reported incident involving the use of restraint, seclusion, restrictive intervention or a significant behavioral episode. Results from the investigation are documented and may require the provider to develop a corrective action plan by the Region’s Quality Assurance unit. More severe action may be taken depending on the history of deficiencies. The Local Review Committee must review behavior analysis providers’ behavior programs before they are implemented. The review ensures technical integrity, appropriateness of interventions, use of the least restrictive methods, and that an individual’s rights are protected.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of

seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Chapter 393, Florida Statutes, requires restrictive procedures to be used only for imminent danger and APD has promulgated Rule 65G-8, F.A.C., "Reactive Strategies," and amended Rule 65G-4, F.A.C., "Behavioral Practice and Procedure," to establish limitations and requirements when these procedures are used with waiver enrolled recipients.

These rules call for use of restraints or seclusion as a last resort, with efforts implemented to use preventative or less restrictive interventions first. All use of restraints and seclusion must be logged by providers, with reports submitted to APD monthly. In addition, behavioral services are monitored by the behavior analyst assigned to provide services either as an independent provider or as part of a residential program. This level of monitoring, as well as monitoring of incident reports provides additional opportunities to assure that reactive strategies are documented and used appropriately.

By rule, all waiver providers serving individuals with significant inappropriate behavior that may require use of physical management techniques are required to train their staff in an APD approved curriculum for emergency procedures. Minimum standards for curriculum content are outlined in Rule 65G-8, F.A.C., "Reactive Strategies." The providers are obligated to notify the APD of the curriculum they have elected to use and maintain records of certification of all staff for review by APD.

Reports of Reactive Strategy use will be reviewed at least monthly during the regular meeting of the APD Local Review Committee (LRC) to assure that individuals meeting limiting criteria for emergency procedure use have a behavior analysis support plan developed and reviewed to monitor the effectiveness of programs when they are in place. Behavior programs for individuals receiving use of reactive strategies will be reviewed at a frequency determined by the LRC chairperson, or at least annually.

Data related to reactive strategies, including seclusion, is monitored for trends and patterns at three levels:

Clinician Level: For those individuals with behavior programs, the behavior analyst providing services is watching the reactive strategy data in conjunction with data for targeted behavior that are the focus of the behavior program. This data is used to evaluate the effectiveness of the program written, along with fidelity data to show how well staff are implementing the plan. These data help to guide the need for revisions to the plan or additional training and monitoring of staff.

Local Field Office Level: The second level of review is conducted by the Area Behavior Analyst who sees data from all providers reporting use of reactive strategies locally. Providers appearing to use higher frequency and duration of procedures are given feedback by the Area Behavior Analyst to make corrections, or closer scrutiny of individualized behavior programs for their residents may be undertaken at the Local Review Committee conducted by the Area Behavior Analyst. This allows peers to offer suggestions for improvements to behavior programs.

State Office Level: The third level of review occurs at the State Office level where all Field Office reports are submitted monthly. Data is reviewed and trended to determine the average frequency, average duration, and numbers of procedures used on average across the state and within each area served by a Field Office. These trends are generated for each local area to allow feedback to be provided to the Area Behavior Analysts for follow-up with providers and/or the individuals they serve.

Rule 65G-4, F.A.C., "(Behavioral) Service Delivery Practice and Procedure," includes the monitoring and oversight of these procedures by the Local Review Committee, as well as the requirement to develop a behavior program when criteria for frequent use of "reactive strategies" has been met.

Seclusion within a locked room is not permitted. However, time-out, used either as a planned intervention within a behavior program or used on an emergency basis, whether used within a separate room or not, exceeding 20 minutes in duration is reported as "seclusion."

Alternative methods to avoid the use of "seclusion" are a required component within the emergency procedure curricula reviewed and approved by the Agency required under Rule 65G-8, F.A.C., "Reactive Strategies." Provider agencies that use emergency procedures are required to ensure staff are trained in one of these approved curricula. The curricula are required to include common preventative or diversionary

approaches such as:
a. Prompting and redirection
b. Varied verbal and nonverbal methods of defusing behavior problems, such as
1. Environmental modifications;
2. Body posture and movement;
3. Facial expression;
4. Empathic listening;
5. Increasing space between the individual and staff;
6. Things to say and how to say them/tone of voice;
7. Taking a walk.
c. Preventative measures, such as
1. Behavioral programs, including a required component for training and reinforcing replacement or alternative behavior;
2. Environmental modifications;
3. Rich, meaningful and diversionary activities;
4. Reinforcement procedures for demonstrating appropriate behavior;
5. Skill training, such as: social skills, problem solving, relaxation training, anger management training;
6. Medication for diagnosed mental health conditions;
7. Medical and dental exams to rule out any underlying physical conditions;
8. Other traditional therapies.

The State utilizes multiple levels of detection for the unauthorized use or misuse of seclusion. Monthly, the licensing staff within each local Field Office across the state monitor all residential providers. During these visits they view the home and the individuals residing there and the direct care staff. While conversing with the residents or staff, reviewing consumer records, log books for cross-shift communication or behavioral data collection sheets, evidence may emerge that leads to the discovery of either appropriate or inappropriate practices. Each of these methods enable reviewers to determine whether these events were addressed appropriately or not.

Similarly, if an event rises to the level of an “incident” or a call to the abuse hotline, the unauthorized use or misuse of seclusion may be identified. In addition, providers are required under Rule 65G-8, F.A.C., “Reactive Strategies” to report all applications of seclusion and restraint. The report indicates whether seclusion was used or not, the duration and whether any injuries occurred. If reported, and reported accurately, this allows the review, analysis and follow-up by the Regional Behavior Analyst, as well as the Agency Senior Behavior Analyst at the State Office level.

The use of seclusion is identified through self-report by providers. There are varied requirements established in statute and rule, including that staff using reactive strategies must be trained in an Agency approved curriculum, that there must be designated “authorizing agents” within a providing agency, as well as prohibitions and limitations on the use of selected procedures, and requirements for documentation and monthly reporting to the Agency. Facilities are monitored monthly for compliance with client behavior management rules, Rule 65G-8, F.A.C., and by the ABA and ASBA for unusual patterns of use and procedures with adverse outcomes, such as a client death, client injury or procedures lasting over 60 minutes. The QIO and CMS Compliance Analysts also monitor these facilities on an annual basis. More specifically, every use of a reactive strategy (seclusion and restraint) is reviewed at the Local Review Committees of Behavior Analysts and may be reported to protective services.

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.

The service providers have rules, policies, and procedures to follow to ensure the safe administration or supervision of medication administration.

The participant's support coordinator is also involved in reviewing the participant's medical records and Medication Administration Record (MAR) if the individual resides in an APD group home. Those residing in a supported living residence, could have a supported living coach who assists, or provides oversight for medication administration.

Field Office staff with the APD monitor group homes on a monthly basis. APD staff, service providers, and support coordinators all work with the APD Medical Case Managers to address areas of concern regarding medication regimens on an ongoing basis.

Medical Case Managers will review medications, physician orders, and MARs, as requested by licensing staff, service providers, and support coordinators. The contracted vendor also monitors provider compliance (if applicable) with medication administration on an ongoing basis, and issues alerts or reports to both the provider and APD for remediation of identified issues.

APD Medical Case Managers provide training to APD Field Office staff on Chapter 393.506, Florida Statutes, and Rule 65G-7, F.A.C., Medication Administration. Any medication error discovered by APD in APD licensed homes results in a "notice of non-compliance" and a corrective action plan. This encourages providers to self-report medication errors and suggest what remediation they will put in place to prevent future occurrences. All medication errors are reviewed by APD Medical Case Managers, with follow-up if necessary. If the Medical Case Manager determines that the error justifies corrective action (additional training, new policy/procedure for the provider, etc.), APD notifies the provider of the corrective action and includes a specific timeframe for completion. APD State Office nursing staff reviews medication error spreadsheets with each Regional/Field office a minimum of twice yearly. All providers who are responsible for medication administration are required to both record and report all medication errors to the APD Regional/Field Office.

In addition, unlicensed direct care staff are trained to compare the prescription to both the medication label and the entry in the MAR with each administration of medication, and to report discrepancies to their supervisors immediately.

Controlled substances in APD licensed group homes must be counted as specified in Rule 65G-7.007(5), F.A.C. These medications must be counted each shift by oncoming and offgoing staff. In cases where there are no shifts there are alternatives provided, all of which require a count at least once in each 24-hour period. Controlled substances must be stored separately from other medications and double locked. While the first line of controlled substance monitoring is performed by group home staff, the second line monitoring for controlled substances in APD-licensed group homes are performed by APD staff during monthly and annual licensure monitoring visits.

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.

The APD Medical Case Managers review and follow-up on issues cited by licensing, providers, APD Field Office staff, support coordinators, and the contracted vendor on an ongoing basis.

Medication errors are reported to the APD on the Medication Error Report Form. The APD Medical Case Managers will review and follow up as necessary. If the APD Medical Case Manager determines that a medication error justifies corrective action, including additional training, the APD will notify the provider and include a specific and reasonable timeframe for completion.

The APD Field Office staff, Medical Case Managers, and contracted vendor monitor and review MARs, recipient Authorization for Medication Administration and Informed Consent, and the direct service provider's Validation Certificate and Medication Administration Training Certificate.

Florida Medicaid has also contracted with a federally qualified contracted vendor to monitor the performance of waiver providers in the administration of medications to waiver participants. This monitoring is conducted during provider discovery reviews and person centered reviews on a continuous basis. The contracted vendor conducts monitoring statewide on a statistically valid sample of providers and individual recipients.

Any medication error discovered in an APD licensed home that was not self-reported, results in a "notice of non-compliance" and a corrective action plan. This encourages group home providers to self-report medication errors, and suggest what remediation they will do to prevent future occurrences. All providers who are responsible for medication administration (anywhere that medication administration occurs, including ADT, supported living, and any other environments where services are provided) are required to both record and report medication errors to the APD Regional/Field Office. All medication errors are reviewed by APD Medical Case Managers, with follow-up if necessary.

If the Medical Case Manager determines that the error justifies corrective action (additional training, new policy/procedure for the provider, etc.), the APD notifies the provider of the corrective action and includes a specific timeframe for completion. The APD State Office reviews medication error spreadsheets with each Regional/Field Office at least twice yearly.

The contracted vendor also monitors provider compliance (if applicable) with medication administration on an ongoing basis, and reports any problems identified to APD for remediation. The state monitoring program gathers information continuously through the Provider Performance Discovery Reviews (PDRs) and Person Centered Reviews (PCRs). Information can readily be categorized into two sets, those requiring immediate follow up and longer term quality improvement activities.

1) Any incident which potentially affects the health, safety, and welfare or the individual rights of a participant is addressed through an Alert. This process provides information to the Operating Agency (APD) immediately on discovery, and notification of the state abuse hotline as indicated by the nature of the issue at hand. The State Medicaid Agency is notified as well to provide continuous follow up on the issue. Alerts are addressed with the participant and/or waiver provider immediately, but not to exceed three business days.

2) Deficiencies not rising to the level of an alert are addressed in the reporting processes of the contracted vendor. The report data is provided to the Operating Agency, the State Medicaid Agency, and the provider. The Operating Agency then follows the remediation activities of the waiver provider to ensure improvement activity. The vendor is monitored to demonstrate improved compliance at intervals of 30 days until all corrective actions are completed.

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).

Chapter 393.506, Florida Statutes and Rule 65G-7, F.A.C., Medication Administration govern the administration of medications or the supervision of medication administration for unlicensed staff. This outlines:

a. Who can administer or supervise;
b. Training required;
c. Validation of skills;
d. Informed consent;
e. Medication administration procedures;
f. Medication errors;
g. Storage requirements;
h. Documentation and record keeping; and
i. Off-site medication administration.

Direct service providers who administer medication must first take a Medication Administration Training course that has been provided by the APD and which is taught by an authorized Registered Nurse or Licensed Practical Nurse. They must pass this course as outlined in Section 393.506, Florida Statutes, and Rule 65G-7, F.A.C., with a score of 80% or greater on the final exam. Before administering medications, they must be 'validated' to administer medications by a LPN, RN, ARNP, MD, or PA, in an actual client setting, with an actual client, and using medication that is ordered for that client. Validation for three simulated routes (topical, transdermal, and otic) is provided either in the required training course or by an approved validation trainer. The simulated route validations do not expire annually. All other routes must be validated with an actual client using that client's actual medications, and each of these must be re-validated each year. Each route of medication administration must be validated separately. The routes direct service providers are allowed to administer are: oral, enteral, topical, otic, inhaled, ophthalmic, rectal, and transdermal. There is no requirement that each direct service provider be validated on all routes, but no direct service provider may administer medication via a route on which they have not received validation. All validations, except for the simulated routes, must be renewed annually. Before revalidating, all direct service providers must take and pass an Annual Update on Medication Administration and Medication Error Prevention, provided online on TRAIN Florida or from their APD Regional Medical Case Manager. If validation of the primary route (usually oral or enteral) is allowed to lapse, the direct service provider must re-take the Medication Administration Training course, and then attempt validation.

Direct service providers who are trained and validated on their primary routes may receive further training from an authorized Trainer to provide Prescribed Enteral Formula Administration to clients. They must be trained and receive validation with an actual client using that client's actual Prescribed Enteral Formula. Direct service providers who provide this service must take and pass an Annual Update on Prescribed Enteral Formula Administration annually with their APD Regional Medical Case Manager.

Licensed Practical Nurses, Registered Nurses, and Advanced Practice Registered Nurses must take and pass a Medication Administration Trainer Training course before being approved to train direct service providers on Medication Administration. When they are approved as Medication Trainers, they receive the approved course materials from their APD Regional Medical Case Manager. Medication Trainers are required to attend and pass an Annual Update course provided by APD Medical Case Managers annually in order to continue to train.

Licensed Practical Nurses, Registered Nurses, Advanced Practice Nurses, Medical Doctors, Doctors of Osteopathy, and Physician Assistants who wish to provide Validation Training to direct service providers must take a training course with their Regional Medical Case Manager before being approved, with the exception of Nurses who are approved as Medication Trainers. Validation Training providers do not have an Annual Update requirement, but may be required to attend further trainings or updates from time to time.

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:

APD Medical Case Managers/Regional/Field Offices review all medication errors submitted.

(b) Specify the types of medication errors that providers are required to *record:*

-Medications given to the wrong person
-Wrong dose of medication given
-Newly prescribed order not initiated within 24 hours
-Medication refill not ordered timely
-Controlled Medication Sheet not accurate
-MAR not accurately documented
-Wrong medication given
-Medication not given
-Medication not given at the right time
-Refused medication
-Medications given by non-validated staff

(c) Specify the types of medication errors that providers must *report* to the state:

-Medications given to the wrong person
-Wrong dose of medication given
-Newly prescribed order not initiated within 24 hours
-Medication refill not ordered timely
-Controlled Medication Sheet not accurate
-MAR not accurately documented
-Wrong medication given
-Medication not given
-Medication not given at the right time
-Refused medication
-Medications given by non-validated staff

Medication errors that occur in other service environments are also reported.

○ **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:

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.

Field Office staff with the APD monitor group homes on a monthly basis. The APD Field Office staff work with the APD Medical Case Managers to address issues of concern.

Medication errors are reported to APD on the Medication Error Report Form. The APD Medical Case Managers review and follow up as necessary. If the APD Medical Case Manager determines that a medication error justifies corrective action, including additional training, the APD will notify the provider and include a specific and reasonable timeframe for completion.

The APD Medical Case Managers provide training to the APD Field Office staff on Chapter 393.506, Florida Statutes, and Rule 65G-7, F.A.C., Medication Administration. Any medication error discovered by APD in an APD licensed homes results in a "notice of non-compliance" and a corrective action plan. This encourages providers to self-report medication errors and suggest what remediation they will put in place to prevent future occurrences. All medication errors are reviewed by the APD Medical Case Managers, with follow-up if necessary. If the Medical Case Manager determines that the error justifies corrective action (additional training, new policy/procedure for the provider, etc.), the APD notifies the provider of the corrective action and includes a specific timeframe for completion. The APD State Office reviews Medication Error Spreadsheets with each Regional/Field office at least twice yearly. All providers who are responsible for medication administration are required to both record and report all medication errors to the APD Regional/Field Office.

The contracted vendor also monitors provider compliance (if applicable) with medication administration on an ongoing basis, and reports any problems identified to APD for follow-up and possible remediation. Regional/Field Office Medical Case Managers record all reported medication errors on an Excel Spreadsheet that is reviewed with to APD State Office, Clinical Support RN staff at least twice yearly. State Office RN staff review the medication error spreadsheets with each Regional/Field Offices, asks for clarification if needed, and aggregates the errors to look for trends. If trends are noted on either a local, regional or statewide level, State Office works with Regional/Field Office staff to develop solutions and improvement strategies. Medication errors are discussed during each monthly Medical Case Management conference call.

The contracted vendor acquires medication administration data through the PDR and PCR process, which is routinely aggregated to inform the state of trends and to support ongoing improvement activity. Data is provided quarterly in addition to ad-hoc requests in response to specific areas of interest. This data is presented in reports to the Quality council, and to the agencies to address ongoing improvement activities.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
(G-1) Percentage of critical incidents reported to APD within required time frames. N: Number of critical incidents reported to APD within required time frames. D: Number of critical incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident reports and data from FMMIS regarding billed ER visits and the codes for the visit.

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:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
(G-2) Percentage of critical incidents finalized, including strategies to mitigate/prevent future incidents, within the required time frame. N: Number of critical incidents finalized, including strategies to mitigate/prevent future incidents, within the required time frame. D: All critical incidents, by type of incident.

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
(G-3) Percentage of reactive strategies reported by providers with adverse outcomes or excessive duration where appropriate follow-up was completed as required. N: Number of reactive strategies with adverse outcomes or excessive duration reported by provider where appropriate follow-up was completed as required. D: Number of reactive strategies with adverse outcomes or excessive duration.

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

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:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
(G-4) Percentage of recipients whose identified health and/or safety needs are addressed. N: Number of recipients whose identified health and/or safety needs are addressed. D: Total number of recipients reviewed with health and/or safety needs.

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: Contracted Vendor	☐ **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: Contracted Vendor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

In addition to issues of abuse, neglect, and exploitation reported through the State's official reporting process or identified by the CV, concerns and complaints from consumers, families, providers, and other stakeholders about any issue of health or safety may be submitted to the APD at any time. The APD will follow-up immediately. They will also enter all issues into the central database for tracking and trending.

The operating agency collects data from FMMIS regarding billed ER visits and the codes for the visit for all APD clients. Once the data is obtained, staff compares the FMMIS data with reported adverse incident data to ensure all adverse incidents have been reported by providers. Any discrepancies that are found are discussed and remediation actions taken with the provider to ensure timely and accurate reporting of all incidents.

For the performance measure related to individuals assisted by providers to know about their rights the CV monitors providers to determine if individuals were assisted to know about their rights. During the Support Coordination Provider Discovery Review, the CV reviews the record and conducts an interview the provider to capture this information. The provider must provide examples of how individuals have been fully assisted to exercise their rights and make informed choices. The provider also must present examples of how the provider has observed the rights and responsibilities of individuals. The CV interviewer, interactively with the provider, reviews documentation supporting the discussion.

As part of the Person Centered Review, the CV also interviews the waiver recipient to determine if the person is educated and assisted by supports and services to learn about rights and to fully exercise rights, but especially those that matter most to the person. This includes dignity, respect, and privacy. The individual is asked probing questions such as:

1) Who talks to you about your rights?
2) What right is most important to you?
3) Is there anything you want to do that you are not allowed to do?
4) Do you feel respected? What does privacy mean to you?
5) Where do you go when you would like to be by yourself (while at home and work)?
6) Has there ever been a time when someone has shared your personal information without your permission?
7) If you feel someone is violating your rights, what do you do?

The CV provides data to APD for reporting and follow-up purposes.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

(G-1) Remediation occurs most frequently at the individual recipient level, and follow-up action is taken on a case-by-case basis at the Operating Agency Regional Office level. Aggregated data at the Operating Agency State Office level will be analyzed to identify systemic problems. Prior to action by the Operating Agency, some issues are dealt with by the provider in response to discovery. The Regional Operating Agency Office where the critical incident occurred would be next to respond and conduct follow-up with the provider to confirm resolution to performance gaps identified. Problems are addressed depending on the risk and the complexity of the situation. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

(G-2) Providers are required to prepare, submit for approval, and then execute approved corrective plans for failure to provide follow up on critical incident reports, which includes strategies to mitigate/prevent future incidents of a repeated or similar occurrence. The implementation and outcomes of corrective plans (strategies to mitigate/prevent future incidents) are tracked by the Operating Agency and reported to the State Medicaid Agency. Additionally, the Operating Agency adopted Rule 65G-14.003, F.A.C. to require reporting of a "violation of ethical or professional conduct" on the part of a Support Coordinator to the Regional Office.

(G-3) Remediation occurs at the individual recipient level, and action is taken on a case-by-case basis at the Operating Agency Regional Office level. Monthly reports from providers are submitted to the local Regional Office and reviewed by the Area Behavior Analyst (ABA). Those cases where there is an adverse outcome (client death or injury) or the application of a reactive strategy that exceeds 60 minutes requires follow-up with the provider by the ABA. These cases, as well as the aggregated data will be used to determine whether an additional Local Review Committee review and behavior program changes are needed. The Operating Agency also reviews and analyzes the aggregated data to identify individual recipient concerns as well as systemic problems that require notification and follow-up by a specific ABA, or all ABAs throughout the State.

(G-4) On a continuous and ongoing basis, providers are required to ensure recipients' identified health and/or safety needs are addressed. For all deficiencies cited in a Provider Discovery Review (that includes Person Centered Review information), providers are required to prepare, submit for approval, and then execute approved remediation pans. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

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:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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.

Basic processes have been put in place for discovery and remediation. The procedure provides instructions for providers and the APD regional staff to report and perform follow-up in a consistent manner. Training was provided to regional staff and Waiver Support Cooridnators. The APD collects the information and aggregrates discovery and remediation data.

Appendix H: Quality Improvement Strategy (1 of 3)

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 QIS 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; and
- 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 OIS* 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 QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

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.

The Operating Agency has established an internal quality assurance and improvement team. This team has established a broad plan to trend data and prioritize needed system changes. A CV has been contracted as a key partner in the discovery component to gather and trend major data elements, such as those reflecting provider quality, and recipient choice and service plan development. The Operating Agency will itself gather and trend other data elements not available to the CV in order to develop and maintain a comprehensive view.

The Operating Agency works with a Quality Council to prioritize system improvements based on an analysis of discovery and remediation information. The Operating Agency oversees the implementation of these systems improvements.

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:	☐ **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.

Based on the CMS framework, QIO responsibilities are shared across a number of levels.

Contracted Vendor
*Quality Improvement
*Discovery
*Data collection
  Person Centered Reviews (PCR)
  Provider Performance Discovery Reviews (PDR)
*Alert Reporting
*Reports and distribution
*Review of provider performance outcomes, trends & patterns
*Recommendations

APD
*Remediation
*Data collection
*Review of data/reports to determine compliance with waiver assurances
*Review of regional/field performance outcomes, trends & patterns
*Approval of remediation plans (Quality Improvement Plan/Plans of Remediation) (QIP/POR)
*Monitors progress & follow up on QIPs/PORs
*Implementation of policies and procedures identified; modified, new or terminated
*Coordination & monitoring of Quality Management System
*Reviews statewide performance outcomes, trends, and patterns
*Initiates policy, procedures and practices to implement system design changes to enhance quality
*Evaluates data sources required to measure system performance
*With input from other stakeholders, determines, prioritizes, and coordinates the implementation of quality improvement system changes

AHCA
*Review of provider billing
*Recoupment of funds from inappropriate billings
*Contract management
*Oversight

Recipient/Family
*Measuring Satisfaction
*Budget Management

Providers
*Development and implementation of person centered supports/plans
*Accountability
*Case management
*Licensed/Trained/Certified

There will be an integration of functions within the Quality Management System that will encompass an overall organizational capacity along with collaboration to ultimately improve services and supports, and provide for waiver assurance oversight.

Data collection will be input from a number of sources, ultimately into a statewide database. Database sources are to include at minimum APD and CV entries. The statewide database would be part of an electronic information management system that will include, but is not limited to:
*Individual Client Electronic Records
*Incident Reporting System
  -Death reports
  -Medication errors
  -Critical/Reportable Incidents
  -Reactive strategies.

-Abuse, Neglect and Exploitation

A Quality Council (QC) has been established to collaborate with stakeholders, organizations, and agencies to ensure that Floridians with developmental disabilities are receiving the highest quality of services by providers and to allow individuals to utilize their abilities to the fullest extent.

The QC will be asked to:
Provide feedback on quality assurance activities for recipients of developmental disabilities receiving services from the Home and Community-Based Services Waivers;
Provide feedback to enhance quality of services and appropriate health, safety and quality of life for people based on data generated by Discovery reviews;
Provide feedback to the Contracted Vendor on their implementation of quality assurance reviews of Home and Community-Based Services Waivers providers;
Provide feedback on quality improvement of service delivery at the:
- provider level,
- area level,
- state level; and
Compare Floridas performance measures to national data.

The APD, in conjunction with the Quality Council, will review longitudinal trend data for the measures related to the system design changes to determine whether system design changes have had the intended effects. Providers, area offices, and recipients and their family members will continue to submit required data and responses as inputs for data collection. The QIO will also continue to collect data and provide reports on trends. Additional data may be collected from these parties to enable the state to assess the implementation and outcome of the system changes.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The evaluation of the Quality Improvement Strategy is an ongoing process. This process will have two main goals: determining whether the Quality Improvement Strategy is being implemented according to the waiver and whether it is in fact improving quality outcomes.

To address the first goal, at least annually, the APD will review the functioning of the QIS to assess compliance with its stated processes, such as whether the various parties involved are performing their responsibilities as outlined in the waiver. This process will also include input from the QIO, APD Regional/Field Offices, and APD stakeholders to identify any improvements that can be made to accurately carry out the strategy contained herein. The Operating Agency will also solicit feedback on how roles, responsibilities, and processes might be modified to enhance the effectiveness of the Quality Improvement Strategy.

Additionally, a high-level analysis of data regarding the outcomes of all of the system design changes made to enhance the systems effectiveness will be conducted and reviewed annually by the headquarters office and the Quality Council. This will help the state determine whether its efforts to prioritize and implement system improvements are in fact effective. For example, positive trends in a majority of indicators related to system improvements will demonstrate that the process for prioritizing and implementing system design changes is broadly effective.

As the Quality Improvement Strategy requires enhancement, the operating agency will work with stakeholders to identify and implement appropriate modifications.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

◉ **No**

- **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- **HCBS CAHPS Survey :**
- **NCI Survey :**
- **NCI AD Survey :**
- **Other** *(Please provide a description of the survey tool used):*

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).*

The State does not require iBudget Waiver providers to secure an independent audit of their financial statements.

The integrity of payments is ensured through AHCA's claim system for the Medicaid program, the Florida Medicaid Management Information System (FMMIS), which interfaces with the APD's iConnect. The Developmental Disabilities Individual Budgeting Waiver providers bill through FMMIS, which interfaces with APD's iConnect, allowing only services approved by the APD regional to be paid. All claims for waiver services are submitted through FMMIS. The FMMIS includes edits to compare waiver enrollment data with dates of service to ensure individuals are eligible on the date of service. The iBudget Waiver services are authorized on a quarterly basis and reviewed by the CV monthly to identify the billing provider, unduplicated recipient counts, amounts billed and actual reimbursement amounts. The state staff monitors waiver providers for fiscal accountability through post payment audits of paid claims. Financial audits are conducted by the APD, the AHCA, and the Auditor General's Office. Periodic independent audits in accordance with the Single Audit Act are conducted by the Auditor General's Office.

Florida Medicaid contracts with a CV to conduct provider discovery reviews. The time period of data the operating agency uses for contracted provider discovery and performance reviews is 12 months. The operating agency performs complaint reviews when the region determines they are necessary. The CV conducts audits as part of the overall monitoring of the iBudget Waiver program. The CV routinely verifies that providers comply with the state's required billing practices. The CV quarterly reports contain data that reflects the review and compliance of providers billing practices. Providers non-compliant with billing requirements are reported to the AHCA and the APD. Reviews are conducted on a statistically valid sample size with a 95% confidence interval and include verification that evidence to support provider billings is in the record of the participant prior to invoicing Medicaid. The CV also conducts person centered reviews, which result in a direct on-site review of every service provider for the participant. This review encompasses the review of all billing and supporting documentation for all services provided to the individual for the last year. These processes are more fully described in Appendix G-3-b-ii; State Oversight and Follow-up. The most recent list of waiver recipients is obtained from the APD's iConnect system to generate a sampling frame of eligible individuals and their corresponding Support Coordinator. The following exclusion criteria are applied:

- *Individuals who do not have a Support Coordinator*
- *Individuals who are missing a waiver begin date*
- *Individuals who participated in a PCR in the past two years*

The Contracted Vendor uses the list to randomly select two individual records from each support coordinator's caseload. For support coordinators who have received a 99% or higher on their last annual provider discovery review, one record is randomly selected.

The State Medicaid Agency conducts periodic and routine reviews through the Medicaid Program Integrity (MPI) office. The CV findings are reviewed for follow up and recoupment directly through the MPI office. The State is also conducting advanced data analysis of billing patterns to detect improper and fraudulent billing. Each contract year (every 12 months) all eligible providers are up for review. Eligible providers offer the following services:

- *Behavior Analysis*
- *Behavior Assistant*
- *CDC+ Consultant*
- *CDC+ Representative*
- *Life Skills Development 1 (Companion)*
- *Life Skills Development 2 (Supported Employment)*
- *Life Skills Development 3 (Adult Day Training)*
- *Life Skills Development 4 (Prevocational Services)*
- *Personal Supports*
- *Residential Habilitation*
- *Respite Care (Under 21)*
- *Special Medical Home Care*
- *Support Coordination*
- *Supported Living Coaching*

Providers who meet Deemed Status criteria based on the previous year's performance are removed from the list. Deemed Status means a provider can skip a year but are then automatically included in the next review cycle.

Medicaid Program Integrity reviews are comprehensive reviews of providers to identify fraud, waste, and abuse. Potential

identification of fraud is referred to the Office of the Attorney General, Medicaid Fraud Control Unit. Waste and abuse are investigated by MPI. The MPI audit is a comprehensive, more in depth audit of the provider's practice and must be defensible in an Administrative Hearing. MPI reviews compliance with Federal and state laws, Rules and promulgated Medicaid policy, including qualifications of all staff, service documentation, and comparison of both eligibility and documentation to billing and reimbursement. MPI identifies overpayments and applies sanctions to the provider.

The APD creates an electronic file which is transferred to the state fiscal agent and includes all approved service authorizations contained in the APD database. Each approved service authorization contains the recipient ID, provider ID, procedure code/modifiers, date range, approved amount and the unit rate. Thus, no claims are paid unless the services were previously authorized and the billing matches the prior authorization record on file.

The APD regional office staff conducts further review to determine whether recoupment action is required and the repayment amount for the provider. As part of the remediation process, the APD Regional Administrator, or designee will meet with the cited provider to explain the parameters of repayment to the state. The discussion typically includes the provider's corrective action plan, detailing how the provider will eliminate the billing deficiency. As with all remediation, the APD Regional Office monitors the provider's progress to ensure it completes the action plan set forth. In some instances the issue is referred to the AHCA MPI unit for further investigation and possible sanctions. When fraud is suspected, the matter is referred to the State Attorney General's Medicaid Fraud Control Unit.

The Operating Agency does not have the authority to recoup any funds that are cited during a provider discovery review (PDR). The "further review" performed by the regional quality assurance staff is done during a face-to-face or phone meeting with the provider while discussing the plan of remediation (corrective action plan) required actions. The APD QA staff provide technical assistance and guidance to the provider on standards cited as "not met" on the PDR as a training and improvement opportunity. This is done specifically to avoid the provider being cited the same discrepancies in the future.

In reference to FMMIS adjustments when a recalculation is made of claims previously paid, resulting from an incorrect Federal Financial Participation (FFP) rate in FMMIS, Medicaid Fiscal Agent Operations adjusts the actual claims payments made to provider(s) for a period of time, until the amount is completely recouped. As a result, Financial Services will see only the adjusted actual cost amount, post FFP adjustment. Given this, Financial Services will then draw sufficient funds to pay the adjusted FMMIS provider costs. Because an adjustment is made in FMMIS claims payments, to pay the provider(s), less the overpayment of FFP amount, the overpayment is effectively returned to CMS. In reference to FFP draw adjustments when the adjustment is not made in FMMIS, and therefore affected by Financial Services. The Grants Unit staff would calculate the amount, or be provided with the amount, of the adjustment to FFP needed. The unit would then reduce one or more FFP draws, by the amount of the inappropriate or recouped billings, until the net federal draw(s) is reduced by the amount of the inappropriate or recouped billings. This option is usually used to adjust for: drug rebates received from drug companies; recouped Medicaid payments sent to providers in error; recouped Medicaid fraud, abuse and overpayments received from providers; or a clear record of the adjustment is needed for an audit response to corresponded to a CMS 64 report. In this way, we effectively return/credit CMS for the FFP previously drawn incorrectly or recouped.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "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. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
(I-1) Percentage of providers billing for services in accordance with the recipient's service authorization. N: Number of providers billing for services in accordance with the recipient's service authorization. D: Number of providers 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:* *Contracted Vendor*	☐ ***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:* *Contracted Vendor*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
(I-2) Percentage of providers billing for waiver services at the correct rate. N: Number of providers billing for waiver services at the correct rate. D: Number of providers reviewed.

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

Responsible Party for	***Frequency of data***	***Sampling Approach****(check*

data collection/generation *(check each that applies):*	***collection/generation*** *(check each that applies):*	*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:* *Contracted Vendor*	☐ ***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:* *Contracted Vendor*	☒ ***Annually***
	☐ ***Continuously and Ongoing***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Other*** *Specify:*

Performance Measure:
(I-3) Percentage of claims paid at the correct rate, as published in the fee schedule submitted in the waiver application. N: Number of claims paid in accordance with the rate in the fee schedule and all other policy requirements. D: Number of total claims paid.

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:* *Contracted Vendor*	☒ ***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:* *Contracted Vendor*	☒ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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.*

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States 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.*

(I-1, I-2, I-3) The provider bills through the FMMIS system which has edits in place to disallow payment of claims unless they have been prior approved by APD and reported on the gatekeeper matrix file.

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***	☐ ***Annually***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
Specify:	
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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).*

The rate model for all waiver services included calculating the direct care staff wages, employment-related expenditures, program-related expenditures, and general and administrative expenditures. In addition to calculating the four rate components, the actuaries developed geographical factors based upon their survey of a sample of provider costs, audited financial reports, and a market analysis of Bureau of Labor statistics for wages and compensation practices, housing rent and lease costs, uninsured workers, crime statistics, and cost of living indices.

Provider rates are subject to the availability of funding provided by the Florida Legislature. Rates may be adjusted upon the direction of the legislature. The State employs the services of actuarial firms to examine rate setting assumptions and methods for establishing provider service rates.
Provider service rate models were developed separately for the three following service groups:
Group One: Life Skills Development Level 2 – Supported Employment, Life Skills Development Level 3 – Adult Day Training, Life Skills Development Level 4 - Prevocational Services, consumable medical supplies, durable medical equipment and supplies, environmental accessibility adaptations, personal emergency response systems, residential habilitation general information, residential habilitation (standard), residential habilitation (behavior focused), residential habilitation (intensive behavior), special medical home care, supported living coaching, supported coordination, behavior analysis services, behavior assistant services, dietitian services, private duty nursing, residential nursing services, skilled nursing, specialized mental health counseling, transportation services, and dental services. Rates for physical therapy, occupational therapy, speech therapy, respiratory therapy, behavioral analysis services assessment, physical therapy assessment, occupational therapy assessment, speech therapy assessment, psychological assessment, respiratory therapy assessment, therapeutic massage assessment, specialized mental health therapy assessment, and special medical home care relied on the same data and hourly therapy rates which did not exceed the home and community based services maximum allowable rates at the time.
Group Two: personal support services, respite services, residential habilitation services (live-in), and Life Skills Development Level 1 - Companion Services.
Group Three: enhanced intensive behavior services.

To ensure the Group Two payment rates were compliant with the Fair Labor Standards Act (FLSA) and included wages comparable to current industry standards, the actuaries surveyed waiver providers who provided waiver services in calendar year 2014, to collect financial and other information related to the provision of those services and associated costs. Additionally, they collected and reviewed publicly available data on wages for workers in the industry based on the North American Industry Classification System for "Services for the Elderly and Persons with Disabilities" category in the "Health Care and Social Assistance" sector. The actuaries also collected and reviewed industry worker's compensation information and public information on taxes and benefits. To address the enhanced intensive behavioral (EIB) needs for some waiver recipients, the APD worked with actuaries to develop a rate for Group Three services that required higher staffing ratios for direct care professionals. The staffing ratio assumption for the new enhanced rate is one-to-one coverage during awake hours and one staff to two recipient coverage during asleep hours.

In 2022, the operating agency contracted with an actuarial vendor to review all Personal Care related services and ensure rates reflect the ability for the provider to pay $15/hour minimum wage to direct care staff of those services. This resulted in changes to the rates for all Personal Care related services.

Rates are promulgated into rule. During the rule promulgation process, the Medicaid agency publishes a notice in the Florida Administrative Register (FAR) alerting the public of scheduled workshops and hearings where input may be provided. Written comments may also be submitted in lieu of oral comments at the public meeting. Providers have the opportunity to provide input on rates through the administrative rule-making process. The AHCA has rule-making authority including promulgation of the Coverage and Limitations Handbook and rate rules.

Rates are posted on the Internet by AHCA and APD and available to waiver participants at the following websites:
https://www.flrules.org/gateway/ruleno.asp?id=59G-13.081
http://apd.myflorida.com/docs/Rate%20Changes%20Effective%2007012016.pdf (APD)
http://apd.myflorida.com/providers/rates-billing/docs/procedure-code-table.pdf (APD)

When changes occur, the public is generally notified through a healthcare alert. The public can enroll to receive healthcare alerts at the following website: http://ahca.myflorida.com/MCHQ/alerts/alerts.shtml

Waiver participants have the option to sign up for notices in the FAR, alerting the public of any new rules at the following website: https://www.flrules.org/Default.asp

When the state legislature, as the appropriating body, provides additional funding to increase provider rates, rates are adjusted proportionately to utilize funding allocated. Providers are notified of rate increases through advisories and receive updated service authorizations. When necessary, the services of actuaries are obtained for rate development.

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 FMMIS system has recipient eligibility and provider information. The recipient information is updated as part of the eligibility determination process. A provider file is established upon enrollment of a provider. Payments will be reflected on the providers file. Edits in FMMIS are designed to ensure that payments for DD Waiver services are made only for authorized services to eligible recipients rendered by enrolled providers.

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.)

☐ ***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:*

The process begins with the support plan or cost plan approval at the APD Regional/Field Office. Support Coordinators are responsible for verifying Medicaid eligibility through FMMIS or the Department of Children and Families, which determines eligibility in Florida. No services can be planned or delivered without that validation. Upon verification of eligibility, the support plan process begins and services are planned and delivered accordingly. The provider bills through the FMMIS system, which has edits in place to disallow payment of claims unless they have been prior approved by the APD Regional/Field Office.

Support Coordinators validate service delivery during monthly visits to ensure the recipient received necessary supports and services. This is also validated during the CV reviews examining claims billed and services delivered.

In reference to FMMIS adjustments when a recalculation is made of claims previously paid, resulting from an incorrect Federal Financial Participation (FFP) rate in FMMIS, Medicaid Fiscal Agent Operations adjusts the actual claims payments made to provider(s) for a period of time, until the amount is completely recouped. As a result, Financial Services will see only the adjusted actual cost amount, post FFP adjustment. Given this, Financial Services will then draw sufficient funds to pay the adjusted FMMIS provider costs. Because an adjustment is made in FMMIS claims payments, to pay the provider(s), less the overpayment of FFP amount, the overpayment is effectively returned to CMS. In reference to FFP draw adjustments when the adjustment is not made in FMMIS, and therefore affected by Financial Services. The Grants Unit staff would calculate the amount, or be provided with the amount, of the adjustment to FFP needed. The unit would then reduce one or more FFP draws, by the amount of the inappropriate or recouped billings, until the net federal draw(s) is reduced by the amount of the inappropriate or recouped billings. This option is usually used to adjust for: drug rebates received from drug companies; recouped Medicaid payments sent to providers in error; recouped Medicaid fraud, abuse and overpayments received from providers; or a clear record of the adjustment is needed for an audit response to corresponded to a CMS 64 report. In this way, we effectively return/credit CMS for the FFP previously drawn incorrectly or recouped.

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:

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.

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:

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.

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.

◉ ***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.***

○ ***This waiver is a part of a concurrent ?1115/?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 ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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:

Appropriation is made to APD. Funds are electronically transferred to AHCA for the payment of providers. AHCA makes the request for the federal match from CMS.

☐ ***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:*

Payments to providers of residential habilitation services are not made for the recipient's room and board, the cost of facility maintenance, upkeep, and improvement, other than such costs for modifications or adaptations to a facility required to ensure the health and safety of residents, or to meet the requirement of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the recipient's immediate family. Payments will not be made for activities or supervision for which payment is made by a source other than Medicaid.

The amount of room and board payment that participants will make is determined by the Florida Department of Children and Families Adult Services Program. The determination is based upon the participant's income from third party benefits and other income. If income is not sufficient to meet the room and board charges of the facility, the participant's circumstances can be reviewed to determine whether they will be eligible for an Optional State Supplement (OSS). The OSS payments are applied toward the cost of room and board.

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-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

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	47817.06	11175.25	58992.31	232539.90	5021.24	237561.14	178568.83
2	49722.39	11622.26	61344.65	241841.50	5222.09	247063.59	185718.94
3	52503.23	12273.11	64776.34	255384.62	5514.52	260899.14	196122.80
4	55442.99	12960.40	68403.39	269686.16	5823.34	275509.50	207106.11
5	58544.01	13686.18	72230.19	284788.58	6149.44	290938.02	218707.83

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

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 Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	40742	40742

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 2	41637	41637
Year 3	43137	43137
Year 4	44637	44637
Year 5	46137	46137

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

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 length of stay on the iBudget waiver during Waiver Year 4 of the current waiver (4/1/2022-3/31/2023) was 344.3. Most recipients on the Developmental Disabilities Individual Budgeting Waiver remain enrolled until they move out of state or pass away.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

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 and methodology for these estimates is as follows:*

The reference period for service estimates is previous Waiver Year 4 (4/1/2022 to 3/31/2023) using claims data available as of 6/27/2023. The reference period 4/1/2022 to 3/31/2023 reflects costs resulting from new reimbursement rates effective 7/1/2022 due to Florida's $15 minimum wage and is likely to be more representative of service utilization after the end of the COVID19 Public Health Emergency than waiver years 2 and 3. Units and recipient counts reflect the entire period 4/1/2022 to 3/31/2023. Costs reflect reimbursements from 7/1/2022 to 3/31/2023.

Average cost per unit for Life Skills Development II hour and Life Skills Development IV have been increased 24.28% to account for rate increases to be effective 7/1/2023. Support Coordination Full and Enhanced have been increased 10% and Support Coordination Limited has been increased 10.01% to account for rate increases to be effective 7/1/2023.

Price inflation rates for waiver year services are from the National Health Expenditure Projections 2021-2030 Forecast Summary published by the Centers for Medicare and Medicaid Services (CMS). For Medicaid, spending growth during the period covered by waiver year 1 is forecasted to be approximately 4.0%. The period covered by waiver years 2 and 3 are expected to increase 5.6% on average. Annualized prices from the reference period (7/1/2022 to 3/31/2023) to waiver year 1 of the renewal were increased approximately by 2.7% per year.

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' estimates are derived from the actual Medicaid cost for State Plan services for waiver recipients. Costs are annualized for the period 7/1/2022-3/31/2023 to represent increased reimbursements due to Florida's $15 minimum wage. Medicaid/Medicare dual eligible individuals receive prescription drugs through Medicare Part D and enrollment in Medicare approved prescription drug plans. Edits in the Florida Medicaid Management Information System (FMMIS) system prevent Medicaid payments of prescription drug costs for Medicaid/Medicare dual eligible recipients.

Price inflation rates for waiver year services are from the National Health Expenditure Projections 2021-2030 Forecast Summary published by the Centers for Medicare and Medicaid Services (CMS). For Medicaid, spending growth during the period covered by waiver year 1 is forecasted to be approximately 4.0%. The period covered by waiver years 2 and 3 are expected to increase 5.6% on average. Annualized prices from the reference period (7/1/2022 to 3/31/2023) to waiver year 1 of the renewal were increased approximately by 2.7% per year.

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 estimates are based on utilization for Intermediate Care Facilities for individuals with Developmental Disabilities from 4/1/2022 to 3/31/2023 using claims from the Florida Medicaid Management Information system that were submitted and adjudicated as of June 2023. Costs are annualized for the period 7/1/2022-3/31/2023 to represent increased reimbursements due to Florida's $15 minimum wage.

Price inflation rates for waiver year services are from the National Health Expenditure Projections 2021-2030 Forecast Summary published by the Centers for Medicare and Medicaid Services (CMS). For Medicaid, spending growth during the period covered by waiver year 1 is forecasted to be approximately 4.0%. The period covered by waiver years 2 and 3 are expected to increase 5.6% on average. Annualized prices from the reference period (7/1/2022 to 3/31/2023) to waiver year 1 of the renewal were increased approximately by 2.7% per year.

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' estimates are derived from the actual Medicaid costs for state plan services for ICF/IDD residents during WY4. Costs are annualized for the period 7/1/2022-3/31/2023 to represent increased reimbursements due to Florida's $15 minimum wage. Medicaid/Medicare dual eligible individuals receive prescription drugs through Medicare Part D and enrollment in Medicare approved prescription drug plans. Edits in the FMMIS system prevent Medicaid payment of prescription drug costs for Medicaid/Medicare dual eligible recipients.

Price inflation rates for waiver year services are from the National Health Expenditure Projections 2021-2030 Forecast Summary published by the Centers for Medicare and Medicaid Services (CMS). For Medicaid, spending growth during the period covered by waiver year 1 is forecasted to be approximately 4.0%. The period covered by waiver years 2 and 3 are expected to increase 5.6% on average. Annualized prices from the reference period (7/1/2022 to 3/31/2023) to waiver year 1 of the renewal were increased approximately by 2.7% per year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

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	
Life Skills Development Level 3 - Adult Day Training	
Life Skills Development Level 4 - Prevocational Services	
Residential Habilitation	
Respite	
Support Coordination	
Adult Dental Services	

Waiver Services	
Occupational Therapy	
Physical Therapy	
Respiratory Therapy	
Skilled Nursing	
Specialized Medical Equipment and Supplies	
Specialized Mental Health Counseling	
Speech Therapy	
Transportation	
Behavior Analysis Services	
Behavior Assistant Services	
Dietitian Services	
Environmental Accessibility Adaptations	
Life Skills Development Level 1 - Companion	
Life Skills Development Level 2 - Supported Employment	
Personal Emergency Response System	
Personal Supports	
Private Duty Nursing	
Residential Nursing	
Specialized Medical Home Care	
Supported Living Coaching	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

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
Life Skills Development Level 3 - Adult Day Training Total:							**131222648.85**
Life Skills Development Level 3 - Adult Day Training	☐	Quarter Hour	15700	1064.73	7.85	**131222648.85**	
Life Skills Development							**26467041.42**

GRAND TOTAL:		**1948162666.77**
Total: Services included in capitation:		
Total: Services not included in capitation:		1948162666.76
Total Estimated Unduplicated Participants:		**40742**
Factor D (Divide total by number of participants):		**47817.06**
Services included in capitation:		
Services not included in capitation:		47817.06
Average Length of Stay on the Waiver:	344	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 4 - Prevocational Services Total:							
Life Skills Development Level 4 (Prevocational Services, hour)	☐	Hour	2576	1040.98	9.87	**26467041.42**	
Residential Habilitation Total:							**872835994.17**
ALF/ASC - Day	☐	Day	116	25.92	123.49	**371299.85**	
ALF/ASC - Month	☐	Month	571	10.13	3694.60	**21370416.16**	
Behavioral Focus - Day	☐	Day	435	24.44	226.99	**2413221.49**	
Behavioral Focus - Month	☐	Month	2738	10.27	6699.56	**188386669.53**	
Enhanced Intensive - Day	☐	Day	3	66.50	956.56	**190833.72**	
Enhanced Intensive - Month	☐	Month	21	10.75	22479.41	**5074726.81**	
Intensive Behavioral - Day	☐	Day	1182	311.20	408.39	**150221524.18**	
Live-in	☐	Day	62	302.17	146.47	**2744048.07**	
Standard - Day	☐	Day	1675	23.45	162.52	**6383582.45**	
Standard - Month	☐	Month	9860	10.60	4742.62	**495679671.92**	
Respite Total:							**14035952.75**
Quarter Hour	☐	Quarter Hour	1234	1961.99	5.64	**13654979.52**	
Day	☐	Day	49	34.87	222.97	**380973.23**	
Support Coordination Total:							**72995135.08**
Full	☐	Month	37751	10.80	172.47	**70317881.68**	
Transitional	☐	Month	32	2.36	417.48	**31528.09**	
Limited	☐	Month				**2645725.32**	

GRAND TOTAL:	**1948162666.77**
Total: Services included in capitation:	
Total: Services not included in capitation:	1948162666.76
Total Estimated Unduplicated Participants:	**40742**
Factor D (Divide total by number of participants):	**47817.06**
Services included in capitation:	
Services not included in capitation:	47817.06
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			3256	9.42	86.26		
Adult Dental Services Total:							**44939.20**
Adult Dental Services	☐	Occurrence	30	4.52	331.41	**44939.20**	
Occupational Therapy Total:							**3383093.97**
Service	☐	Quarter Hour	687	291.49	16.88	**3380281.27**	
Assessment	☐	Occurence	55	1.00	51.14	**2812.70**	
Physical Therapy Total:							**3905085.53**
Assessment	☐	Occurence	52	1.00	51.13	**2658.76**	
Service	☐	Quarter Hour	846	273.27	16.88	**3902426.77**	
Respiratory Therapy Total:							**1139652.50**
Assessment	☐	Occurrence	3	1.00	51.15	**153.45**	
Service	☐	Quarter Hour	115	586.66	16.89	**1139499.05**	
Skilled Nursing Total:							**1001908.33**
RN	☐	Occurence	12	204.56	32.30	**79287.46**	
LPN	☐	Occurence	49	640.66	29.39	**922620.87**	
Specialized Medical Equipment and Supplies Total:							**21075819.08**
Consumable Medical Supplies	☐	Item	10039	1762.56	1.16	**20525434.21**	
Durable Medical Equipment	☐	Item	206	5.24	509.88	**550384.87**	
Specialized Mental Health Counseling Total:							**547251.97**
Specialized Mental Health Counseling	☐	Quarter Hour	214	178.33	14.34	**547251.97**	
Speech Therapy Total:							**2021150.24**
Service	☐	Quarter Hour				**2018695.04**	

GRAND TOTAL:	**1948162666.77**
Total: Services included in capitation:	
Total: Services not included in capitation:	1948162666.76
Total Estimated Unduplicated Participants:	**40742**
Factor D (Divide total by number of participants):	**47817.06**
Services included in capitation:	
Services not included in capitation:	47817.06
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			486	246.51	16.85		
Assessment	☐	Occurence	48	1.00	51.15	2455.20	
Transportation Total:							44817183.74
Trip	☐	Occurrence	10166	329.25	12.55	42006801.52	
Month	☐	Occurrence	1591	10.05	159.04	2542978.03	
Mile	☐	Occurrence	85	2643.64	1.19	267404.19	
Behavior Analysis Services Total:							27024583.73
Masters Degree	☐	Quarter Hour	1486	206.49	19.99	6133814.36	
Assessment	☐	Occurrence	647	1.00	403.96	261362.12	
Doctorate Degree	☐	Quarter Hour	3645	215.46	20.80	16335315.36	
Bachelor Degree	☐	Quarter Hour	1351	208.56	15.24	4294091.89	
Behavior Assistant Services Total:							2608464.66
Behavior Assistant Services	☐	Quarter Hour	103	1984.71	12.76	2608464.66	
Dietitian Services Total:							20247.40
Dietitian Services	☐	Quarter Hour	23	60.67	14.51	20247.40	
Environmental Accessibility Adaptations Total:							982480.06
Environmental Accessibility Adaptations	☐	Occurrence	195	7.11	708.63	982480.06	
Life Skills Development Level 1 - Companion Total:							146598024.19
Life Skills Davelopment Level 1 - Companion	☐	Quarter Hour	9957	2927.06	5.03	146598024.19	
Life Skills Development							13108245.62

GRAND TOTAL:	1948162666.77
Total: Services included in capitation:	
Total: Services not included in capitation:	1948162666.76
Total Estimated Unduplicated Participants:	40742
Factor D (Divide total by number of participants):	47817.06
Services included in capitation:	
Services not included in capitation:	47817.06
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 2 - Supported Employment Total:							
Life Skills Development Level II (Supported Employment, hour)	☐	Hour	52	410.51	20.81	**444221.08**	
Life Skills Development Level II (Supported Employment, quarter hour)	☐	Quarter Hour	2683	327.33	14.42	**12664024.54**	
Personal Emergency Response System Total:							**45582.14**
Service	☐	Occurrence	122	9.87	36.99	**44541.14**	
Installation	☐	Occurrence	4	1.00	260.25	**1041.00**	
Personal Supports Total:							**486125597.72**
Personal Supports - Day	☐	Day	1861	217.24	154.80	**62583107.47**	
Personal Supports - Quarter Hour	☐	Quarter Hour	13649	5581.12	5.56	**423542490.25**	
Private Duty Nursing Total:							**31615964.71**
RN	☐	Quarter Hour	19	6126.00	7.67	**892741.98**	
LPN	☐	Quarter Hour	294	15667.28	6.67	**30723222.73**	
Residential Nursing Total:							**15478319.54**
LPN	☐	Quarter Hour	144	15955.94	6.59	**15141548.82**	
RN	☐	Quarter Hour	22	2132.00	7.18	**336770.72**	
Specialized Medical Home Care Total:							**3281254.65**
Specialized Medical Home Care	☐	Day	24	270.42	505.58	**3281254.65**	
Supported Living Coaching Total:							**25781045.49**

	GRAND TOTAL:	**1948162666.77**
	Total: Services included in capitation:	
	Total: Services not included in capitation:	1948162666.76
	Total Estimated Unduplicated Participants:	**40742**
	Factor D (Divide total by number of participants):	**47817.06**
	Services included in capitation:	
	Services not included in capitation:	47817.06
	Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Living Coaching	☐	Quarter Hour	4711	686.64	7.97	25781045.49	
					GRAND TOTAL:		1948162666.77
					Total: Services included in capitation:		
					Total: Services not included in capitation:		1948162666.76
					Total Estimated Unduplicated Participants:		40742
					Factor D (Divide total by number of participants):		47817.06
					Services included in capitation:		
					Services not included in capitation:		47817.06
					Average Length of Stay on the Waiver:		344

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Life Skills Development Level 3 - Adult Day Training Total:							139402117.66
Life Skills Development Level 3 - Adult Day Training	☐	Quarter Hour	16045	1064.73	8.16	139402117.66	
Life Skills Development Level 4 - Prevocational Services Total:							28121637.49
Life Skills Development Level 4 (Prevocational Services, hour)	☐	Hour	2633	1040.98	10.26	28121637.49	
Residential Habilitation Total:							927617458.87
ALF/ASC - Day	☐	Day	118	25.92	128.43	392810.86	
					GRAND TOTAL:		2070290956.18
					Total: Services included in capitation:		
					Total: Services not included in capitation:		2070290956.18
					Total Estimated Unduplicated Participants:		41637
					Factor D (Divide total by number of participants):		49722.39
					Services included in capitation:		
					Services not included in capitation:		49722.39
					Average Length of Stay on the Waiver:		344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
ALF/ASC - Month	☐	Month	583	10.13	3842.38	22692289.38	
Behavioral Focus - Day	☐	Day	445	24.44	236.07	2567450.11	
Behavioral Focus - Month	☐	Month	2799	10.27	6967.54	200287023.60	
Enhanced Intensive - Day	☐	Day	3	66.50	994.82	198466.59	
Enhanced Intensive - Month	☐	Month	21	10.75	23378.59	5277716.69	
Intensive Behavioral - Day	☐	Day	1208	311.20	424.73	159668579.01	
Live-in	☐	Day	63	302.17	152.33	2899862.03	
Standard - Day	☐	Day	1711	23.45	169.02	6781581.01	
Standard - Month	☐	Month	10077	10.60	4932.32	526851679.58	
Respite Total:							14927087.53
Quarter Hour	☐	Quarter Hour	1261	1961.99	5.87	14522787.32	
Day	☐	Day	50	34.87	231.89	404300.22	
Support Coordination Total:							77583222.59
Full	☐	Month	38580	10.80	179.37	74737021.68	
Transitional	☐	Month	33	2.36	434.18	33813.94	
Limited	☐	Month	3328	9.42	89.71	2812386.97	
Adult Dental Services Total:							46737.25
Adult Dental Services	☐	Occurrence	30	4.52	344.67	46737.25	
Occupational Therapy Total:							3596264.04
Service	☐	Quarter Hour	702	291.49	17.56	3593232.21	
Assessment	☐	Occurrence	57	1.00	53.19	3031.83	
Physical Therapy Total:							4153625.88

GRAND TOTAL:	2070290956.18
Total: Services included in capitation:	
Total: Services not included in capitation:	2070290956.18
Total Estimated Unduplicated Participants:	41637
Factor D (Divide total by number of participants):	49722.39
Services included in capitation:	
Services not included in capitation:	49722.39
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assessment	☐	Occurrence	53	1.00	53.18	**2818.54**	
Service	☐	Quarter Hour	865	273.27	17.56	**4150807.34**	
Respiratory Therapy Total:							**1206150.70**
Assessment	☐	Occurrence	3	1.00	53.20	**159.60**	
Service	☐	Quarter Hour	117	586.66	17.57	**1205991.10**	
Skilled Nursing Total:							**1061702.85**
RN	☐	Occurrence	12	204.56	33.59	**82454.04**	
LPN	☐	Occurrence	50	640.66	30.57	**979248.81**	
Specialized Medical Equipment and Supplies Total:							**22467776.16**
Consumable Medical Supplies	☐	Item	10260	1762.56	1.21	**21881477.38**	
Durable Medical Equipment	☐	Item	211	5.24	530.28	**586298.78**	
Specialized Mental Health Counseling Total:							**582299.17**
Specialized Mental Health Counseling	☐	Quarter Hour	219	178.33	14.91	**582299.17**	
Speech Therapy Total:							**2144758.98**
Service	☐	Quarter Hour	496	246.51	17.52	**2142152.18**	
Assessment	☐	Occurence	49	1.00	53.20	**2606.80**	
Transportation Total:							**47626593.07**
Trip	☐	Occurrence	10389	329.25	13.05	**44638546.16**	
Month	☐	Month	1626	10.05	165.40	**2702851.02**	
Mile	☐	Occurrence	87	2643.64	1.24	**285195.88**	
Behavior Analysis Services Total:							**28723783.40**

GRAND TOTAL:	**2070290956.18**
Total: Services included in capitation:	
Total: Services not included in capitation:	*2070290956.18*
Total Estimated Unduplicated Participants:	**41637**
Factor D (Divide total by number of participants):	**49722.39**
Services included in capitation:	
Services not included in capitation:	*49722.39*
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Masters Degree	☐	Quarter Hour	1519	206.49	20.79	6520956.26	
Assessment	☐	Occurence	661	1.00	420.12	277699.32	
Doctorate Degree	☐	Quarter Hour	3725	215.46	21.63	17359989.26	
Bachelor Degree	☐	Quarter Hour	1381	208.56	15.85	4565138.56	
Behavior Assistant Services Total:							2765395.68
Behavior Assistant Services	☐	Quarter Hour	105	1984.71	13.27	2765395.68	
Dietitian Services Total:							21972.25
Dietitian Services	☐	Quarter Hour	24	60.67	15.09	21972.25	
Environmental Accessibility Adaptations Total:							1042745.63
Environmental Accessibility Adaptations	☐	Occurrence	199	7.11	736.98	1042745.63	
Life Skills Development Level 1 - Companion Total:							155779538.19
Life Skills Davelopment Level 1 - Companion	☐	Quarter Hour	10176	2927.06	5.23	155779538.19	
Life Skills Development Level 2 - Supported Employment Total:							13933905.03
Life Skills Development Level II (Supported Employment, hour)	☐	Hour	53	410.51	21.64	470822.13	
Life Skills Development Level II (Supported Employment, quarter hour)	☐	Quarter Hour	2742	327.33	15.00	13463082.90	
Personal Emergency							48545.00

GRAND TOTAL:		2070290956.18
Total: Services included in capitation:		
Total: Services not included in capitation:		2070290956.18
Total Estimated Unduplicated Participants:		41637
Factor D (Divide total by number of participants):		49722.39
Services included in capitation:		
Services not included in capitation:		49722.39
Average Length of Stay on the Waiver:	344	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response System Total:							
Service	☐	Month	125	9.87	38.47	**47462.36**	
Installation	☐	Occurrence	4	1.00	270.66	**1082.64**	
Personal Supports Total:							**516466304.35**
Personal Supports - Day	☐	Day	1902	217.24	160.99	**66519535.38**	
Personal Supports - Quarter Hour	☐	Quarter Hour	13948	5581.12	5.78	**449946768.97**	
Private Duty Nursing Total:							**33596986.56**
RN	☐	Quarter Hour	20	6126.00	7.98	**977709.60**	
LPN	☐	Quarter Hour	300	15667.28	6.94	**32619276.96**	
Residential Nursing Total:							**16417206.66**
LPN	☐	Quarter Hour	147	15955.94	6.85	**16066833.78**	
RN	☐	Quarter Hour	22	2132.00	7.47	**350372.88**	
Specialized Medical Home Care Total:							**3554670.90**
Specialized Medical Home Care	☐	Day	25	270.42	525.80	**3554670.90**	
Supported Living Coaching Total:							**27402470.32**
Supported Living Coaching	☐	Quarter Hour	4814	686.64	8.29	**27402470.32**	

GRAND TOTAL:	**2070290956.18**
Total: Services included in capitation:	
Total: Services not included in capitation:	2070290956.18
Total Estimated Unduplicated Participants:	**41637**
Factor D (Divide total by number of participants):	**49722.39**
Services included in capitation:	
Services not included in capitation:	49722.39
Average Length of Stay on the Waiver:	344

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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
Life Skills Development Level 3 - Adult Day Training Total:							**152565438.53**
Life Skills Development Level 3 - Adult Day Training	☐	Quarter Hour	16623	1064.73	8.62	**152565438.53**	
Life Skills Development Level 4 - Prevocational Services Total:							**30754962.96**
Life Skills Development Level 4 (Prevocational Services, hour)	☐	Hour	2728	1040.98	10.83	**30754962.96**	
Residential Habilitation Total:							**1014901761.48**
ALF/ASC - Day	☐	Day	123	25.92	135.62	**432378.26**	
ALF/ASC - Month	☐	Month	604	10.13	4057.55	**24826200.83**	
Behavioral Focus - Day	☐	Day	461	24.44	249.29	**2808710.54**	
Behavioral Focus - Month	☐	Month	2899	10.27	7357.72	**219059410.98**	
Enhanced Intensive - Day	☐	Day	3	66.50	1050.53	**209580.74**	
Enhanced Intensive - Month	☐	Month	22	10.75	24687.79	**5838662.34**	
Intensive Behavioral - Day	☐	Day	1252	311.20	448.51	**174749542.62**	
Live-in	☐	Day	65	302.17	160.86	**3159459.30**	
Standard - Day	☐	Day	1773	23.45	178.49	**7421051.96**	
Standard - Month	☐	Month	10440	10.60	5208.53	**576396763.92**	
Respite Total:							**16342815.98**
Quarter Hour	☐	Quarter Hour	1307	1961.99	6.20	**15898789.77**	
Day	☐	Day	52	34.87	244.88	**444026.21**	

GRAND TOTAL:	**2264831932.19**
Total: Services included in capitation:	
Total: Services not included in capitation:	2264831932.19
Total Estimated Unduplicated Participants:	**43137**
Factor D (Divide total by number of participants):	**52503.23**
Services included in capitation:	
Services not included in capitation:	52503.23
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Coordination Total:							**84877385.95**
Full	☐	Month	39970	10.80	189.41	**81763751.16**	
Transitional	☐	Month	34	2.36	458.49	**36789.24**	
Limited	☐	Month	3448	9.42	94.73	**3076845.56**	
Adult Dental Services Total:							**50999.48**
Adult Dental Services	☐	Occurrence	31	4.52	363.97	**50999.48**	
Occupational Therapy Total:							**3932185.31**
Service	☐	Quarter Hour	727	291.49	18.54	**3928871.28**	
Assessment	☐	Occurrence	59	1.00	56.17	**3314.03**	
Physical Therapy Total:							**4542606.32**
Assessment	☐	Occurrence	55	1.00	56.16	**3088.80**	
Service	☐	Quarter Hour	896	273.27	18.54	**4539517.52**	
Respiratory Therapy Total:							**1316956.24**
Assessment	☐	Occurrence	3	1.00	56.18	**168.54**	
Service	☐	Quarter Hour	121	586.66	18.55	**1316787.70**	
Skilled Nursing Total:							**1162455.17**
RN	☐	Occurrence	12	204.56	35.47	**87068.92**	
LPN	☐	Occurrence	52	640.66	32.28	**1075386.25**	
Specialized Medical Equipment and Supplies Total:							**24619516.66**
Consumable Medical Supplies	☐	Item	10629	1762.56	1.28	**23979840.31**	
Durable Medical Equipment	☐	Item	218	5.24	559.98	**639676.35**	
Specialized							**634362.61**

GRAND TOTAL:		**2264831932.19**
Total: Services included in capitation:		
Total: Services not included in capitation:		2264831932.19
Total Estimated Unduplicated Participants:		**43137**
Factor D (Divide total by number of participants):		**52503.23**
Services included in capitation:		
Services not included in capitation:		52503.23
Average Length of Stay on the Waiver:	344	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Mental Health Counseling Total:							
Specialized Mental Health Counseling	☐	Quarter Hour	226	178.33	15.74	**634362.61**	
Speech Therapy Total:							**2346872.59**
Service	☐	Quarter Hour	514	246.51	18.50	**2344063.59**	
Assessment	☐	Occurrence	50	1.00	56.18	**2809.00**	
Transportation Total:							**52100096.52**
Trip	☐	Occurence	10763	329.25	13.78	**48832430.60**	
Month	☐	Occurence	1684	10.05	174.66	**2955980.77**	
Mile	☐	Occurrence	90	2643.64	1.31	**311685.16**	
Behavior Analysis Services Total:							**31429498.20**
Masters Degree	☐	Quarter Hour	1574	206.49	21.95	**7134084.96**	
Assessment	☐	Occurence	685	1.00	443.65	**303900.25**	
Doctorate Degree	☐	Quarter Hour	3860	215.46	22.84	**18995470.70**	
Bachelor Degree	☐	Quarter Hour	1431	208.56	16.74	**4996042.29**	
Behavior Assistant Services Total:							**3030830.79**
Behavior Assistant Services	☐	Quarter Hour	109	1984.71	14.01	**3030830.79**	
Dietitian Services Total:							**24176.99**
Dietitian Services	☐	Quarter Hour	25	60.67	15.94	**24177.00**	
Environmental Accessibility Adaptations Total:							**1139871.65**
Environmental Accessibility Adaptations	☐	Occurrence	206	7.11	778.25	**1139871.64**	
Life Skills Development Level 1 -							**170331007.19**

	GRAND TOTAL:	***2264831932.19***
	Total: Services included in capitation:	
	Total: Services not included in capitation:	*2264831932.19*
	Total Estimated Unduplicated Participants:	***43137***
	Factor D (Divide total by number of participants):	***52503.23***
	Services included in capitation:	
	Services not included in capitation:	*52503.23*
	Average Length of Stay on the Waiver:	*344*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Companion Total:							
Life Skills Davelopment Level 1 - Companion	☐	Quarter Hour	10542	2927.06	5.52	**170331007.19**	
Life Skills Development Level 2 - Supported Employment Total:							**15246229.80**
Life Skills Development Level II (Supported Employment, hour)	☐	Hour	55	410.51	22.85	**515908.44**	
Life Skills Development Level II (Supported Employment, quarter hour)	☐	Quarter Hour	2841	327.33	15.84	**14730321.36**	
Personal Emergency Response System Total:							**53262.80**
Service	☐	Month	130	9.87	40.62	**52119.52**	
Installation	☐	Occurrence	4	1.00	285.82	**1143.28**	
Personal Supports Total:							**564776755.83**
Personal Supports - Day	☐	Day	1971	217.24	170.01	**72794888.60**	
Personal Supports - Quarter Hour	☐	Quarter Hour	14451	5581.12	6.10	**491981867.23**	
Private Duty Nursing Total:							**36748445.11**
RN	☐	Quarter Hour	20	6126.00	8.43	**1032843.60**	
LPN	☐	Quarter Hour	311	15667.28	7.33	**35715601.51**	
Residential Nursing Total:							**18037195.31**
LPN	☐	Quarter Hour	153	15955.94	7.23	**17650301.27**	
RN	☐	Quarter Hour	23	2132.00	7.89	**386894.04**	
Specialized							**3903848.02**

GRAND TOTAL:	**2264831932.19**
Total: Services included in capitation:	
Total: Services not included in capitation:	2264831932.19
Total Estimated Unduplicated Participants:	**43137**
Factor D (Divide total by number of participants):	**52503.23**
Services included in capitation:	
Services not included in capitation:	52503.23
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical Home Care Total:							
Specialized Medical Home Care	☐	Day	26	270.42	555.24	**3903848.02**	
Supported Living Coaching Total:							**29962394.70**
Supported Living Coaching	☐	Quarter Hour	4987	686.64	8.75	**29962394.70**	

GRAND TOTAL:		**2264831932.19**
Total: Services included in capitation:		
Total: Services not included in capitation:		2264831932.19
Total Estimated Unduplicated Participants:		**43137**
Factor D (Divide total by number of participants):		**52503.23**
Services included in capitation:		
Services not included in capitation:		52503.23
Average Length of Stay on the Waiver:	344	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Life Skills Development Level 3 - Adult Day Training Total:							**166661228.64**
Life Skills Development Level 3 - Adult Day Training	☐	Quarter Hour	17201	1064.73	9.10	**166661228.64**	
Life Skills Development Level 4 - Prevocational Services Total:							**33606665.21**
Life Skills Development Level 4 (Prevocational Services,	☐	Hour	2822	1040.98	11.44	**33606665.21**	

GRAND TOTAL:		**2474808807.30**
Total: Services included in capitation:		
Total: Services not included in capitation:		2474808807.30
Total Estimated Unduplicated Participants:		**44637**
Factor D (Divide total by number of participants):		**55442.99**
Services included in capitation:		
Services not included in capitation:		55442.99
Average Length of Stay on the Waiver:	344	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
hour)							
Residential Habilitation Total:							**1109183916.09**
ALF/ASC - Day	☐	Day	127	25.92	143.21	**471424.41**	
ALF/ASC - Month	☐	Month	625	10.13	4284.77	**27127950.06**	
Behavioral Focus - Day	☐	Day	477	24.44	263.25	**3068936.91**	
Behavioral Focus - Month	☐	Month	3000	10.27	7769.75	**239385997.50**	
Enhanced Intensive - Day	☐	Day	3	66.50	1109.36	**221317.32**	
Enhanced Intensive - Month	☐	Month	23	10.75	26070.31	**6445884.15**	
Intensive Behavioral - Day	☐	Day	1296	311.20	473.63	**191022178.18**	
Live-in	☐	Day	68	302.17	169.87	**3490414.02**	
Standard - Day	☐	Day	1835	23.45	188.49	**8110866.07**	
Standard - Month	☐	Month	10803	10.60	5500.21	**629838947.48**	
Respite Total:							**17861518.44**
Quarter Hour	☐	Quarter Hour	1352	1961.99	6.55	**17374598.64**	
Day	☐	Day	54	34.87	258.59	**486919.80**	
Support Coordination Total:							**92748590.52**
Full	☐	Month	41360	10.80	200.02	**89346533.76**	
Transitional	☐	Month	35	2.36	484.17	**39992.44**	
Limited	☐	Month	3568	9.42	100.03	**3362064.32**	
Adult Dental Services Total:							**55592.38**
Adult Dental Services	☐	Occurrence	32	4.52	384.35	**55592.38**	
Occupational Therapy Total:							**4295563.92**

GRAND TOTAL:	**2474808807.30**
Total: Services included in capitation:	
Total: Services not included in capitation:	2474808807.30
Total Estimated Unduplicated Participants:	**44637**
Factor D (Divide total by number of participants):	**55442.99**
Services included in capitation:	
Services not included in capitation:	55442.99
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service	☐	Quarter Hour	752	291.49	19.58	**4291945.40**	
Assessment	☐	Occurrence	61	1.00	59.32	**3618.52**	
Physical Therapy Total:							**4963351.66**
Assessment	☐	Occurrence	56	1.00	59.30	**3320.80**	
Service	☐	Quarter Hour	927	273.27	19.58	**4960030.86**	
Respiratory Therapy Total:							**1448254.33**
Assessment	☐	Occurrence	3	1.00	59.33	**177.99**	
Service	☐	Quarter Hour	126	586.66	19.59	**1448076.34**	
Skilled Nursing Total:							**1278982.00**
RN	☐	Occurrence	13	204.56	37.46	**99616.63**	
LPN	☐	Occurrence	54	640.66	34.09	**1179365.37**	
Specialized Medical Equipment and Supplies Total:							**26871925.03**
Consumable Medical Supplies	☐	Item	10999	1762.56	1.35	**26171636.54**	
Durable Medical Equipment	☐	Item	226	5.24	591.34	**700288.48**	
Specialized Mental Health Counseling Total:							**693539.64**
Specialized Mental Health Counseling	☐	Quarter Hour	234	178.33	16.62	**693539.64**	
Speech Therapy Total:							**2565625.63**
Service	☐	Quarter Hour	532	246.51	19.54	**2562540.47**	
Assessment	☐	Occurrence	52	1.00	59.33	**3085.16**	
Transportation Total:							**56922920.89**
Trip	☐	Occurrence	11137	329.25	14.55	**53352772.99**	

GRAND TOTAL:	**2474808807.30**
Total: Services included in capitation:	
Total: Services not included in capitation:	2474808807.30
Total Estimated Unduplicated Participants:	**44637**
Factor D (Divide total by number of participants):	**55442.99**
Services included in capitation:	
Services not included in capitation:	55442.99
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Month	☐	Occurrence	1743	10.05	184.44	3230863.15	
Mile	☐	Occurrence	93	2643.64	1.38	339284.76	
Behavior Analysis Services Total:							34342462.56
Masters Degree	☐	Quarter Hour	1629	206.49	23.18	7797107.83	
Assessment	☐	Occurrence	708	1.00	468.49	331690.92	
Doctorate Degree	☐	Quarter Hour	3994	215.46	24.12	20756399.43	
Bachelor Degree	☐	Quarter Hour	1480	208.56	17.68	5457264.38	
Behavior Assistant Services Total:							3316986.28
Behavior Assistant Services	☐	Quarter Hour	113	1984.71	14.79	3316986.28	
Dietitian Services Total:							25526.90
Dietitian Services	☐	Quarter Hour	25	60.67	16.83	25526.90	
Environmental Accessibility Adaptations Total:							1244604.01
Environmental Accessibility Adaptations	☐	Occurrence	213	7.11	821.83	1244604.01	
Life Skills Development Level 1 - Companion Total:							186159464.66
Life Skills Davelopment Level 1 - Companion	☐	Quarter Hour	10909	2927.06	5.83	186159464.66	
Life Skills Development Level 2 - Supported Employment Total:							16654832.80
Life Skills Development Level II (Supported Employment, hour)	☐	Hour	56	410.51	24.13	554713.95	

GRAND TOTAL:	2474808807.30
Total: Services included in capitation:	
Total: Services not included in capitation:	2474808807.30
Total Estimated Unduplicated Participants:	44637
Factor D (Divide total by number of participants):	55442.99
Services included in capitation:	
Services not included in capitation:	55442.99
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Life Skills Development Level II (Supported Employment, quarter hour)	☐	Quarter Hour	2940	327.33	16.73	16100118.85	
Personal Emergency Response System Total:							57932.78
Service	☐	Month	134	9.87	42.89	56725.46	
Installation	☐	Occurrence	4	1.00	301.83	1207.32	
Personal Supports Total:							616970135.79
Personal Supports - Day	☐	Day	2039	217.24	179.53	79523237.19	
Personal Supports - Quarter Hour	☐	Quarter Hour	14953	5581.12	6.44	537446898.60	
Private Duty Nursing Total:							40192198.00
RN	☐	Quarter Hour	21	6126.00	8.90	1144949.40	
LPN	☐	Quarter Hour	322	15667.28	7.74	39047248.60	
Residential Nursing Total:							19661753.35
LPN	☐	Quarter Hour	158	15955.94	7.63	19235523.91	
RN	☐	Quarter Hour	24	2132.00	8.33	426229.44	
Specialized Medical Home Care Total:							4280994.68
Specialized Medical Home Care	☐	Day	27	270.42	586.33	4280994.68	
Supported Living Coaching Total:							32744241.13
Supported Living Coaching	☐	Quarter Hour	5161	686.64	9.24	32744241.13	

GRAND TOTAL:	2474808807.30
Total: Services included in capitation:	
Total: Services not included in capitation:	2474808807.30
Total Estimated Unduplicated Participants:	44637
Factor D (Divide total by number of participants):	55442.99
Services included in capitation:	
Services not included in capitation:	55442.99
Average Length of Stay on the Waiver:	344

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Life Skills Development Level 3 - Adult Day Training Total:							**181915711.18**
Life Skills Development Level 3 - Adult Day Training	☐	Quarter Hour	17779	1064.73	9.61	**181915711.18**	
Life Skills Development Level 4 - Prevocational Services Total:							**36681387.01**
Life Skills Development Level 4 (Prevocational Services, hour)	☐	Hour	2917	1040.98	12.08	**36681387.01**	
Residential Habilitation Total:							**1210329347.36**
ALF/ASC - Day	☐	Day	131	25.92	151.23	**513504.49**	
ALF/ASC - Month	☐	Month	646	10.13	4524.72	**29609677.19**	
Behavioral Focus - Day	☐	Day	493	24.44	277.99	**3349479.27**	
Behavioral Focus - Month	☐	Month	3101	10.27	8204.86	**261302391.73**	
Enhanced Intensive - Day	☐	Day	3	66.50	1171.48	**233710.26**	
Enhanced Intensive - Month	☐	Month	23	10.75	27530.25	**6806854.31**	
Intensive Behavioral - Day	☐	Day	1339	311.20	500.15	**208410904.52**	
Live-in	☐	Day	70	302.17	179.38	**3794227.82**	
Standard - Day	☐	Day	1896	23.45	199.05	**8850001.86**	

	GRAND TOTAL:	***2701044830.68***
	Total: Services included in capitation:	
	Total: Services not included in capitation:	*2701044830.68*
	Total Estimated Unduplicated Participants:	***46137***
	Factor D (Divide total by number of participants):	***58544.01***
	Services included in capitation:	
	Services not included in capitation:	*58544.01*
	Average Length of Stay on the Waiver:	*344*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Standard - Month	☐	Month	11166	10.60	5808.22	687458595.91	
Respite Total:							19490735.51
Quarter Hour	☐	Quarter Hour	1397	1961.99	6.92	18967028.21	
Day	☐	Day	55	34.87	273.07	523707.30	
Support Coordination Total:							101232404.92
Full	☐	Month	42750	10.80	211.22	97520274.00	
Transitional	☐	Month	36	2.36	511.28	43438.35	
Limited	☐	Month	3687	9.42	105.63	3668692.57	
Adult Dental Services Total:							62374.10
Adult Dental Services	☐	Occurrence	34	4.52	405.87	62374.10	
Occupational Therapy Total:							4687712.58
Service	☐	Quarter Hour	777	291.49	20.68	4683766.26	
Assessment	☐	Occurrence	63	1.00	62.64	3946.32	
Physical Therapy Total:							5417504.17
Assessment	☐	Occurrence	58	1.00	62.62	3631.96	
Service	☐	Quarter Hour	958	273.27	20.68	5413872.21	
Respiratory Therapy Total:							1578127.35
Assessment	☐	Occurrence	3	1.00	62.65	187.95	
Service	☐	Quarter Hour	130	586.66	20.69	1577939.40	
Skilled Nursing Total:							1373707.92
RN	☐	Occurrence	13	204.56	39.56	105201.12	
LPN	☐	Occurrence	55	640.66	36.00	1268506.80	
Specialized Medical							29417534.54

GRAND TOTAL:	2701044830.68
Total: Services included in capitation:	
Total: Services not included in capitation:	2701044830.68
Total Estimated Unduplicated Participants:	46137
Factor D (Divide total by number of participants):	58544.01
Services included in capitation:	
Services not included in capitation:	58544.01
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Equipment and Supplies Total:							
Consumable Medical Supplies	☐	Item	11369	1762.56	1.43	**28655118.84**	
Durable Medical Equipment	☐	Item	233	5.24	624.46	**762415.70**	
Specialized Mental Health Counseling Total:							**757385.34**
Specialized Mental Health Counseling	☐	Quarter Hour	242	178.33	17.55	**757385.34**	
Speech Therapy Total:							**2800408.81**
Service	☐	Quarter Hour	550	246.51	20.63	**2797025.72**	
Assessment	☐	Occurrence	54	1.00	62.65	**3383.10**	
Transportation Total:							**62115286.68**
Trip	☐	Occurrence	11512	329.25	15.36	**58219407.36**	
Month	☐	Occurrence	1801	10.05	194.77	**3525346.74**	
Mile	☐	Occurrence	96	2643.64	1.46	**370532.58**	
Behavior Analysis Services Total:							**37480533.45**
Masters Degree	☐	Quarter Hour	1683	206.49	24.48	**8507354.96**	
Assessment	☐	Occurrence	732	1.00	494.73	**362142.36**	
Doctorate Degree	☐	Quarter Hour	4128	215.46	25.47	**22653498.87**	
Bachelor Degree	☐	Quarter Hour	1530	208.56	18.67	**5957537.26**	
Behavior Assistant Services Total:							**3627136.91**
Behavior Assistant Services	☐	Quarter Hour	117	1984.71	15.62	**3627136.91**	
Dietitian Services Total:							**28030.75**
Dietitian Services	☐	Quarter Hour	26	60.67	17.77	**28030.75**	

GRAND TOTAL:	**2701044830.68**
Total: Services included in capitation:	
Total: Services not included in capitation:	2701044830.68
Total Estimated Unduplicated Participants:	**46137**
Factor D (Divide total by number of participants):	**58544.01**
Services included in capitation:	
Services not included in capitation:	58544.01
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations Total:							**1357490.97**
Environmental Accessibility Adaptations	☐	Occurrence	220	7.11	867.85	**1357490.97**	
Life Skills Development Level 1 - Companion Total:							**203296025.24**
Life Skills Davelopment Level 1 - Companion	☐	Quarter Hour	11275	2927.06	6.16	**203296025.24**	
Life Skills Development Level 2 - Supported Employment Total:							**18178220.40**
Life Skills Development Level II (Supported Employment, hour)	☐	Hour	58	410.51	25.48	**606668.10**	
Life Skills Development Level II (Supported Employment, quarter hour)	☐	Quarter Hour	3038	327.33	17.67	**17571552.30**	
Personal Emergency Response System Total:							**63409.63**
Service	☐	Month	139	9.87	45.29	**62134.71**	
Installation	☐	Occurrence	4	1.00	318.73	**1274.92**	
Personal Supports Total:							**673396806.09**
Personal Supports - Day	☐	Day	2108	217.24	189.58	**86816629.19**	
Personal Supports - Quarter Hour	☐	Quarter Hour	15456	5581.12	6.80	**586580176.90**	
Private Duty Nursing Total:							**43891415.44**
RN	☐	Quarter Hour	22	6126.00	9.40	**1266856.80**	
LPN	☐					**42624558.64**	

GRAND TOTAL:	**2701044830.68**
Total: Services included in capitation:	
Total: Services not included in capitation:	2701044830.68
Total Estimated Unduplicated Participants:	**46137**
Factor D (Divide total by number of participants):	**58544.01**
Services included in capitation:	
Services not included in capitation:	58544.01
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Quarter Hour	333	15667.28	8.17		
Residential Nursing Total:							**21431634.85**
LPN	☐	Quarter Hour	163	15955.94	8.06	**20962594.85**	
RN	☐	Quarter Hour	25	2132.00	8.80	**469040.00**	
Specialized Medical Home Care Total:							**4688130.92**
Specialized Medical Home Care	☐	Day	28	270.42	619.16	**4688130.92**	
Supported Living Coaching Total:							**35746368.54**
Supported Living Coaching	☐	Quarter Hour	5334	686.64	9.76	**35746368.54**	

GRAND TOTAL:	**2701044830.68**
Total: Services included in capitation:	
Total: Services not included in capitation:	2701044830.68
Total Estimated Unduplicated Participants:	**46137**
Factor D (Divide total by number of participants):	**58544.01**
Services included in capitation:	
Services not included in capitation:	58544.01
Average Length of Stay on the Waiver:	344