State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: /_/ No limitations /X/ With limitations*

2.a. Outpatient hospital services.

Provided: /_/ No limitations /X/ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan).

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided: /_/ No limitations /X/ With limitations*

3. Other laboratory and x-ray services.

Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ___ No Limitations __X__ With limitations*

4. b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4. c. Family planning services and supplies for individuals of child-bearing age.

Provided: ___No limitations __X___With limitations.*

4. d. Face-to-face tobacco cessation counseling services benefit package for pregnant women

Provided: ____ No limitations __X___ With limitations*

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: ____No limitations __X___ With limitations.*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a) (5) (B) of the Act).
Provided: ___ No limitations ___X___ With limitations.*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: _____ No limitations ___X__ with limitations*

* Description provided on attachment.

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

c. Chiropractors' services.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

d. Other practitioners' services.

/X/ Provided: Identified on attached sheet with description of limitations, if any.

/_/ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: /_/No limitations /X/With limitations*

b. Home health aide services provided by a home health agency.

Provided: /_/No limitations /X/With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: /_/No limitations /X/With limitations*

*Description provided on attachment.

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

8. Private duty nursing services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

X Provided: __ No limitations X With limitations* (7-1-85)

__ Not provided.

10. Dental services.

X Provided: __ No limitations X With limitations*

__ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

X Provided: __ No limitations X With limitations*

__ Not provided.

b. Occupational therapy.

X Provided: __ No limitations X With limitations*

__ Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

X Provided: __ No limitations X With limitations*

__ Not provided.

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed Drugs.

X Provided: __ No limitations X With limitations* (6-1-75)

__ Not provided.

b. Dentures.

X Provided: __ No limitations X With limitations* (7-1-80)

__ Not provided.

c. Prosthetic devices.

X Provided: __ No limitations X With limitations* (7-1-80)

__ Not provided.

d. Eyeglasses.

X Provided: __ No limitations X With limitations* (7-1-06)

__ Not provided.

13. Other diagnostic, screening, preventative and rehabilitative services, i.e., other than those provided elsewhere in the plan

a. Diagnostic services.

X Provided: __ No limitations X With limitations*

__ Not provided.

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

_X_Provided __No limitations _X_With limitations*

__Not provided

c. Preventive services.

_X_Provided __No limitations _X_With limitations*

__Not provided

d. Rehabilitative services

_X_Provided __No limitations _X_With limitations*

__Not provided

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

_X_Provided __No limitations _X_With limitations*

__Not provided

b. Nursing facility services.

__Provided __No limitations __With limitations*

_X_Not provided

*Description provided on attachment.

Revision: HCFA-PM-86-20 (BERC)
September 1986

State/Territory: Florida

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

[X] Provided [ ] No limitations [X] With limitations* [ ] Not Provided:

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

[X] Provided [ ] No limitations [X] With limitations* [ ] Not Provided:

16. Inpatient psychiatric facility services for individuals under 22 years of age.

[X] Provided [ ] No limitations [ ] With limitations* [ ] Not Provided:

17. Nurse-midwife services

[X] Provided [ ] No limitations [X] With limitations* [ ] Not Provided:

18. Hospice care (in accordance with section 1905(o) of the Act).

[X] Provided [ ] No limitations

[X] Provided in accordance with section 2302 of the Affordable Care Act

[X] With limitations* [ ] Not Provided:

*Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

___ Provided: ___ With limitations

X Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

___ Provided: ___ With limitations*

X Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

X Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

X Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

23. Certified pediatric or family nurse practitioners' services.

Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.
[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided

b. Services of Christian Science nurses.
[ ] Provided [ ] No limitations [ ] With limitations*
[X] Not Provided

c. Care and services provided in Christian Science sanitoria.
[ ] Provided [ ] No limitations [ ] With limitations*
[X] Not Provided

d. Nursing facility services for patients under 21 years of age.
[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided

e. Emergency hospital services.
[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided

f. Personal care services furnished in recipient's home, and at the state's option, in another location, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
[X] Provided [ ] No limitations [X] With limitations*
[ ] Not Provided

*Description provided on Attachment.

State of FLORIDA
PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Categorically Needy

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, and described in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided X not provided

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

X provided _____ not provided

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

State of Florida
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

Amount, Duration, and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

28. _X_ Self-Directed Personal Assistance Services, as described in Supplement _4_ to Attachment 3.1-A.

_X_ Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

____ No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.

TELEMEDICINE SERVICES

Telemedicine services under Florida Medicaid are subject to the specifications, conditions, and limitations set by the State. Telemedicine is defined as the practice of health care delivery by a practitioner who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, or recommendation of treatment.

Providers rendering telemedicine within their scope of practice must involve the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time, interactive communication between the recipient and the practitioner to provide and support care when distance separates participants who are in different geographical locations. Telephone conversations, chart review, electronic mail messages, or facsimile transmissions are not considered telemedicine.

All equipment required to provide telemedicine services is the responsibility of the providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
DESCRIPTION OF LIMITATIONS
PREDETERMINATION OF ELIGIBILITY AND PRIOR AUTHORIZATIONS

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STATE OF FLORIDA

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED

DESCRIPTION OF LIMITATIONS

PREDETERMINATION OF ELIGIBILITY AND PRIOR AUTHORIZATIONS

1/1/78 The Medicaid program includes the basic concept of pre-determination of eligibility of recipients for all services rendered, established by the medical care provider, prior to rendering services, by viewing of the recipient's Medicaid identification card and/or calling on a toll-free telephone line to the fiscal contractor for verification of eligibility. Authorization by the state agency is required for exceptions to limitations as described below.

SPECIFIC LIMITATIONS IN SERVICES

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

4/1/91 All services provided for in Section 1905(a) of the Act which are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions are provided for EPSDT participants.

ARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND

10/01/93 REHABILITATIVE SERVICES: Early Intervention Services (13.d)

Rehabilitative services include a range of coordinated rehabilitative or remedial medically necessary services provided to a child in order to identify, evaluate, correct, reduce, or prevent further deterioration of deficits in the child's mental or physical health.

Early intervention services are provided under the Individuals with Disabilities Education Act (IDEA), Part C, and are designed to ameliorate or prevent further developmental disabilities and physical and mental illnesses in children with developmental delays or established conditions that could result in developmental delays at as early an age as possible in order to optimize their functioning capacity. These services are designed to enhance, not duplicate, existing Title XIX mandatory or optional services; to ensure maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level.

Developmental delays are defined as a delay in the development in one or more of the following domains: cognitive, physical/motor, sensory (including vision and hearing), communication, social, emotional, or adaptive.

Early intervention services are provided based on the determination of medical need in any of the identified domains.

A developmental delay is a verified delay by use of two or more of the following: appropriate standardized instrument(s); observational assessment; parent report(s); developmental inventory; behavioral checklists; adaptive behavior scales; or professional judgment. When a standardized instrument is used, the following will be used to establish a developmental delay: a score of 1.5 standard deviation below the mean in at least one area of the identified domains, or a 25 percent delay on measures yielding scores in months in at least one of the identified domains.

Amendment 2004-010
Effective 07/01/2004
Supersedes 93-57
Approval 02/03/2005

Revised Submission _____

Early intervention services must be face-to-face encounters, medically necessary, within the scope of practice of the provider, and intended to maximize reduction of identified disabilities or deficits. Suspicious deficits, disabilities or developmental delays are identified and verified through comprehensive screening, assessments and evaluations. Sessions that address the identified delays must be a collaboration of identifying, planning and maintaining a regimen related to the child's functioning. Sessions may be provided in individual or group settings in the following locations: hospital, other clinical settings, home, day care center, or other locations identified as a natural environment for the child.

Provision of services where the family or caregivers are involved must be directed to meeting the identified child's medical treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified needs of the child are not covered by Medicaid.

A. Eligible Providers

An eligible provider must enroll as a Medicaid individual provider or group provider that employs or contracts with staff who hold a valid and active license in full force and effect to practice in the state of Florida and have three hours of continuing education per calendar year, or be a non-healing arts certified Infants and Toddler Developmental Specialist (ITDS). The Florida Department of Health, Children's Medical Services Early Steps Program verifies the qualifications, training, experience and certification of the potential Medicaid enrollees, and recommends the provider for Medicaid participation.

In accordance with 42 CFR 431.51, all willing and qualified providers may participate in this program.

Eligible providers must meet the following requirements to enroll as a Medicaid Early Intervention Services provider:

1. Physician - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Physicians and have a minimum of one year experience in early intervention.
2. Physician's assistant - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Physicians and have a minimum of one year experience in early intervention.

Amendment 2004-010
Effective 07/01/2004
Supersedes 93-57
Approval 02/03/2005

Revised Submission _____

3. Nurse practitioner - Be licensed through the Florida Department of Health Medical Quality Assurance Board of Nursing and have a minimum of one year experience in early intervention. Meet requirements contained in 42 CFR 440.166.
4. Registered nurse (RN) - Be licensed through the Florida Department of Health Medical Assurance Board of Nursing and have a minimum of one year experience in early intervention.
5. Practical Nurse (LPN) - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Nursing and have a minimum of one year experience with early intervention.
6. Physical therapist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Physical Therapy Practice and have a minimum of one year experience in the area of early intervention. Meet requirements contained in 42 CFR 440.110.
7. Occupational therapist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Occupational Therapy Practice and have a minimum of one year experience in the area of Early Intervention. Meet requirements contained in 42 CFR 440.110.
8. Speech-language pathologist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Occupational Therapy Practice and have a minimum of one year experience in the area of Early Intervention. Meet requirements contained in 42 CFR 440.110.
9. Audiologist - Be licensed through Florida Department of Health Medical Quality Assurance, Board of Speech-language Pathology and Audiology with a minimum of one year experience in the area of early intervention. Meet the requirements contained in 42 CFR 440.110(c).
10. Respiratory therapist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Respiratory Care with a minimum of one year experience in the area of early intervention.
11. Clinical psychologist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Psychology and have a minimum of one year experience in the area of early intervention.
12. School Psychologist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Psychology and have a minimum of one year experience in the area of early intervention.
13. Clinical social worker - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. Minimum of one year experience in the area of early intervention.
14. Marriage and family counselor - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Clinical

Social Work, Marriage and Family Therapy, and Mental Health Counseling. Must have a master's level degree or higher and have a minimum of one year experience in the area of early intervention.

15. Mental health counselor - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. Must have a master's level degree or higher and have a minimum of one year experience in the area of early intervention.
16. Registered dietician - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Dietetics and Nutrition and have a minimum of one year experience in the area of early intervention.
17. Nutrition counselor - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Dietetics and Nutrition and have a minimum of one year experience in the area of early intervention.
18. Infants and Toddlers Developmental Specialist (ITDS) - Have a bachelor's degree or higher from an accredited college or university in early childhood or early childhood/special education, child and family development, family life specialist, communication sciences, psychology or social work or equivalent degree based on transcript review. Must have a minimum of one year experience in early intervention or a minimum of five years documented experience may substitute for an out of field degree. The ITDS provides early intervention services under the direction of a licensed physician or other health care professional acting within their scope of practice. The licensed healing arts professionals on the Family Support Plan Team who provide the evaluation, the service planning assessment, the development of the IFSP and the development of the plan of care follow the child and direct and support the activities of the ITDS through consultation at team meetings or by accompanying the ITDS on visits with the child and family.

Experience requirements are set by the Department of Health, Early Steps Program. Early Steps defines one year of experience in early intervention as equaling 1600 hours of hands-on experience with 0-5 year old children with special needs or their families. A maximum of 400 hours hands-on work with 0 to 5 year old children with special needs or their families obtained as part of the educational requirement to obtain a degree can substitute for 25% of the 1 year experience. Certification of all experience is required upon

enrollment from the Department of Health, Early Steps Program. Certification can consist of letters from former and current employers, letters from professors, or course syllabi describing internship experience and hours with transcripts showing the successful completion of the course.

B. Benefits and Limitations

Early intervention services are medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level. Early intervention services are provided to Medicaid-eligible children for whom all services are medically necessary.

Rehabilitative services include the following range of services, referred to as early intervention services:

1) Screening Services: a screening is a brief assessment of a child that is intended to identify the presence of a high probability of delayed or abnormal development which may require further evaluation and assessment. A screening must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice under state law. The component(s) of the screening performed must be within the scope of practice of the provider. Screenings are performed by one early intervention professional and are limited to three per year per recipient.

Exceptions to the service limitations will be granted based on medical necessity. Authorization to increase the limitation of frequency or time must be requested and approved prior to providing the service. Such authorization is limited to a 3-month period.

Providers retain 100 percent of the payments provided for in Attachment 4.19-B.

2) Interdisciplinary Psychosocial and Developmental Evaluation Services: This is either an initial or follow-up comprehensive, interdisciplinary psychosocial and developmental evaluation to determine a child's level of functioning in each of the following developmental areas: (1) gross motor; (2) fine motor;

(3) communication; (4) self-help and self-care; (5) social and emotional development; and (6) cognitive skills. An evaluation is based on informed clinical opinion through objective testing and includes, at a minimum, a review of pertinent records related to the child's current health status and medical history; an evaluation of the child's level of functioning in each of the developmental areas; an assessment of the unique strengths and needs of the child; and identification of services appropriate to meet the needs of the child.

When used, a standardized test should be thorough, efficient, objectively scored, reliable, valid, culturally fair, and have a broad developmental focus. Tests are to be administered by providers.

The initial evaluation is limited to one per lifetime per recipient. Follow-up evaluations are limited to three per year per recipient. Evaluations must be recommended by a licensed healing arts professional or paraprofessional.

Exceptions to the service limitations will be granted based on medical necessity. Authorization to increase the limitation of frequency or time must be requested and approved prior to providing the service. Such authorization is limited to a 3-month period.

Providers retain 100 percent of the payments provided for in Attachment 4.19-B.

3) Group, Individual, and Home Visiting Sessions: Sessions are face-to-face encounters of at least 30 minutes, not to exceed 60 minutes, with the child or the child's parent, family member or caregiver or both. The purpose of the session is to provide medically necessary services to alleviate or minimize the child's developmental disability, or the condition that could lead to the developmental disability or delay. Sessions must be provided by a Medicaid enrolled professional or paraprofessional early intervention provider within their scope of practice.

An individual session is held with one child or one of the child's parents, family member or caregiver or both.

A group session is held with more than one child, more than one of the child's parents, family member or caregiver; or, more than one child and those children's parents, family members or caregivers. A minimum number of participants in a group is two. The recommended maximum for a group is four.

A home-visit session is an individualized session with one child or that child's parent(s), family member(s) or caregiver(s) or both in the child's home, child care facility or other location conducive to the natural environment of the child, and does not have a center-based or developmental day program.

Billable activities are those identified in the Medicaid Early Intervention Session(s) Plan of Care for the period authorized. Session services cannot duplicate or supplant existing Medicaid services. Services are designed to enhance development in physical/motor, communication, adaptive, cognitive, social or emotional and sensory domains, or to teach compensatory skills for deficits that directly result from medical, developmental, or other health-related conditions.

Providers retain 100 percent of the payments provided for in Attachment 4.19-B.

Providers can be reimbursed for only one type of early intervention session (group, individual, or home-visit) per day, per child. A session cannot be split between providers, nor can more than one type of provider provide a session per day for the same child.

Exceptions to the service limitations will be granted based on medical necessity. Authorization to increase the limitation of frequency or time must be requested and approved prior to providing the service. Such authorization is limited to a 3-month period.

C. Early Intervention Services By Provider Type

Early intervention services are rehabilitative services that include a range of coordinated rehabilitative or remedial medically necessary services provided to a child in order to identify, evaluate, correct, reduce, or prevent further deterioration of deficits in the child's mental or physical health. Early intervention services, which include screening,

evaluations and sessions, are designed to enhance, not duplicate, existing Title XIX mandatory or optional services; to ensure maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.

The following services are provided by the appropriate provider type within his scope of practice, and when medically necessary, as part of an early intervention screening, evaluation or session. Services include:

1) Developmental - services under the direction of a licensed physician or other health care professional acting within their scope of practice. The licensed healing arts professionals on the Family Support Plan team provide the evaluation, the service planning assessment, the development of the Individualized Family Support Plan (IFSP) and the development of the plan of care, follow the child and direct and support the activities through consultation at team meetings, or by accompanying a provider on visits. These consultative services encompass identifying and rehabilitating a child's medical or other health-related condition and integrating developmental intervention strategies into the daily routines of a child and family to restore or maintain function or reduce dysfunction resulting from a mental or physical disability or developmental delay. Ensuring carryover of medically necessary developmental intervention strategies into all of the child's daily activities to increase the range of normal daily functioning and experience.
2) Medical - services for diagnostic or evaluation purposes, services to determine a child's developmental status and need for early intervention services.
3) Psychological - services are administering psychological and developmental tests, interpreting results, obtaining and integrating information about the child's behavior, child and family conditions related to learning, mental health and development, and planning and managing a program of psychological services, including psychological counseling, family counseling, consultation on child development, parent training and education programs.
4) Occupational Therapy - services to address the functional needs of a child related to adaptive development, adaptive behavior and

play, and sensory, motor, and postural development to improve the child's functional ability to perform tasks, including identification, assessment, intervention, adaptation of the environment, and selection of assistive and orthotic devices.

5) Physical Therapy - services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. It includes evaluation to identify movement dysfunction, obtaining, interpreting and integrating information for program planning and treatment to prevent or compensate for functional problems.
6) Speech/Language - services to identify children with communicative or oropharyngeal disorders and delays in communication skills development, referral for medical or other professional services and the provision of services necessary for their rehabilitation.
7) Nutritional - services that include conducting nutritional assessments, developing and monitoring appropriate plans to address the nutritional needs of the child, based on the findings of the nutritional needs of the child, based on the findings of the nutritional assessment, and making referrals to appropriate community resources to carry out nutritional goals.
8) Audiological - services to identify children with auditory impairment, using at risk criteria and appropriate audiologic evaluation procedures to determine the range, nature, and degree of hearing loss and communication functions. It includes referral for medical and other services necessary for rehabilitation, provision of auditory training and aural rehabilitation, and determination of the child's need for amplification and its selection, use and evaluation.
9) Respiratory Therapy - services to identify, evaluate and provide interventions to children with respiratory disorder which may result in a developmental delay in any of the identified domains.

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Revised Submission _____

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND: (Continued)

10/1/90 (13d) 15. REHABILITATIVE SERVICES: Exceptions to the service limitations can be granted based on medical necessity.

a. Intensive therapeutic on-site services include the provision of therapeutic services, with the goal of preventing more restrictive, costly placement by teaching problem solving skills, behavior strategies, normalization activities and other treatment modalities as appropriate. On-site is defined as where the child is living, working or receiving schooling. Children residing in a public institution or who are under the control of the juvenile justice system are not eligible for Medicaid.

While it is recognized that involvement of family (including legal guardians) in the treatment of the child is necessary and appropriate, provision of services where the family is involved clearly must be directed to meeting the identified child's treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified needs of the child are not covered by Medicaid.

Billable services are face-to-face encounters with the child and/or the child's family. Services must be rendered by a mental health professional with a minimum of a B.A. degree from an accredited university a with emphasis in the areas of psychology, social work, health education or a related human services field.

Intensive therapeutic on-site services include:

o Behavioral assessment of the child in order to define, delineate, evaluate and diagnose treatment needs. Assessment services include; psychosocial evaluation, psychiatric mental status exam, psychological testing, and developmental assessment of the child within the home, community, educational or vocational setting.

o Development of a behavioral management program for the child designed to reduce behavior problems and/or functional deficits stemming from the existence of a mental disorder that interfere with the child's personal, familial, vocational and/or community adjustment.

o Monitoring of the child's compliance with the behavioral management program.

o Individual counseling or psychotherapy between the child and the mental health professional designed to maximize strengths and to reduce behavior problems and or functional deficits stemming from the existence of a mental disorder that interferes with the child's personal, familiar, vocational and/or community adjustment.

o Family counseling or psychotherapy involving the child, his/her family and or significant others and a mental health professional designed to maximize strengths and to reduce behavior problems and or functional deficits stemming from the existence of a mental disorder that interfere with the child's personal, familial, vocational and/or community adjustment.

o Other medically necessary therapeutic services specified by the psychiatrist in the child's plan of care.

Services are limited to one visit per day. Additional visits can be granted based on medical necessity.

Amendment 90-67
Effective 10/1/90
Supersedes 92-26
Approved 5-12-94
Revised Submission 2/20/92
Revised Submission 8/7/92
Revised Submission 2/3/94

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND: (Continued)

4/1/96 (13d) 15. REHABILITATIVE SERVICES: (Continued)

b. Home-based rehabilitative services are designed for the restoration or modification, and/or maintenance of social, personal adjustment, and basic living skills. These services shall be an effective intervention in assuring that a child with a psychiatric disability possesses those physical, emotional, and intellectual skills to live, learn and work in his or her own particular environment. Home-based is defined as the child's official place of residence. Children residing in a public institution, or who are under the control of the juvenile justice system, are not eligible for Medicaid.

While it is recognized that involvement of family (including legal guardians) in the treatment of the child is necessary and appropriate, provision of services where the family is involved clearly must be directed to meeting the identified child's treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified needs of the child are not covered by Medicaid.

Billable services are face-to-face encounters with the child and/or the child's family. Services must be rendered by an individual who is experienced in the needs of severely emotionally disturbed children, is capable of implementing services which address the child's needs identified in the care plan, demonstrate skills and abilities to deliver therapeutic services to severely emotionally disturbed children, complete an ADM approved pre-service training program and participate in annual training to improve skills. Providers may not be relatives of the recipient. Services are limited to those provided by or under the recommendation of a physician, psychiatrist or other licensed practitioner of the healing arts acting within the scope of his/her practice under State law.

Home-based rehabilitative services include:

o One to one supervision of the child's therapeutic activities in accordance with his or her behavioral management program.

o Skill training of the child for ~~development and/or~~ HCFA Pub Change 8-12-96 restoration of those basic living and social skills necessary to function in his or her own particular environment.

o Assistance to the child and family in implementing behavioral goals identified through family counseling or treatment planning.

Services are limited to 56 hours per month. Additional hours can be approved based on medical necessity.

Amendment 96-03
Effective 4/1/96
Supersedes 95-16
Approved 8-12-96

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

1/1/98 (13d) REHABILITATIVE SERVICES: (Continued)

School-Based Therapy Services

Under the rehabilitative services option, the following services, referred to as "school-based services" are provided.

Rehabilitative therapy services provided are occupational, physical, and speech. For each of these therapies, a maximum of four individual or four group treatment sessions are allowed per recipient per day with each treatment session being a minimum of 15 minutes. The maximum speech therapy group size is contained in the Florida Medicaid Certified Match School Handbook. The maximum group size for physical and occupational therapies is four children. Exceptions to service limitations can be granted based on medical necessity.

School-based physical, occupational and speech therapy services are provided by school districts to EPSDT eligible children who are eligible under Parts B or H of the Individuals with Disabilities Education Act (IDEA), and who have their need for a Medicaid compensable, medically necessary service documented in an Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP). Medicaid recipients whose need for medically necessary services is not documented in an IEP or IFSP may receive therapy services at school but Medicaid cannot reimburse for those services due to the free care policy.

Therapists rendering covered services must meet the requirements contained in 42 CFR 440.110. School districts will be the Medicaid provider. The state will require school districts to verify that school-based treating therapists meet the criteria contained in 42 CFR 440.110. The state Medicaid agency will monitor this factor and complete an agreement with each school district which will clearly outline the district's responsibilities in ensuring compliance with provider enrollment criteria.

Therapy services must be recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under state law, for the maximum reduction of physical or mental disease or disability and restoration of a recipient to his best possible functioning level. Consent to receive school-based therapy services and bill Medicaid is obtained from parents/ guardians by school providers.

Therapy services are also provided in other settings (for example, including but not limited to home health, therapists in private practice, inpatient and outpatient hospitals, nursing homes, prescribed pediatric care facilities) and by providers meeting the requirements of 42 CFR 440.110, thus, there are no limitations on freedom of choice or comparability. This means that recipients can choose to receive therapy services from a school or community provider. Recipients are not required to receive therapy services at school.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

10/1/01
(13d)

REHABILITATIVE SERVICES (Continued)

School-Based Psychological Services

Psychological services are diagnostic or active treatments related to the individual educational plan (IEP) or family support plan (FSP) with the intent to reasonably improve the individual's physical or mental condition or functioning. Any medical or remedial services will be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice under state law. All requirements of 42 CFR 440.130 will be met.

Psychological services may include testing and evaluation that apprise cognitive, emotional and social functioning and self-concept; interviews and behavioral evaluations including interpretations of information about the individual's behavior and conditions relating to functioning; therapy, including providing a program of psychological services for the individual with diagnosed psychological problems; unscheduled activities for the purpose of resolving an immediate crisis situation and other medically necessary services within the scope of practice. Psychological services may be provided in either an individual or group setting.

School districts will be the Medicaid provider of services provided in the school setting. However, the state Medicaid agency will require school districts to verify that school-based treating psychologists or school psychologists are licensed or Department of Education (DOE) certified, or equivalent psychologists or are graduate degree psychologists obtaining the required work experience for licensing or DOE certification, working under the supervision of a licensed or equivalent psychologist or school psychologist. The state Medicaid agency will require an agreement with each school district to this effect and will monitor this factor.

Psychologists are required to have experience in providing services in school settings to Medicaid eligible children with multiple medical needs. Providers must be able to access children in school settings and must establish linkages in order to coordinate and consult with school authorities, as well as families, to assess a child's medical needs and identify treatment options.

Billable activities include: developmental assessment, case consultation, evaluation, and testing of the individual; therapy and counseling services with the individual, including face-to-face, collaborative, consultative, and crisis interventions. Procedure codes are Individual Psychological service and Group Psychological service - locally assigned codes to be established.

Medicaid recipients whose need for medically necessary services is not documented in an IEP or IFSP may receive the services at school but Medicaid cannot reimburse for those services unless they are receiving services due to Parts B or H under the Individuals with Disabilities Education Act (IDEA) or Title V due to free care policy.

Amendment 01-17
Effective 10/1/01
Supersedes 97-12
Approved FEB 06 2002

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

10/1/99 (13d) REHABILITATIVE SERVICES (Continued)

School-Based Social Work Services

Social work services are diagnostic or active treatments related to the individual educational plan (IEP) or family support plan (FSP) provided with the intent to reasonably improve the individual's physical or mental condition or functioning. Any medical or remedial services will be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice under state law. All requirements of 42 CFR 440.130 will be met.

Social work services may include those services provided to assist the individual or family members in understanding the nature of the disability, the special needs of the individual, and the individual's development. Service activities may include screenings; assessments; evaluations; social development studies; counseling and therapy; unscheduled activities for the purpose of resolving an immediate crisis situation and other medically necessary services within the scope of practice. Social work services may be provided in either an individual or group setting.

School districts will be the Medicaid provider of services provided in the school setting. However, the state Medicaid agency will require school districts to verify that school-based treating providers meet the following provider eligibility requirements. The state Medicaid agency will require an agreement with each school district to monitor this factor.

Social workers will have a bachelor's or master's level degree or higher in social work from an accredited college or university, or be certified by the Department of Education as a school social worker with a minimum of a bachelor's level degree, or be licensed as a clinical social worker. Social workers with a bachelor's level degree will provide services under the supervision of a licensed or certified master's level social worker or equivalent. Social work services may also be provided by a master's level degree social worker obtaining the required work experience for licensure, working under the supervision of a licensed or equivalent social worker.

Mental health counselors and marriage and family therapists will have master's level degrees or higher and be licensed by the State of Florida. Also, master's level degree mental health counselors and marriage and family therapists who are provisionally licensed or board registered interns, must work under the supervision of a licensed mental health counselor or marriage and family therapist until their work experience for licensure is satisfied. Behavior analysts will have master's level degrees or higher and be certified by the Department of Families and Children. Bachelor level degreed certified behavior analysts (CBAs) can also be providers of services if they work under the supervision of a Master's level certified behavior analyst. Certified associate behavior analysts (CABAs) will have bachelor's level or higher degrees and be certified by the Department of Children and Families. Guidance counselors will have master's level or higher degrees and be certified by the Department of Education.

Social work treating providers are required to have experience in providing services in school settings to Medicaid eligible children with multiple medical needs. Providers must be able to access children in school settings and must establish linkages in order to coordinate and consult with school authorities, as well as families, to assess a child's medical needs and identify treatment options.

Billable activities include: developmental assessment, case consultation, evaluation, and testing of the individual; counseling and therapy services with the individual, including face-to-face, collaborative, consultative, and crisis interventions.

Medicaid recipients whose need for medically necessary services is not documented in an IEP or IFSP may receive the services at school but Medicaid cannot reimburse for those services unless they are receiving services due to Parts B or H under the Individuals with Disabilities Education Act (IDEA) or Title V, due to the free care policy.

Amendment 99-16
Effective 10/1/99
Supersedes 98-32
Approved 1/24/2000
Revised Submission 1/20/2000

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

10/01/97 (13d) REHABILITATIVE SERVICES (Continued)

School-Based Nursing Services

Nursing coverage can include services such as catheterizations, tube feeding, maintenance of tracheostomies, oxygen administration, limited nursing examinations, assessments and treatments, specimen collection, ventilator care, and monitoring and consultation/ medical activities with staff, parents/guardians, students or pertinent medical professionals such as physicians. Nursing coverage is limited to those services related to a student's individual educational plan (IEP) or family support plan (FSP).

Medication administration will include the dispensing of the medication and necessary documentation of oral, and/or inhalator medications. A licensed registered nurse (RN) and licensed practical nurse (LPN) may administer the medication within their scope of practice.

Services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice, per 42 CFR 440.130. All requirements of 42 CFR 440.130 will be met.

Services may be rendered by or under the direction of a licensed registered nurse (RN) as allowed by state licensure laws, and must be within the scope of the professional practice act.

Licensed practical nurses (LPN) may render services as allowed by state licensure laws and under the professional practice act, if under the supervision of a registered nurse.

Nurses are required to have experience in providing services in school settings to Medicaid eligible children with multiple medical needs. Providers must be able to access children in school settings and must establish linkages in order to coordinate and consult with school authorities, as well as families, to assess a child's medical needs and identify treatment options.

Medicaid will cover the services of a school health aide under the supervision of a registered nurse. The nurse practice act allows supervision of school health aides from off-site locations but patient specific training of health aides must be face-to-face.

The credential requirements for an aide are that each aide must have completed the following courses/training through or by the school district:

- Cardiopulmonary resuscitation,
- First aid,
- Medication administration, and
- Patient specific training.

School districts will be the Medicaid provider of services provided in the school setting. However, the state Medicaid agency will require school districts to verify that school-based treating registered nurses and licensed practical nurses are licensed. The state Medicaid agency will require an agreement with each school district to this effect and will monitor this factor.

Medicaid recipients whose need for medically necessary services is not documented in an IEP or IFSP may receive the services at school, but Medicaid cannot reimburse for those services unless they are receiving services due to Part B or Part H of the Individuals with Disabilities Education Act (IDEA) or Title V due to the free care policy.

Amendment 97-22
Effective 10/1/97
Supersedes 97-14
Approved 9/4/98

Revised Submission 8/28/98

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

7/1/98
(13d) REHABILITATIVE SERVICES (Continued)
School-Based Nursing Services by County Health Departments

County Health Departments will only provide nursing services on the school campus and in the student's home that are not reimbursable under the clinic services program. Nursing services under the rehabilitative services program include the basic nursing care students require while they are in the school or in school home-bound programs.

Medication administration will include the dispensing of the medication and necessary documentation of oral, and/or inhalator medications. A licensed registered nurse (RN) and licensed practical nurse (LPN) may administer the medication within their scope of practice.

Services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice, per 42 CFR 440.130. All requirements of 42 CFR 440.130 will be met.

Services may be rendered by or under the direction of a licensed registered nurse (RN) as allowed by state licensure laws, and must be within the scope of the professional practice act.

Licensed practical nurses (LPN) may render services as allowed by state licensure laws and under the professional practice act, if under the supervision of a registered nurse.

County Health Departments will be the paid-to-provider. All of the treating providers, both RNs and LPNs will be enrolled in the Medicaid program as treating providers.

Amendment 98-12
Effective 7/1/98
Supersedes NEW
Approved 9/4/98

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

REHABILITATIVE SERVICES

School-Based Behavioral Services by County Health Departments

County Health Departments will provide behavioral services that are not reimbursable under the clinic services program, only on the school campus and in the student's home. Behavioral services under the rehabilitative services program include the behavioral health students require while they are in the school or in school home-bound programs.

Behavioral services are diagnostic testing or active treatments to be rendered with the intent to reasonably improve the individual's physical or mental condition or functioning. Services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice, per 42 CFR 440.130. All requirements of 42 CFR 440.130 will be met.

Behavioral services are intervention services that focus on treatment. Behavioral services may include testing and evaluation that apprise cognitive, emotional and social functioning and self-concept; interviews and behavioral evaluations including interpretations of information about the individual's behavior and conditions relating to functioning; therapy, including providing a program of behavioral services for the individual with diagnosed behavioral problems; unscheduled activities for the purpose of resolving an immediate crisis situation; and other medically necessary services within the scope of practice. Behavioral services may be provided in either an individual or group setting.

County Health Departments will be the Medicaid pay to provider of services provided in the school setting with treating providers either employed or individually contracted. Treating providers of behavioral services must have at a minimum a Master's degree in social work from an accredited college, and work under the supervision of a licensed clinical social worker (LCSW) as required by Florida Statutes in order to obtain the work experience necessary for licensure or certification. The state agency will require County Health Departments to verify that school-based treating behavioral services providers meet provider requirements. The state Medicaid agency will require an agreement with each County Health Department to this effect and will monitor this factor. Behavioral services providers should have experience in providing services in school settings to Medicaid eligible children and must establish linkages in order to coordinate and consult with school authorities, as well as families, to assess a child's needs and identify treatment options.

Employees of the Health Department providing behavioral health services in schools will not duplicate services provided by school district employees. Health Department staff will provide services only when the need of the student exceeds the level of staff employed by the school district or is not available from school district staff.

Health Department social workers (MSW and LCSW) will provide services to all Medicaid eligible students in the school setting who are in need of such services.

Amendment 2002-02
Effective 7/1/02
Supersedes NEW
Approval Date JUN 0 6 2002
Revised Submission May 30, 2002
Revised Submission June 3, 2002

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

4/1/91
(4a)

1. Screening examinations are scheduled to occur at birth, two months, four months, six months, 9 months, 12 months, 15 months, and 18 months, once per year for the age group two through six years old, and once every two years for children seven through twenty years of age as recommended by the American Academy of Pediatrics and the Florida Pediatric Society. Additional screening examinations are also available upon referral from a healthcare, developmental or educational professional, when factors suggesting the need for EPSDT are presented, or upon the request of the parent/recipient. The periodicity schedule meets the requirements of Section 1905(r) of the Act.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

4/1/91
(10)
(12b)

2. Dental Services. A direct dental referral is required for every child, 3 years of age and older, or earlier as medically indicated to adhere to the recommendation for preventive pediatric health care as recommended by the American Academy of Pediatrics and the Committee on Practice and Ambulatory Medicines. The periodicity schedule meets the requirements of Section 1905(r) of the Act. Following the initial dental referral, subsequent examinations by a dental professional are recommended every six months or more frequently as prescribed by a dentist or other authorized provider. Orthodontic services require prior authorization to be obtained for medical necessity.

1/02
3d)

REHABILITATIVE SERVICES:

Rehabilitative services are limited to mental health and substance abuse services that are provided for the maximum reduction of the recipient's mental health and substance abuse disability and restoration to the best possible functional level. Services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

Services are limited to those which are medically necessary and are recommended by a licensed practitioner of the healing arts, psychiatrist, or other physician and included in a treatment plan. Exceptions to the service limitations can be granted based on medical necessity. Service limitations for EPSDT recipients are listed in the EPSDT section.

In keeping with the 2001-2002 General Appropriations Act, certain high cost mental health procedure codes are subject to prior authorization.

To be eligible to participate in this program, providers must:

- Have a current contract pursuant to the provision of Chapter 394, Florida Statutes, for the provision of community mental health or substance abuse services from the district or regional Department of Children and Families, Alcohol, Drug Abuse and Mental Health (ADM) program office; and

- Employ or have under contract a Medicaid-enrolled psychiatrist or other physician.

In addition to the above requirements:

- Alcohol prevention, treatment, or drug abuse treatment and prevention programs must hold a regular (i.e., not probationary or interim) license as defined in Chapter 397, F.S.

- Individuals seeking enrollment as providers of comprehensive behavioral health assessments must be reviewed and certified as meeting specific provider qualifications.

- Agencies seeking enrollment as providers of comprehensive behavioral health assessments or specialized therapeutic foster care services (Level I, Level II, and Crisis Intervention) must be reviewed and certified as meeting specific provider qualifications.

PERSONAL CARE/ASSISTIVE CARE SERVICES

Personal Care/Assistive Care Services are provided to Medicaid eligible recipients requiring an integrated set of services on a 24-hour basis. Recipients must have health assessments establishing the medical necessity of at least two components of the integrated personal/assistive care services. The medical necessity must be determined by a physician or other licensed practitioner of the healing arts acting within the scope of their practice under state law. All requirements of 42 CFR 440.167 will be met.

Eligible providers must be able to provide the integrated set of personal care/assistive care services on a 24-hour basis and maintain a standard license under Chapters 400.407, 400.468 or 394.875, F.S. Only trained personnel employed by the service provider will be able to provide care under this service.

The personal care/assistive care services are: health support, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and assistance with self-administration of medication.

Health support is defined as requiring the provider to observe the resident's whereabouts and well being, to remind the resident of any important tasks, and to record and report any significant changes in the resident's appearance, behavior, or state of health to the resident's health care provider, designated representative or case manager.

Assistance with activities of daily living is defined as individual assiatance with ambulating, transferring, bathing, dressing eating grooming and toileting. Assistance with instrumental activities of daily living is defined as individual assistance with shopping for personal items, making telephone calls and managing money.

Assistance with self-medication administration of medication is defined as assistance with or supervision of self-administration to the extent permitted by state law.

Personal Care/Assistive Care Services will be provided based upon individual care plans developed from health assessments. The personal care/assistive care service provider is responsible for developing the recipient's care plan. Care plans will be reviewed by the Agency for Health Care Administration (AHCA) annually.

Amendment 2000-11
Effective 1/1/2001
Supersedes NEW
Approval 4/5/2001

Rehabilitative Services:

Community-based Substance Abuse Services

Community-based substance abuse rehabilitative services will be available to all Medicaid eligible individuals with substance abuse disorders who are medically determined to need rehabilitative services. These services must be delivered by an agency licensed by the state to deliver substance abuse services and under contract with a county to receive county tax dollars that are certified as the state share of reimbursement for these services. These services must be recommended by a physician or other practitioner of the healing arts within the scope of his/her practice under state regulation and furnished by or under the direction of a physician or other practitioner operating within the scope of applicable state regulations, to promote the maximum reduction of symptoms of substance abuse and/or restoration of a recipient to his/her best possible functional level. The services are as follows:

Comprehensive Community Support Services for Substance Abuse

These services are designed to assist clients to strengthen and/or regain skills, to develop the environmental support necessary to help clients thrive in the community, and to aide clients in meeting life goals the promote recovery and resiliency. Services include substance abuse education, family/parenting guidance, life skills, anger/stress management, and support counseling. Services do not include meetings of Narcotics Anonymous, Alcoholics Anonymous, or other twelve-step programs.

Comprehensive Community Support Services for Substance Abuse-Bachelors Degree Level

Comprehensive community support services are medically necessary clinical aftercare services that are directed toward individuals who have received and successfully completed substance abuse treatment within a correctional or other institutional setting or a community-based program, and need continued therapeutic services to maintain their recovery as they re-enter the community. The purpose of comprehensive community support services is to provide integrative therapeutic supports and aftercare in collaboration with available and relevant ancillary medical and behavioral support services in the community to promote the receipt and effectiveness of those services. These services are based on a recovery support services model that addresses interpersonal and coping skills in home, work, and school situations and facilitates medication monitoring and symptom monitoring through therapeutic service provision. Identifying barriers that impede the development of skills necessary for independent functioning in the community will also be an integral part of these services. These out patient services may be provided in a variety of community-based settings that are licensed by the state to provide substance abuse services. Effective after care services are comprised of the following activities: supportive and psycho-educational counseling about substance abuse disorders; specific recovery support services such as guidance in locating housing, counseling to support employment; monitoring recipient progress toward meeting goals of the aftercare plan; coordinating any necessary services with other sources and subsequently making any referrals for medically necessary services. Services must be provided by a substance abuse counselor who has knowledge of existing support services within the community. Services shall be supervised by a licensed practitioner of the healing arts or a master's level C.A.P. Reimbursement for this service is limited to 60 units per state fiscal year per recipient. Each unit must be 30 minutes in duration.

Alcohol and/or Drug Intervention Service

Alcohol and/or Drug Intervention Service is provided for the purpose of early identification of substance abuse problems and rapid linkage to needed services. This service is used to detect alcohol or other drug problems and to provide a brief intervention to arrest the progression of such problems, thereby avoiding the need for more costly and intensive levels of treatment. The intervention service is delivered on an outpatient basis in community-based settings such as licensed substance abuse providers, schools, work sites, community centers, and homes. The goal is to provide the medically necessary clinical services to minimize and ameliorate substance abuse risk factors and behaviors early in the process as an alternative to a more restrictive level of treatment. The following activities are included under this service: clinical screening and evaluation; identification and provision of medically necessary treatment needs; referral to other clinically indicated services; and ensuring referral appointments are met. Services must be delivered by a substance abuse counselor under the supervision of a licensed practitioner of the healing arts or a master's level C.A.P. Reimbursement for this service is limited to 24 units of at least 30 minutes each, per state fiscal year per recipient.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

10/1/95 (6b) 3. Optometric Services: A specific periodicity schedule has been established as mandated by OBRA 1989 for vision screenings in accordance with the recommendations of the appropriate medical consultants. The schedule for screenings adhere to the Recommendation for Preventative Pediatric Health Care as recommended by the American Academy of Pediatrics and the Committee on Practice and Ambulatory Medicines. The periodicity schedule meets the requirements of Section 1905(r) of the Act.

Amendment 95-20
Effective 10/1/95
Supersedes 93-02

Approval 1-23-96

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

10/1/90 (12d) 4. Eyeglasses are limited to one pair per recipient every two years, prior authorization is required for additional pairs and will be granted based on medical necessity. Contact lenses will be provided for limited conditions, and require prior authorization. Replacement of lost or stolen eyeglasses or contact lenses are not reimbursable unless prior authorization has been granted by the state agency based on medical necessity.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

10/1/95 (11c) 5. Hearing Services: A specific periodicity schedule has been established as mandated by OBRA 1989 for hearing screenings in accordance with the recommendations of the appropriate medical consultants. The schedule for hearing services screening adheres to the Recommendations for Preventative Pediatric Health Care as recommended by the American Academy of Pediatrics and the Committee on Screening and Ambulatory Medicine. The periodicity schedule meets the requirements of Section 1905(r) of the Act.

Amendment 95-20
Effective 10/1/95
Supersedes 93-02

Approval 1-23-96

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

7/1/91 (12c) 6. Hearing aid devices are limited to those items determined medically necessary by a licensed otolaryngologist, otologist or general physician. A physician or an advanced registered nurse practitioner other than an otolaryngologist or otologist shall refer Medicaid recipients to an audiologist, otolaryngologist or otologist for evaluation and testing. Following the provision of the initial hearing aid, approval can be granted by the state agency based on medical necessity for additional aids.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

7/1/98
(6d)

Respiratory Services

Medicaid recipients under the age of 21 may receive medically necessary respiratory therapy services which are reimbursable to Medicaid enrolled providers. Services must be prescribed in writing by the recipient's primary care physician (or designated physician assistant or advanced registered nurse practitioner) or a designated MD specialist. Services must be provided by a registered respiratory therapist who is licensed by the state of Florida, has met the requirements of 42 CFR 440.60 and has been enrolled as a Medicaid provider. The registered respiratory therapist must administer treatment according to the primary care provider's specific approved written plan of care and written prescription. Florida allows all eligible licensed registered respiratory therapists to enroll as providers to ensure freedom of choice of providers in accordance with 42 CFR 440.70.

Reimbursement for one evaluation or re-evaluation per recipient is allowed every six months. Respiratory therapy visits must be a minimum of fifteen (15) minutes in duration with reimbursement available for a maximum of two individual treatment sessions per day. Exceptions to these limitations may be made based on medical necessity.

Therapy treatments are subject to prior authorization.

Amendment 03-23
Effective 10/1/03
Supersedes 98-14

Approval DEC 2 3 2003

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

Home Health Services

3/1/97 (7d)

Therapy services provided are occupational, physical, and speech. For these therapies, a maximum of two individual treatment sessions are allowed per recipient per day with each treatment session being a minimum of 15 minutes. Services must be prescribed in writing by the recipient's attending physician. The attending physician is the doctor in charge of the recipient's medical condition that causes the recipient to need home health services.

One evaluation or re-evaluation per recipient is allowed every six months. Exceptions to the service limitations can be granted based on medical necessity. Services must be provided through a licensed home health agency or a facility licensed by the state to provide medical rehabilitative services. Florida allows all eligible providers to enroll as Home Health Agencies, to ensure freedom of choice of providers in accordance with 42 CFR 440.70.

Amendment 97-05
Effective 3/1/97
Supersedes 96-06

Approval 9/22/97

Revised Submission 8/29/97

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND: (Continued)

CFR 440.167 (24f) 9. Personal Care Services must be prior-authorized by the state agency based upon medical necessity. Personal care services provided in a recipient's home must be furnished by an individual with health care training appropriate to the health care needs of the child. Recipients may receive personal care services through a licensed home health care agency or an individual or entity which is determined by the state agency to meet comparable standards for providing home based health care services, or at the state's option in another location not primarily engaged in providing services to individuals with mental health diagnoses. Personal care services are limited to a minimum of 1 hour and a maximum of 24 hours per day, per recipient.

10/1/11 Personal Care Services provided in a Prescribed Pediatric Extended Care (PPEC) must be medically necessary, ordered by a physician, outlined in the Plan of Care (POC), authorized by Medicaid or an approved designee, and provided daily up to 12 hours, or hourly up to 4 hours. PPEC rate methodology is described in Attachment 4.19-B of this plan and includes the following:

1. Basic Services as defined in 400.902, Florida Statutes – includes, but is not limited to, implementation of a comprehensive protocol of care, developed in conjunction with the parent or guardian, which specifies the medical, nursing, psycho-social and developmental therapies required by the medically dependent or technologically dependent child served, as well as the caregiver training needs of the child's legal guardian.

2. Medically Necessary Services as defined in 59g-1.010(202) Florida Administrative Code (FAC):
    1. Be necessary to protect life, prevent significant illness or disability or to alleviate severe pain:
    2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
    3. Be consistent with generally accepted medical standards as determined by the Medicaid program, and not experimental or investigational;
    4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available;
    5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caregiver, or the provider.

Some examples of these specific services would be: physical assessment, oral hygiene, bathing and grooming, range of motion and positioning, toileting, tracheostomy care, medication administration, tube feedings, etc. per the recipient's plan of care.

PPEC providers that provide other Medicaid services not covered in the PPEC rates must be enrolled as a Medicaid provider of those services and follow the reimbursement requirements as specified in the Florida Medicaid coverage and limitations handbook for the specific service.

PPECs are licensed by the State, and must meet all State licensure laws and regulations based on established criteria and policies in 59A-13 FAC. Staffing includes the following, at a minimum:

1. Medical Director: National Board Certified Pediatrician
2. Director of Nursing: Licensed Registered Nurse (RN) with current certification in cardio pulmonary resuscitation (CPR) and a minimum of 2 years pediatric nursing experience and 6 months caring for medically fragile infants or children in a pediatric intensive care, neo-natal intensive care, PPEC or similar care setting during the last 5 years.
3. Registered Nursing Staff: Licensed RNs with 2 or more years of pediatric experience, 6 months caring for medically dependent or technologically dependent children, and current certification in CPR.
4. Licensed Practical Nurses: 2 years of experience in pediatrics and current certification in CPR. All LPNs must be supervised by an RN.
5. Direct Care Personnel: 1 year experience in care of infants and toddlers with employment references and current CPR certification. Must be supervised by an RN.

Physicians, Registered Nursing staff and Licensed Practical Nurses are also provided and described elsewhere in the plan, pursuant to 42 CFR 440.

All willing and qualified providers will be permitted to participate in accordance with 42 CFR 431.51. All medically necessary services will be provided to individuals qualifying under the EPSDT mandate.

Amendment: 2011-001
Effective: 10/01/11
Supersedes: NEW
Approval: 1/17/12

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

10/1/90 (8)

10. Private duty nursing services are limited to a minimum of four hours of services per day and a maximum of sixteen hours per day and must be pre-authorized by the state agency. Exceptions to these limitations will be made based on medical necessity. Recipients may receive private duty nursing services based upon medical necessity. Services must be provided by a registered nurse or licensed practical nurse. Provider eligibility is limited to home health care agencies or an individual or entity which is determined by the state agency to have met comparable standards regarding the provision of home-based private nursing care.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

1/1/98 (11) Therapy Services

Services must be prescribed in writing by the recipient's primary care provider (or designated physician assistant or advanced registered nurse practitioner) or a designated MD specialist. One evaluation or re-evaluation per recipient is allowed every six months. Exceptions to the service limitations can be granted based on medical necessity. All therapists must meet the requirements of 42 CFR 440.110.

Medically necessary occupational, physical and speech therapy services may be provided for recipients under 21 years of age. Therapy sessions administered to recipients on an individual basis must be a minimum of 15 minutes in duration with reimbursement available for a maximum of two individual treatment sessions per day. Speech therapy may also be administered in group sessions, provided that the group contains a maximum of six children, for a minimum of thirty (30) minutes per group. Therapy sessions are subject to prior authorization.

Evaluations for Augmentative and Alternative Communication (AAC) systems must be conducted and documented by the speech therapist. An initial evaluation as well as a follow-up evaluation upon delivery of the system are required to ensure appropriateness of the unit. Re-evaluation of both the unit and the user is required every six months. One initial AAC evaluation is allowed every three (3) calendar years. The follow-up/re-evaluations are limited to two (2) per calendar year. Exceptions to these limitations may be made based on medical necessity.

Fitting/adjustment/training sessions for AAC systems are limited to eight (8) 30 minute sessions per year, per device. Exceptions to these limitations may be made based on medical necessity.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

1/1/93
(12c)

12. Services for prosthetic and orthotic devices must be service authorized by the state agency and approved based on medical necessity. Prosthetic eyes are limited to one initial prosthetic eye for each eye per individual. Exceptions are granted based on medical necessity. Examples of medically necessary replacements are that the prosthetic eye is no longer the appropriate size or the eye has been inadvertently damaged, destroyed or stolen.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

Home Health Services

3/1/97 (7c) Medical supplies and durable medical equipment must be prescribed in writing by the recipient's primary care provider or a designated MD specialist and are limited to the items listed in the agency's provider handbook. Exceptions can be granted based on medical necessity.

Amendment 97-05
Effective 3/1/97
Supersedes 93-05

Approval 9/22/97

Revised Submission 8/29/97

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

1/1/94 14. Chiropractic Services: Chiropractic services are limited to twenty-four visits within a calendar year. Exceptions to the service limitations can be granted based on medical necessity.

Amendment 94-01
Effective 1/1/94
Supersedes 93-02

Approval JUN 17 1994

10/1/11 INPATIENT HOSPITAL SERVICES: Payment for inpatient hospital days is limited to 45 per fiscal year per patient 21 years of age or over. There is no limit for patients under 21 years of age.

Payment for inpatient hospital days for patients 21 years of age or older are exempt from the 45 day per fiscal year limit when services are related to the treatment of Tuberculosis provided by a public health hospital, currently known as A.G. Holley Hospital, and/or its designated replacement facility (or facilities).

Payment is excluded for experimental procedures and cosmetic surgery. Sterilization procedures which meet federal requirements and abortion procedures meeting federal requirements are allowed.

Claims that meet emergency criteria in the Balanced Budget Act of 1997 may be considered for reimbursement beyond the 45-day inpatient limit.

Inpatient hospital admissions for psychiatric services for all ages require prior authorization from a quality improvement organization (QIO) under contractual agreement with Medicaid to perform such services.

Elective inpatient hospital admissions for medical, surgical, and rehabilitative services require prior authorization from a QIO under contractual agreement with Medicaid to perform such services. Excluded from the prior authorization requirement are:

1. Emergency admissions;
2. Urgent admissions;
3. Admissions for
    a. Recipients covered by Medicaid managed care plans other than fee-for-service or MediPass;
    b. Recipients with any Medicare coverage; and
    c. Newborn deliveries.

For dates of service January 1, 2010, and after, for all Medicaid patients, requests for prior authorization of additional inpatient hospital days attributable to a Medicare identified hospital acquired condition not present on admission will be denied by the QIO and are not reimbursable. Inpatient hospital days denied by the QIO for a hospital acquired condition should be excluded from the hospital cost report, Attachment 4.19-A, Part 1 of the Medicaid State Plan.

For purposes of the plan, elective surgery is defined as those surgical procedures that can be safely deferred without:

1. Threatening the life of the recipient, or
2. Causing irreparable physical damage, or
3. Resulting in the loss or serious impairment of a bodily function, or
4. Resulting in irretrievable loss of growth and development.

Amendment 2011-015
Effective 10/1/2011
Supersedes 2009-015
Approval: 07-12-12

OUTPATIENT HOSPITAL SERVICES: Pursuant to Florida Statutes, services are limited to a maximum of $1,500 for non-EPSDT recipients 21 years of age and over per fiscal year. There is no limitation for EPSDT recipients. To best serve the needs of Florida's Medicaid population, the Agency has exempted the following services from the $1500 limitation: emergencies, outpatient surgeries, and life sustaining treatments such as chemotherapy and dialysis.

7/1/92 EMERGENCY HOSPITAL SERVICES: Same limitations as for Outpatient or Inpatient Hospital Services.

Amendment 93-02
Effective 1/1/93
Supersedes NEW

Approval APR 22 1993

08/01/12
(5)

PHYSICIAN SERVICES: Limits visits outside the hospital to not more than one per recipient per day per physician (except for emergencies) and initial consultations outside the hospital to one per medical specialty per recipient per medical condition per year (except for emergencies). Limits general visits to two visits per month provided by physicians, advanced registered nurse practitioners, and physician assistants for non-pregnant adults. Exceptions to the limits will be authorized based on medical necessity. A consultation includes services rendered by a physician whose opinion or advice is requested by another physician or agency in the evaluation or treatment of a patient's illness or problem. Also limits one physician visit per recipient per month in all types of long term care facilities (except for emergencies). Exceptions to the limits will be authorized on a case by case basis and will be evaluated based on medical necessity. Excludes clinically unproven procedures and cosmetic surgery. Sterilization procedures which meet federal requirements and abortion procedures meeting federal requirements are allowed. Health screening examinations for non-EPSDT recipients 21 years of age and older are limited to one per recipient per year. Health screening examinations are provided under EPSDT for EPSDT participants.

Elective surgical procedures require prior authorization or EPSDT screening for inpatient hospital services. For purposes of the plan, elective surgery is defined as those surgical procedures' that can be safely deferred without:

1. Threatening the life of the recipient, or
2. Causing irreparable physical damage, or
3. Resulting in the loss or serious impairment of a bodily function, or
4. Resulting in irretrievable loss of growth and development.

Medicaid program medical consultant staff will make individual patient decisions as appropriate regarding whether a patient's procedure meets the above criteria on either a prior or postauthorization basis.

ADVANCED REGISTERED NURSE PRACTITIONERS (ARNP):

8/1/12

New patient office, home or hospital visits are limited to one per recipient per provider every three years. Subsequent office, home or hospital visits are limited to one per day per recipient, except for emergency services. Visits for general services are limited to two visits per month provided by physicians, advanced registered nurse practitioners, and physician assistants for non-pregnant adults. Exceptions to the limits will be authorized based on medical necessity. Routine physical examinations are provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program or Adult Health Screenings.

1/1/91 (6a) PODIATRISTS: Limits visits outside the hospital to not more than one per recipient per day per podiatrist not to exceed two visits per month (except for emergencies) and one per recipient per month per podiatrist upon referral from the recipient's attending physician in long term care facilities (except for emergencies). One hospital visit per day per recipient per provider is allowed. A visit is not allowed on the same day as a surgical procedure unless it is indicated by an asterisk in the provider handbook. All elective surgical procedures require prior authorization or an EPSDT referral to determine medical necessity. Excludes routine foot care unless medically indicated (ex., allowed for diabetics), also excludes experimental and clinically unproven surgical procedures.

1/1/95
(6c)

CHIROPRACTIC SERVICES: Visits to a chiropractor are limited to twenty-four visits within a calendar year. Nursing home and ICF/DD residents require a referral from a physician (M.D. or D.O.). Service limitations for EPSDT recipients are listed in the EPSDT section.

HOME HEALTH SERVICES

8/1/12 (7a)	Home health visits are limited to no more than three visits per day per recipient for non-pregnant adults. The three visits may be any combination of licensed nurse and home health aide visits. Consistent with EPSDT requirements, this limit does not apply to recipients under the age of 21. Home health services are authorized by a physician's orders and must accompany a written plan of care that the physician reviews every 60 days except for medical supplies, equipment, and appliances suitable for use in the home.
3/14/95 (7b)	Home health aide services are provided under the direction and supervision of a registered nurse.
1/1/93 (7c)	Diabetic supplies, that is, disposable needle/syringe combinations and blood glucose test strips are available without limitation. For non-EPSDT recipients 21 years of age or older, medical supplies, appliances, and durable medical equipment (DME) furnished through a home health agency and/or medical supply/appliance/DME supplier are limited to those items listed in the agency's provider handbook. Refer to EPSDT section for EPSDT limitations.
1/1/2003 (7d)	Therapy services are not provided for non-EPSDT recipients 21 years of age and older except with the following exception: physical therapist and occupational therapist initial evaluation for the need for a wheelchair, one follow-up evaluation when the wheelchair is delivered to make adjustments and to fit the wheelchair to the recipient, one follow-up evaluation six (6) months after the wheelchair is delivered to recommend any additional adjustments, and additional re-evaluations that are deemed medically necessary by the primary care provider. Service limitations for EPSDT recipients are listed in the EPSDT section.
11/1/09	All home health service visits require prior authorization by the state agency or agency designee, based on medical necessity.

Amendment TN: 2012-013
Effective: 08/01/2012
Supersedes: 2009-024
Approved: 11-30-12

FAMILY PLANNING

4/1/2001 (4c)

An initial/annual family planning visit is limited to one per year and a supply visit is limited to one every month. Sterilizations are limited to recipients who meet the requirements of 42 CFR 441.253.

HIV testing and counseling are limited to four per year for recipients acknowledging HIV risks.

HIV testing and counseling are limited to two per lifetime for preventive measures.

Amendment 2001-05
Effective 4/1/2001
Supersedes 98-26

Approval JUN 2 7 2001

Coverage Template for Freestanding Birth Center Services

Attachment 3.1A: Freestanding Birth Center Services

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ☒ **No limitations** With limitations None licensed or approved

Florida Medicaid birth centers provide prenatal and delivery services for recipients expected to experience a medically low risk pregnancy and delivery.

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: No limitations ☒ **With limitations (please describe below)**

Please describe any limitations: Florida Medicaid limits prenatal visits to a maximum of 10 visits provided in a licensed birth center to a recipient expected to experience a low-risk pregnancy and delivery, however, additional visits may be provided based on medical necessity in a medically appropriate setting.

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☒ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

(c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services: Florida Licensed Midwives

10/1/93 CLINIC SERVICES: Ambulatory Surgical Centers

For ambulatory surgical centers, services are limited to those procedures which can be safely done outside of the inpatient hospital setting as determined by Medicare and the state agency policy.

Amendment 93-61
Effective 10/1/93
Supersedes NEW

Approval FEB 18 1994

1/1/93 CLINIC SERVICES: County Public Health Units

For county public health units, services are limited to one clinic encounter per recipient, per day, per provider for preventive or primary care.

Amendment 93-61
Effective 10/1/93
Supersedes NEW

Approval FEB 18 1994

7/1/98 CLINIC SERVICES: Freestanding Dialysis Center Services

Services are limited to one hemodialysis treatment per recipient, per day, up to three times per week provided by a freestanding dialysis center.

Peritoneal dialysis treatments occur as medically indicated and all care is coordinated by the freestanding dialysis center.

All dialysis treatments include: supervision, management, and training of the dialysis treatment routine, durable and disposable medical supplies, equipment, laboratory tests, support services, parenteral drugs and applicable drug categories (including substitutions) provided by and at the freestanding dialysis center.

7/1/97 TRANSPORTATION: Excludes the provision of transportation by ambulance for ambulatory patients; ambulance services to a physician's private office; transportation to pharmacies; and transportation of nursing home patients to a physician's private office to fulfill utilization control requirements.

Transportation to and from school is allowed for students who are eligible under the provisions of Parts B and H of the Individuals with Disabilities Education Act (I.D.E.A.) and receive Medicaid reimbursable services listed in their Individual Education Plans (IEP) or Family Support Plans (FSP) at the school site on the date transportation is provided. Transportation service must be listed as a required service in the IEP or FSP.

Amendment 97-10
Effective 7/1/97
Supersedes 93-02

Approval 9/18/97

(10)
(12.b)

DENTAL SERVICES: For non-EPSDT recipients twenty-one years of age and older, services that are provided in accordance with 42 CFR 440.100 and 440.120(b) are limited to:

a. Dentures. The dental services provided are limited to procedures related to dentures and those procedures necessary to seat the dentures. The recipient is limited to either a complete upper denture, a complete lower denture, or one complete set of dentures per lifetime. Replacement of broken or lost dentures is excluded from coverage. Repairs of dentures are covered services. Adjustments and relines are covered after three months for immediate dentures and six months for non-immediate dentures from the date of service.

b. Partial Dentures. The dental services provided are limited to the fabrication, repair, reline and adjustment of a removable partial denture. The recipient is limited to either an upper partial, a lower partial, or one set of partials per lifetime. Replacement of a broken or lost partial is excluded from coverage. Adjustments and relines are covered up to six months after original seating of partial. Repairs of partial dentures are covered.

c. Oral and maxillofacial surgery for injury or disease when provided by a qualified oral surgeon (dentist).

d. Emergency dental services are medically necessary emergency procedures to relieve pain or infection. The services are limited to emergency oral examinations, necessary radiographs, extractions, and the incision and drainage of an abscess.

Dental services limitations for EPSDT recipients, provided in accordance with 42 CFR 441.56, are listed in the EPSDT section.

10/1/97
(6b)

Optometric Services

For non-EPSDT recipients twenty-one years of age and older, visual examinations are limited to two per year per recipient for the purpose of determining the refractive powers of the eyes. Exception authorization for any service limitation may be made by the state agency based on medical necessity. Service limitations for EPSDT recipients are listed in the EPSDT section.

Amendment 97-17
Effective 10/1/97
Supersedes 93-02

Approval 1/20/98

7/1/06 (12d) Eyeglasses/Contact Lenses: For non-EPSDT recipients twenty-one years of age and older, contact lenses will be provided for limited conditions, and require prior authorization. Prosthetic eyes and services related to measuring, fitting and dispensing are reimbursed.

Effective January 1, 2010, eyeglass frames for adult recipients twenty-one years of age and older are limited to one pair every two years and lenses for adult recipients twenty-one years of age and older are limited to one pair every 365 days. A second pair of eyeglass frames and lenses may be provided during that period, after prior authorization.

Service limitations for EPSDT recipients are listed in the EPSDT section.

7/1/06
(11c)

HEARING SERVICES: For non-EPSDT recipients 21 years of age and older, services are provided with limitations. Hearing aid evaluations are limited to one every 3 years with additional evaluations requiring prior authorization. Diagnostic testing is reimbursed in addition to the evaluation when performed within accepted practice parameters. Hearing aids are limited to one aid, per ear, every 3 years with additional aids requiring prior authorization. Hearing aid fitting and dispensing services are limited to one of each, per each ear, every 3 years with additional services requiring prior authorization. Hearing aid repairs are limited to three repairs per 366 days outside the warranty period, starting after one full year from the date the aid was dispensed. The cochlear implant device is limited to one per recipient in either ear, but not both, if established medical criteria are met through prior authorization. Cochlear implant device repairs outside the warranty period may be post authorized and cochlear implant device accessories must be prior authorized.

Service limitations for EPSDT recipients are listed in the EPSDT section.

7/1/06
(12c)

Prosthetic Devices: For non-EPSDT recipients 21 years of age and older, the hearing aid is limited to one per recipient. This aid can be replaced if medically necessary every three years from the date the last hearing aid was received. Binaural, special hearing aids, or an exception to the limitations require prior authorization. The cochlear implant device is limited to one per recipient in either ear, but not both, if established medical criteria are met through prior authorization.

No other prosthetics or orthotics are available. Refer to EPSDT section for EPSDT limitations.

HOSPICE SERVICES

10/1/89 Benefit periods are the same as those established by Medicare.

NURSING FACILITY SERVICES

1/1/91 Individuals who are mentally ill or mentally retarded can only receive nursing services in accordance with the preadmission screening and annual resident review requirements of section 1919(b)(3)(F) and (e)(7) of the Act.

EXTENDED SERVICES FOR PREGNANT WOMEN

4/1/93 The same services that are offered to any categorically needy recipient, as described in Attachment 3.1-A, are available to women for 60 days after the pregnancy ends. No additional coverage beyond what is provided to the general categorically needy recipient is provided and the group receiving services under this provision are subject to the same service limitations as the general categorically needy recipients as outlined in Attachment 3.1-A.

Ten prenatal obstetrical visits to low risk pregnant women and fourteen visits to high risk pregnant women are provided. Additional visits can be authorized if the Medicaid program medical consultant finds the additional visits medically necessary.

Amendment 93-21
Effective 4/1/93
Supersedes 93-02

Approval SEP 20 1993

Tobacco Cessation Counseling Services for Pregnant Women

4. d

1) Face-to-Face Tobacco Cessation Counseling Services provided:

1-1-14

(i) By or under supervision of a physician; and

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; or*

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

*describe if there are any limits on who can provide these counseling services

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: No limitations X With limitations*

Please describe any limitations:

*Pregnant women are allowed up to two (2) quit attempts per 12 month period and as many as four (4) counseling sessions per quit attempt.

7/1/98 OTHER PRACTITIONERS SERVICES

(6d) RESPIRATORY THERAPY: Services are available for non-EPSDT recipients 21 years of age and older in the outpatient and inpatient hospital settings and in nursing facilities. Refer to the EPSDT section for EPSDT limitations.

Amendment 98-14
Effective 7/1/98
Supersedes NEW
Approval 10/12/98

PERSONAL CARE SERVICES

10/1/90 (23) No services are available for non-EPSDT recipients 21 years of age and older. Service limitations for EPSDT recipients are listed in the EPSDT section.

PRIVATE DUTY NURSING SERVICES

10/1/90 (8) No services are available for non-EPSDT recipients 21 years of age and older. Refer to the EPSDT section for EPSDT limitations.

Amendment 93-02
Effective 1/1/93
Supersedes NEW

Approval APR 22 1993

1/01/2003 THERAPIES

(11a) Physical Therapy: Services are available for non-EPSDT recipients 21 years of age and older in the outpatient and inpatient hospital settings and in nursing facilities, and in community settings for the provision of wheelchair evaluations, re-evaluations, and fittings. Refer to the EPSDT section for EPSDT limitations.

(11b) Occupational Therapy: Services are available in nursing facilities for non-EPSDT recipients 21 years of age and older, and in community settings for the provision of wheelchair evaluations, re-evaluations, and fittings. Refer to the EPSDT section for EPSDT limitations.

(11c) Speech Therapy: Services are available in nursing facilities for non-EPSDT recipients 21 years of age and older. In addition, for non-EPSDT recipients 21 years of age and older, one initial evaluation for Augmentative and Alternative Communication (AAC) systems and eight (8) 30-minute fitting/adjustment/training sessions for AAC systems are available per person, per device, per year. Refer to the EPSDT section for EPSDT limitations.

Amendment 2003-03
Effective 1/01/2003
Supercedes 98-14
Approved 05/30/03

Nurse Midwives

7/1/2011	Nurse Midwives provide services to recipients with medically low risk pregnancies for prenatal, delivery and postpartum care, within their scope of practice under State law.

The following is a list of items and services furnished in nursing facilities that are reimbursed under the NF per diem rate. The recipient can not be charged for these items or services.

1. Room and board including all of the items necessary to furnish a resident's room;
2. Dietary, rehabilitative and nursing services including the professional handling and personal care of the resident;
3. Medical supplies provided for a resident when medically necessary, including;
   - Catheters, catheter irrigation trays, and related supplies.
   - Bandages, adhesive strips, dressings and sterile gauze.
   - Linen savers, diapers, waterproof pads, rubber pants, and sanitary napkins.
   - Needles and syringes.
   - Air matresses, neoprene plastic pads, bed pads, heel protectors, and sheepskins.
   - Laxatives - at least one product of each of the following categories: bulk, fecal softner, irritant, saline, emollient, enema.
   - Non-legend analgesics - at least one product of each of the following categories: asprin, acetaminophen, ibuprofen.
   - Non-legend antacid - at least one product of each of the following categories: Magnesium hydroxide and aluminum hydroxide with or without Simethicone, Aluminum hydroxide.
   - Non-legend vitamins - at least one product of each of the following categories: oil and water soluble multiple vitamins without minerals, oil and water soluble multiple vitamins with minerals, ferrous sulfate, ferrous gluconate and ferrous fumarate products, therapeutic multivitamin mineral combination, B-complex with vitamin C, stress formula.
   - Dietary supplements, salt and sugar substitutes, and tube feedings.
   - Medicinal alcohol, hydrogen peroxide, astringents, tinture benzoin, bulk epsom salts for soaking, and providone-iodine ointment and solution.
   - Cotton balls, tissue, applicators, body oil or body lotion, powder, lemon glycerin swabs, and cotton swabs.
   - Colostomy bags and related supplies and ileostomy supplies.
   - Non-legend cough preparation - at least one product of each of the following categories: expectorant, combination of expectorant and cough suppressant.
   - Blood glucose strips.
   - Topical anti-bacterial preparation.
   - Bland ointment.
   - Ophthalmic lubricant.
   - Oxygen and the equipment and supplies needed to dispense the oxygen.
   - First aid supplies.
   - Anti-diarrheal preparation.
   - Moisturizing spray and ointment for treatment of pressure sores.
   - Absorbent bladder control garments and external catheters.
   - Sterile saline solution for wound dressing.
4. Medical equipment to be available for use by the resident on a short-term basis but not for the exclusive use of the resident on a long-term ongoing basis which shall include at a minimum, the following: wheelchairs, geri-chairs, walkers, crutches and canes, bedside commodes.
5. Medical equipment for use by or on a resident when determined medically necessary: traction equipment, blood pressure equipment, oral and rectal thermometers, protective restraints, suction equipment.
6. Routine personal hygiene items and services including but not limited to: hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razors, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, hair and nail hygiene services, bathing supplies, basic personal laundry, incontinence care, water pitcher and drinking glass, wash pan, emesis basin, bedpan and urinal, and straws.

Amendment 93-58
Supersedes 93-02
Effective 10/1/93
Approval 2-18-94

Covered Legend Drugs:

Covered outpatient drugs are those produced by any manufacturer that has entered into and complies with an agreement under Section 1927(a) of the Act, and which are prescribed for a medically accepted indication. Drugs must be prescribed and dispensed in accordance with medically accepted indications for uses and dosages.

Coverage for immunizations is limited to the following recipients who are not covered by Medicare Part D:

- Influenza and pneumococcal vaccine for institutionalized recipients age 21 through 64 ; and
- Herpes Zoster (Shingles) vaccine for institutionalized recipients age 60 through 64

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B as provided by Section 1935 (d)(1) of the Act.

The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

As provided by Section 1927(d)(2) of the Act, certain outpatient drugs may be excluded from coverage. Those excluded are DESI drugs; experimental drugs; anorectics (unless prescribed for an indication other than obesity); non-legend drugs (except as specified below), aspirin, aluminum and calcium products used as phosphate binders, sodium chloride for specific medical indications; and any drugs for which the manufacturer has not entered into rebate agreements with the Department of Health and Human Services, the Veteran's Administration and the Public Health Service.

As provided by Section 1935(d)(2) of the ACT:

☑ **The following excluded drugs are covered:**

☐ (a) agents when used for anorexia, weight loss, weight gain
☑ *None of the drugs under this drug class are covered*

☐ (b) agents when used to promote fertility
☑ *None of the drugs under this drug class are covered*

☐ (c) agents when used for cosmetic purposes or hair growth
☑ *None of the drugs under this drug class are covered*

☑ (d) agents when used for the symptomatic relief cough and colds
☑ *Some drugs categories covered under the drug class*

- Legend cough and cold preparations, including antitussives, decongestants, and expectorants are covered for recipients under the age of 21 years.
- Legend or OTC single entity guaifenesin products are covered for all recipients.

☑ (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride.

☑ *Some drug categories covered under the drug class*
- Legend vitamin and mineral products are covered for dialysis patients.

☑ (f) nonprescription drugs

☑ *Some drug categories covered under the drug class*
- Aspirin; 650mg acetaminophen tablets; aluminum and calcium products used as phosphate binders; sodium chloride for specific medical indications for all recipients

When prescribed the following OTC medications that have previously been legend drugs are covered:
- Topical antiparasitics
- Vaginal antifungals
- OTC single-entity antihistamines (Loratidine and Cetirizine with age restrictions on liquids) and antihistamine-decongestant combinations (Loratidine D and Cetirizine D with age restrictions on liquids).

☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

☑ *None of the drugs under this drug class are covered*

Drug Rebate Agreement: The state is in compliance with Section 1927 of the Act. Based on the requirements for Section 1927 of the Act, the state has the following policies for drug rebate agreements:

- The drug file permits coverage of participating manufacturers' drugs.
- Compliance with the reporting requirements for state utilization information and restrictions to coverage.

- A supplemental rebate agreement, Version 05/20/2013, between the state and a drug manufacturer that is separate from the drug rebate agreements of Section 1927 is authorized by the Centers for Medicare and Medicaid Services. The agreement to be used between the State of Florida and drug manufacturers for supplemental rebates for drugs provided to the Medicaid population has been reviewed and authorized by the Centers for Medicare and Medicaid Services. The state reports rebates from separate agreements to the Secretary for Health and Human Services. The state will remit the federal portion of any cash state supplemental rebates collected.

- Manufacturers are allowed to audit utilization data.

- The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

- Prior authorization programs provide for a 24-hour turn-around on prior authorization from receipt of a completed request, and at least a 72-hour supply in emergency situations.

13c **Preventive Services:**

10/1/09 Licensed Medicaid providers practicing within their scope of practice will administer the H1N1 influenza vaccine to adult recipients age 21 and over, following recommendations by the Centers for Disease Control and Prevention.

Amendment TN: 2009-025
Effective: 10/1/09
Supersedes: NEW
Approval Date: 02-04-10

13c Preventive Services for Pregnant Women:

Licensed Medicaid providers practicing within their scope of practice will administer the influenza vaccine to adult pregnant female recipients age 21 and over. The reimbursement rate will be the same as those vaccines that are covered for Medicaid recipients between the ages of 18-20, and will be effective for dates of service between and including December 19, 2013 through March 31, 2014.

CERTIFIED PEDIATRIC OR FAMILY NURSE PRACTITIONERS (ARNP):

10/1/95 (23) New patient visits are limited to one per recipient per provider every three years. Subsequent office, home and hospital visits are limited to one per day per recipient except for emergency services. Routine physical examinations are provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program or Adult Health Screenings.

Rural Health Clinic Services

Services are limited to one visit per day in a rural health clinic. Exceptions will be granted based on medical necessity. For example, a recipient seen at a rural health clinic who subsequently experiences an accident or his condition worsens, may seek the necessary additional medical care from the rural health clinic on the same day.

Federally Qualified Health Center Services

Services provided in a federally qualified health center are limited to one medical, one dental, and one mental health visit per day, per recipient. Exceptions will be granted based on medical necessity. For example, a recipient seen at a federally qualified health center who subsequently experiences an accident or his condition worsens, may seek the necessary additional medical care from the federally qualified health center on the same day.

Other Laboratory Services

The recipient must be referred by a physician or other practitioner of the healing arts and the services must be performed in a Clinical Laboratory Improvement Amendment of 1988 (CLIA) certified independent laboratory.

Other X-Ray Services

The service must be ordered by a physician or other practitioner of the healing arts and must be provided in either:
(1) a physician's office, including an independent, private, diagnostic x-ray facility; or
(2) if the recipient is homebound, at the recipients' residence, including an ICF/MR or nursing home.

Inpatient psychiatric services for individuals in institutions for mental diseases

Inpatient psychiatric services are provided to high-risk recipients who have experienced multiple admissions into psychiatric units in acute care hospital settings or have longer than the state's average length of stay in these settings. For individuals age 65 and older, Medicaid will provide extended inpatient psychiatric treatment in state treatment facilities licensed under Chapter 395, Florida Statutes.

For the purpose of cost sharing for Qualified Medicare Beneficiaries, Medicaid payments for qualified private freestanding specialty psychiatric hospital inpatient services shall be limited to the Medicare deductible per spell of illness and coinsurance for qualified Medicare beneficiaries. Medicaid payments for these services shall be limited to the Medicaid established qualified Medicare beneficiary rate less any amounts paid by Medicare, but only up to the amount of Medicare coinsurance. The Medicaid rate shall be the rate in effect for the dates of service of the crossover claims and may not be subsequently adjusted due to subsequent per diem adjustments.

Admissions and continued stays may be subject to utilization review. Medical necessity criteria include: a reasonable course of acute inpatient treatment has failed to bring about adequate resolution of symptoms; the recipient's condition requires services on an inpatient basis under the direction of a physician; services can be expected to improve the recipient's condition or prevent regression; and ambulatory care resources available in the community do not meet treatment needs. Recipients who meet level of care criteria must receive active treatment in accordance with an individual plan of care. Service components include psychiatric, medical, psychological assessment and diagnosis; psychiatric and routine medical treatment; clinical and therapy services; family or other caregiver involvement; peer support groups; recreational and vocational services, when appropriate; and comprehensive discharge, after care and follow-up services.

4/27/98
(15) Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Service

Limitations:

1) The recipient's need for ICF/DD services must be determined by the agency's designee based on medical necessity.

2) The agency's designee will maintain a waiting list for persons who have been determined by the agency's designee to be eligible for, require, and have chosen ICF/DD placement. The time from placement on the waiting list until admission to an ICF/DD for such persons will not exceed 90 days.

Amendment 96-12
Supersedes 92-58
Effective 4/27/98
Approval 7/7/98

Revised Submission 5/1/98

Ambulatory Prenatal Care

All prenatal services are provided except for inpatient hospital services.

Nursing Facility Services for Patients under 21 years of Age

Recipient's need must be determined by the agency based on medical necessity.

Licensed Midwives

7/1/2011	Licensed Midwives provide services to recipients with medically low risk pregnancies for prenatal, delivery and postpartum care, within their scope of practice under State law.

8/1/12 (6d) PHYSICIAN ASSISTANT:

New patient office, home or hospital visits are limited to one per recipient per provider every three years. Subsequent office, home or hospital visits are limited to one per day per recipient, except for emergency services. Limits general services visits to two visits per month provided by physicians, advanced registered nurse practitioners, and physician assistants for non-pregnant adults. Exceptions to the limits will be authorized based on medical necessity. Routine physical examinations are provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program or Adult Health Screenings. Assistant at surgery fees are limited to surgical codes that allow an assistant surgeon.

7/1/97
(6d)

REGISTERED NURSE FIRST ASSISTANT:

Assistant at surgery fees are limited to surgical codes that allow an assistant surgeon.

Amendment 97-08
Effective 7/1/97
Supersedes NEW
Approval 8/25/97

Inpatient Psychiatric Services for Individuals under 21

Inpatient Psychiatric Services for Individuals under 21 are provided to high-risk recipients who have experienced multiple admissions into psychiatric units in acute care hospital settings or who have longer than the state's average length of stay in these settings.

For individuals under age 18, this service will provide extended inpatient psychiatric treatment in Residential Treatment Centers licensed under Chapter 394, Florida Statutes, or in a hospital licensed under Chapter 395, Florida Statutes. Providers must be accredited by the Joint Commission on Accreditation of Health Care Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children or a comparable nationally recognized accrediting organization.

Admissions and continued stays are subject to certification of need for this level of care. These criteria include: a reasonable course of acute inpatient treatment has failed to bring about adequate resolution of symptoms; the recipient's condition requires services on an inpatient basis under the direction of a physician; services can be expected to improve the recipient's condition or prevent regression; and ambulatory care resources available in the community do not meet treatment needs. Recipients who meet level-of-care criteria must receive active treatment in accordance with an individual plan of care. Service components include psychiatric, medical, psychological assessment and diagnosis; psychiatric and routine medical treatment; clinical and therapy services; mandatory family or other caregiver involvement; peer support groups; recreational and vocational services, when appropriate; a certified education program; and comprehensive discharge, after care and follow-up services.

Comparable services for individuals 18 to 21 years of age are provided through extended stays in acute care psychiatric care settings until symptoms are resolved to permit admission into intensive treatment services in the community. Florida Assertive Community Treatment Programs for persons with severe and persistent mental illnesses are available statewide to individuals 18 and over. These services provide intensive, psychiatric, rehabilitation, and support services for persons with severe and persistent mental illnesses. The program is designed to reduce the frequency and duration of hospitalization, increase functioning and improve quality of life in the community. Additionally, this age group has access to residential treatment services and state mental hospitals, funded through the Florida Department of Children and Families, if longer-term inpatient services are deemed necessary.

State/Territory: Florida

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: X

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

X Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

X A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

X A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: FLORIDA

CASE MANAGEMENT SERVICES

A. Target Group: By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are: (see page 2)

B. Areas of State in which services will be provided:

/X/ Entire State.

/ / Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/ / Services are provided in accordance with section 1902(a)(10)(B) of the Act.

/X/ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case management is defined as those activities which assist eligible individuals in gaining access to needed medical, social, educational and other support services. Consistent with the requirements of Section 1902 a (23) of the Act, the providers will insure that clients receive services to which they are referred. These activities may include but are not limited to: (see page 2)

E. Qualification of Providers:

Case management providers must be certified by the department as meeting the following criteria:

1. Demonstrate capacity to provide all core elements of case management services including:

   a. Comprehensive client assessment
   b. Comprehensive care/service plan development (see page 2)

State/Territory: FLORIDA

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

A. continued from page 1

1. Aged 0-21 and meet the medical eligibility criteria of Children's Medical Services (CMS), the states Title V Crippled Children's Agency,
2. SSI-Disabled Children's Program Clients age 0-16, or
3. Aged 21 and over with a handicapping condition and who had received services from Children's Medical Services before their 21st birthday.
4. Not receiving case management services under an approved 1915(c) waiver program.

D. continued from page 1

1. assessment of clients' medical, social and functional status and identification of client service needs,
2. arranging for service delivery from the clients chosen provider to insure access to required services,
3. periodic review and reassessment of client functional status and service needs,
4. insure access to needed services by explaining the need and importance of services in relation to the clients condition,
5. insure access, quality and delivery of necessary services and,
6. preparation and maintenance of case record documentation to include service plans, forms, reports and narratives, as appropriate.

E. continued from page 1

c. Linking/coordination of services
d. Monitoring and follow-up of services
e. Reassessment of the client's status and needs

2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

3. Demonstrated experience with the target population. (See page 3)

E. Continued from page 2

4. An administrative capacity to insure quality of services in accordance with State and federal requirements.

5. A financial management capacity and system that provides documentation of services and costs.

6. Capacity to document and maintain individual case records in accordance with State and federal requirements.

7. Consistent with Section 1902 a (23), demonstrate a capacity for referral to acute care facilities for patients with special health needs. Such facilities should have and average daily census of fifteen children, excluding normal newborn and neonatal intensive care patients. The facilities must also have defined pediatric units and preferably have pediatric intensive care centers and neonatal intensive care centers. The facilities must accept Medicaid patients.

Qualifications of Case Managers:

1. Licensed to practice as a registered professional nurse in the State of Florida and be employed as a community health nurse at the entry level or above, or

2. Hold a bachelors degree from an accredited university with emphasis in the areas of psychology, social work, health education or interdisciplinary sociology or

3. Able to demonstrate to the department that comparable qualifications are met.

4. The staff must have received approved departmental training appropriate to their area of speciality.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: FLORIDA

CASE MANAGEMENT SERVICES

A. Target Group: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who:

1. Are aged 0 to 18 and are Medicaid eligible.

2. Have a serious emotional disturbance as indicated by:

   a. A defined mental disorder diagnosable under DSM III-R or current edition.

   b. A level of functioning of disability which requires two or more coordinated and integrated mental health services to enable the person to live in a home in the community and be successful in school.

   c. The duration of the disability which will, in professional judgement, last for at least one year.

B. Areas of State in which services will be provided:

/X/ Entire State.

/ / Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/ / Services are provided in accordance with section 1902 (a)(10)(B) of the Act.

State/Territory: FLORIDA

/X/ Services are not comparable in amount, duration and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case management is defined as those activities which assist eligible individuals in gaining access to needed medical, social, mental, substance abuse, educational and other support services. These activities may include but are not limited to:

1. Assisting the eligible individual and his or her mental health professionals in obtaining the necessary assessment to adequately develop a plan of care;

2. Developing and reviewing the plan of care;

3. Assuring access to the needed services documented in the plan of care;

4. Monitoring and reviewing the plan of care with other mental health professionals;

5. Advocating for the eligible individual at service planning meeting;

6. Referring to service providers and establishing a linkage between providers for eligible individuals;

7. Assessing and reassessing the need for services;

8. Monitoring the quality of care;

9. Preparing and maintaining case record documentation to include service plans, forms reports and narratives as appropriate; and

10. Ensuring access to needed services by explaining the need and importance of the services in relation to the individual's condition.

State/Territory: FLORIDA

E. Qualifications of Providers:

1. Case management providers must be under contract with and certified annually by the Office of Alcohol, Drug Abuse and Mental Health as meeting the following criteria:

   a. Have adequate administrative capacity to assure availability and accessibility of qualified case managers;

   b. Have the ability to recruit qualified case management staff to serve the target group;

   c. Have administrative capacity to insure quality of services in accordance with state and federal requirements;

   d. Is community based and has established linkages with residential and non residential treatment services;

   e. Have adequate in-service training capability to assure the competent case management knowledge, skills and abilities of all case managers;

   f. Maintain programmatic records which show that the agency is able to develop and maintain assessment and services documentation; and

   g. Have financial management capacity and systems that provide documentation of costs.

2. Individual case managers must be employed by an agency certified to provide case management services and who meet the following qualifications:

   a. Must have a minimum of a baccalaureate degree from an accredited university, with emphasis in the areas of psychology, social work, health education or a related human services field;

   b. Must have a minimum of one year of experience working with children who have serious emotional disturbances; or

State/Territory: FLORIDA

c. Must be able to demonstrate that comparable degree and experience are met.

d. Must be knowledgeable of the residential and nonresidential resources available in the geographic area served.

f. Must demonstrate capacity to provide case management services.

g. Must be knowledgeable of, and comply with, the statutes, rules and policies which affect the target population.

h. Must have completed or complete within one year of enrollment as a case manager, Health and Rehabilitative Services approved case management training and complete periodic retraining as required by the Alcohol, Drug Abuse, and Mental Health Program Office.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payment made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: FLORIDA

CASE MANAGEMENT SERVICES

A. Target Group: By invoking the exception to comparability allowed by 1915 (g) (1) of the Social Security Act, this service will be reimbursed when provided to persons who:

1. Are aged 18 or older that are Medicaid eligible.

2. Are in need of case management services as evidenced by a physician's order.

3. Have a serious emotional disturbance as indicated by a defined mental disorder diagnosable under DSM III-R or current edition.

4. Are defined as a priority client in active status under sections 10E-15.031 and 10E-15.041, Florida Administrative Code.

5. Have been approved for case management services by the district Alcohol, Drug Abuse and Mental Health Program Office.

B. Areas of State in which services will be provided:

/X/ Entire State.

/__/ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/__/ Services are provided in accordance with section 1902 (a)(10)(B) of the Act.

/X/ Services are not comparable in amount, duration and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

State/Territory: FLORIDA

D. Definition of Services: Case management is defined as those activities which assist eligible individuals in gaining access to needed medical, social, mental, educational and other support services. These activities may include but are not limited to:

1. The completion of an overall assessment of the individual's living situation, strengths and weaknesses, needs and resources and the strengths and weaknesses of the individual's support system;

2. The development of the individual's plan of care which comprehensively addresses his or her needs;

3. Linking the client with specified services and resources as identified in the service plan to the extent appropriate;

4. Advocating for the acquisition of services and resources as necessary to implement the service plan;

5. Coordinating the delivery of services as specified in the service plan;

6. Working with the clients, families and natural support system, as appropriate;

7. Monitoring service delivery to continually evaluate recipient status and the quality of service provided;

8. Periodic reviewing and updating of service plans and records, and documenting case management activities according to state standards and recipient needs.

E. Qualifications of Providers:

1. Case management providers must have a contract with the department to provide community mental health services and be certified by the district Alcohol, Drug Abuse and Mental Health Program Office as meeting the following criteria:

a. Adequate administrative ability to provide case management services to the target population.

State/Territory: FLORIDA

b. Have the ability to recruit qualified case management staff to serve the target group and assure availability and accessibility of case managers;

P&I 5-5-92 HCFA

c. Have knowledgeable of and comply with the statutes, rules and policies which affect the target population;

d. Have administrative capacity to insure quality of services in accordance with state and federal requirements;

e. Have established linkages with the resources available in the geographical area served;

f. Have adequate inservice training capability to assure competent case management knowledge, skills and abilities of all case managers;

g. Maintain individual and programmatic records which comply with state and federal documentation requirements, including the registration of case management clients;

h. Maintain a financial management capacity and systems that provide documentation of costs; and

i. Involve district Alcohol, Drug Abuse and Mental Health office staff in case management services related activities and be responsive to corrective action plans.

2. Individual case managers must be employed by an agency certified to provide case management services and meet the following qualifications:

a. Must have a minimum of a baccalaureate degree from an accredited university, with major course work in the areas of psychology, social work, health education or a related human services field, or

State/Territory: FLORIDA

b. Must have two years of undergraduate course work or Associates degree related to the field and year for year experience in mental health equivalent to the educational requirements in a.

c. Must have completed or complete within one year of enrollment, Health and Rehabilitative Services approved case management training and complete periodic retraining as required by the Alcohol, Drug Abuse, and Mental Health Program Office.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payment made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Florida

CASE MANAGEMENT SERVICES

A. Target Group:

By invoking the exception to comparability allowed by 1915 (g) (1) of the Social Security Act, this service will be reimbursed when provided to:

All Medicaid eligible children, ages 0-21, who have been placed under protective supervision by a protective investigator based on a determination of either some indication of maltreatment or verified maltreatment, or have been court ordered into shelter or foster care. (See Chapters 415 and 39, F.S.)

B. Areas of the State in which services will be provided:

The authority of section 1915 (g) (1) of the Act is invoked to provide services on a less than statewide basis. Services shall be provided in Sarasota, Manatee, Pasco and Pinellas Counties.

C. Comparability of Services:

Services are not comparable in amount, duration and scope. Authority of section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a) (10) (B) of the Act.

D. Definition of Services:

Case management is defined as those activities which will assist individuals eligible under the Plan in gaining access to needed medical, social, educational, and other services. The case manager, in partnership with the child, family, significant others, or identified caregivers, facilitates access to and coordinates the services, treatments and supports necessary to achieve the goals and objectives stated in the service plan.

Case management activities include:

1. Completion of a comprehensive needs assessment which identifies the service needs of the child. The process of completing the needs assessment includes assisting the eligible child in obtaining access to providers who will perform the full range of assessments necessary to identify the biological, psychological, social, developmental and environmental aspects of the child's needs.

2. Assuring access to the needed services and supports which have been identified in the assessment of the eligible child and are reflected in the child's service plan.

3. Ongoing monitoring and follow-up of the services and supports being provided as indicated in the service plan. This includes determining the degree to which the plan is being followed, progress is being achieved on plan objectives, and ensuring that services are coordinated with the active participants in the child's life. Monitoring is accomplished through face-to-face, telephone, or written contact with the child or others on behalf of the child (physicians, therapists, teachers, other service providers, etc.), as appropriate.

4. Development of a service plan that identifies services, assistance, and activities which are needed to address the child's needs that are represented in the comprehensive needs assessment. Service planning includes participating in meetings with the child, family members and appropriate others (physicians, therapists, teachers, other service providers) to develop goals, objectives and tasks directed toward addressing the child's needs in all areas. The case manager is responsible for activities that will assure that the unique needs of the child are being addressed, and for promoting integration and continuity of services.

5. Developing referral review packets.

6. Referring the child to service providers and establishing a linkage between providers for the child .

7. Activities to assist the child in accessing needed services and service providers so that the objectives and goals identified in the service planning documents can be achieved. The case manager is responsible for coordinating and ensuring continuity of services (social, medical, educational, etc.) for the child by multiple providers, involving and updating them on developments in the child's situation and advocating on behalf of the child for needed community resources.

8. Communicating and collaborating with the biological parents or other family members as appropriate regarding the child's care, needs and progress if the child is in foster/out of home care.

9. Making home visits and phone calls for the purpose of assessing, arranging, integrating and coordinating the services and supports which have been identified as necessary to achieve the child's stability.

10. Encouraging and supporting the child and family's participation in the services offered as part of the case plan.

Activities that are not included are:

1. Title IV-E eligibility determination and redetermination.

2. Initial and annual adoption subsidy development, review, and processing.

3. Transportation.

4. Consultation with child welfare legal services, preparing legal documents, court preparation and appearances, staff travel related to court preparation and appearances.

5. Performing adoption pre-placement and placement activities, arranging termination of parental rights.

6. Placement services including locating initial out-of-home care, managing the disruption of a placement and re-placement if necessary. Working with the foster family to avoid disruptions and coordination of placement visits.

7. Relative Caregiver Program oversight.

E. Qualifications of Providers:

Providers will be approved and certified by either the designated public entity or the eligible lead community based privatization provider. (Chapter 409.1671, F.S.) Payment for services will be made to the case management provider. The public or community based provider will accept applications for provider enrollment from any provider meeting the following requirements:

1. Agency providers must meet all of the following criteria:

   a. Be knowledgeable of and comply with state and federal statutes, rules and policies that pertain to this service and target population.

   b. Have the ability to administer case management services to the target population as evidenced by sufficient numbers of managerial staff, targeted case management supervisors and certified case managers.

   c. Be a community based provider agency with at least five years of prior professional experience with this target population.

d. Have the financial management capacity and system to provide documentation of costs.

e. Have established linkages with the local network of human services providers, schools and other resources in the service area.

f. Have a Quality Improvement Program with written policies and procedures, which include an active case management peer review process and ongoing recipient and family satisfaction surveys.

g. Have established pre-service and in-service training programs that promote the knowledge, skills, and competency of all case managers.

h. Have an established credentialing process which will assess and validate the qualifications of all case managers and supervisors of case managers.

i. Have the capacity to provide supervision by a person who has a Masters degree in a human services field and three years of professional case management experience or other professional experience serving this target population. In addition, the individual must have completed the state approved child welfare and case management training and any other training, including periodic retraining, which is required and offered by the Department of Children and Families.

j. Maintain for a period of five years after the delivery of service, programmatic records that include clearly identified targeted case management certifications for eligibility, assessments, services plans and service documentation.

k. Cooperate with and participate in monitoring conducted by the Agency for Health Care Administration and the Department of Children and Families, Office of Family Safety and Preservation.

2. Agency providers agree that the services identified below shall constitute the minimum amount of service to be provided by the targeted case manager to the child on a monthly basis.

a. A home visit which shall include a face-to-face meeting with the child. The home visit shall be for the purpose of assessing the child and family's progress toward the achievement of the goals and objectives which specifically pertain to the child's needs and stability in the living environment and are stated in the service plan.

b. The case manager shall have verbal (i.e., telephonic or face-to-face) or written contact with a minimum of two separate providers who are rendering services

to the child or the child's family as related to assisting the child toward achievement of identified needs. This contact shall be for the purpose of determining whether the child, and family as appropriately related to meeting the child's needs, are responding to services and if said services are appropriate and rendered at the correct level of intensity.

c. A second face-to-face visit with the child, which may occur in the home or in the setting in which the child spends most of his or her time. The case manager shall observe the child and assess whether or not his or her level of functioning has remained unchanged, improved, deteriorated or stabilized.

d. The case manager shall complete or obtain at least one of the following:
   1. A client satisfaction survey
   2. A Current Status Summary that includes descriptions of functional issues, behavior problems, or developmental concerns. The summary is developed by gathering information from various service providers, teachers, family members or caretakers, and other significant individuals involved in the child's life.

   or
   3. A comprehensive summary statement which depicts the child's progress toward the achievement of established goals and objectives and addresses the status of the child's stability within the identified living environment.

3. Individual case manager providers must meet all of the following criteria:

   a. Be employed by or under contract with an agency that has been certified by the Agency for Health Care Administration as qualified to provide case management services to the target population.

   b. Have a minimum of a baccalaureate degree from an accredited university, with major course work in the areas of psychology, social work, child development or a related human services field and have a minimum of one year of professional experience working with children who have been abused, neglected or abandoned, or are at risk of abuse, neglect or abandonment.

   c. Have successfully completed the state mandated child welfare and case management training and any other training, including periodic retraining, which is required and approved by the Department of Children and Families.

   d. Be certified by the Department of Children and Families district office as meeting the requirements to be a Children's Protection Group targeted case manager.

e. Be enrolled as a Medicaid approved individual treating provider, Provider Type 32.

f. Specific to the identified service area, have knowledge of the resources that are available for children who are abused, neglected or abandoned or at risk for abuse, neglect or abandonment.

g. Be knowledgeable of, and comply with, the state and federal statutes and rules and policies that pertain to this service and target population.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of the individual case management providers.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

1. Providers shall bill a monthly rate of $450.00 per child. In order for reimbursement to occur, the clinical record must contain documentation, which indicates that the services identified above in section E-2a-d, were provided.

REQUIREMENTS AND LIMITS
12-91 APPLICABLE TO SPECIFIC SERVICES 4302.3(Cont.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Florida

CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children, whose parents request services, who are not receiving Targeted Case Management under another target group or waiver; and who, based on the results of a formal assessment to be delivered to children who voluntarily take part in case management services, must meet one of the following criteria:

1. Is or has been determined to present at least two of the following seven risk factors:

    a) Is the child of a parent who is unable to meet his or her basic needs (access to food, clothing, transportation);
    b) is the child of a parent who has inadequate income and/or housing;
    c) is the child of a parent who is socially isolated/has limited natural supports
    d) is or has been a witness to domestic violence;
    e) is the child of a parent with a history of mental illness requiring treatment or hospitalization;
    f) is the child of a mother who, upon knowledge of pregnancy, used tobacco, alcohol, and/or drugs;
    g) is the child of a mother who received little to no pre-natal care (less than five visits)

2. Is the child of a parent who is or has been a victim of domestic violence.
3. Is the child of a parent suffering from mental health, post-partum depression or substance abuse problems.
4. Is the subject of a report of abuse and neglect made to the Department of Children and Families and/or Community Based Care Lead Agency that did not result in a court order into foster care/shelter care or Protective Supervision.

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B. Areas of State in Which Services Will Be Provided:

☐ Entire State

☑ Only in the following geographic areas (authority of §1915(g)(1) of the Act is invoked to provide services less than statewide):

Services will be provided in Florida counties where a Children's Services Council (CSC) or local government entity (LGE) exists that funds programs to support children and families in need, currently including Duval County; Palm Beach County; Hillsborough County; Pinellas County; Broward County; Miami-Dade County; and, Martin County.

C. Comparability of Services:

☐ Services are provided in accordance with §1902(a)(10)(B) of the Act.

☑ Services are not comparable in amount, duration and scope. Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of §1902(a)(10)(B).

D. Definition of Services:

Targeted Case Management is a set of interrelated activities under which the responsibility for locating, coordinating, and monitoring appropriate services for an recipient rests with a specific person (case manager). The purpose of case management is to assist recipients in the target group to gain access to medical, social, educational, and other services. Targeted Case Management includes:

A. Collecting all assessment data.

B. Developing an individualized plan of care;
C. Coordinating needed services and providers;
D. Making home visits and collateral contacts as needed;
E. Maintaining client case records; and,
F. Monitoring and evaluating client progress and service effectiveness.

Activities that are not included are:

1. All Title IV-E eligibility determination and redetermination;

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2. Medicaid eligibility determination and redetermination;
3. Medicaid Outreach;
4. Individual or Group therapy;
5. Transportation; and
6. Title IV.b. and Title XX activities.

E. Qualifications of Providers:

Providers will be approved and certified by either the designated public entity or the Children's Services Council. The Children's Services Council will accept applications for provider enrollment for any provider meeting the following requirements:

1. Agency providers must meet all of the following criteria:

a. Be receiving funding from the Children's Services Council/Local Government Entity
b. Be knowledgeable of and comply with state and Federal statutes, rules and policies that pertain to this service and target population.
c. Have the ability to administer case management services to the target population as evidenced by sufficient numbers of managerial staff, targeted case management supervisors and case managers.
d. Be a community based provider agency with a demonstrated capability with this target population.
e. Have the financial management capacity and system to provide documentation of costs.
f. Have established linkages with the local network of human services providers, schools and other resources in the service area.
g. Have a Quality Improvement Program with written policies and procedures, which include an active case management peer review process and ongoing recipient and family satisfaction surveys.
h. Have established pre-service and in-service training programs that promote the knowledge, skills, and competency of all case managers.
i. Have an established credentialing process which will assess and validate the qualifications of all case managers and supervisors or case managers.
j. Have the capacity to provide supervision by a person who has a Bachelor's degree in a human services field and two years of professional case management experience or 3 years of other professional experience serving this target population or any combination thereof.
k. Maintain documentation/programmatic records that include clearly identified targeted case management certifications for eligibility, assessments, service plans and service documentation.
l. Cooperate with and participate in monitoring conducted by the Agency for Health Care Administration and the Children's Services Council.

2. Individual case managers must meet all of the following criteria:

   a. Be employed by or under contract with an agency that has been certified by the Children's Services Council as qualified to provide case management services to the target population
   b. Have a minimum of high school equivalent with a minimum of one year of experience working with children who have been abused, neglected or abandoned, or are at risk of abuse, neglect or abandonment.
   c. Have successfully completed the CSC approved training and any other training including periodic retraining.
   d. Have completed mandated reporter training that addresses abuse and neglect.
   e. Be enrolled as a Medicaid approved individual training provider, Provider Type 32.
   f. Specific to the identified service area, have knowledge of the resources that are available for children who are abused, neglected or abandoned or at risk for abuse, neglect or abandonment.
   g. Be knowledgeable of, and comply with, the state and federal statues and rules and policies that pertain to this service and target population.
   h. Be certified by the certified agency as meeting these requirements.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

A monthly rate will reflect the reasonable and necessary costs for required staff including salaries, taxes, benefits and the associated overhead In order for reimbursement to occur, the clinical record must maintain documentation that the case manager provided all of the following minimum monthly service requirements:

   a. A home visit that shall include a face-to-face meeting with the child. The home visit shall be for the purpose of assessing the child and family's progress toward the achievement of the goals and objectives, which

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specifically pertain to the child's needs and stability in the living environment and are stated in the service plan.

b. The case manager shall have verbal (i.e. telephonic or face-to-face) or written contact with at least one provider who is rendering services to the child or the child's family as related to assisting the child toward achievement of identified needs. This contact shall be for the purpose of determining whether the child, and family are responding to services and if said services are appropriate and rendered at the correct level of intensity.

c. A second face-to-face visit with the child which may occur in the home or in the setting in which the child spends most of his or her time. The case manager shall observe the child and assess whether or not his or her level of functioning has remained unchanged, improved, deteriorated or stabilized.

d. The case manager shall complete or obtain at least one of the following:
   i. A client satisfaction survey
   ii. A current status summary that includes descriptions of functional issues, behavior problems, or developmental concerns. The summary is developed by gathering information from various service providers, teachers, family members or caretakers, and other significant involved in the child's life.
   iii. A comprehensive summary statement which depicts the child's progress toward the achievement of established goals and objectives and addresses the status of the child's stability within the identified living environment.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES FOR THE CATEGORICALLY NEEDY

1. The State of _____ provides home and community care to functionally disabled elderly individuals to the extent described and defined in this Supplement (and Appendices) in accordance with section 1929 of the Social Security Act.

2. Home and community care services are available Statewide.

_____ Yes _____ No

If no, these services will be available to individuals only in the following geographic areas or political subdivisions of the State (specify): _____

3. The home and community care services specified in this Supplement will be limited to the following target groups of recipients (specify all restrictions that will apply):

a. _____ aged (age 65 and older, or greater than age 65 as limited in Appendix B)

b. _____ In accordance with §1929(b)(2)(A) of the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals are specified in Appendix A. Minimum disability standards for these individuals are specified in Appendix B.

c. _____ In accordance with §1929(b)(2)(A) of the Act, individuals who were served under a waiver granted pursuant to section 1915(d) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals are specified in Appendix A. Minimum disability standards for these individuals are specified in Appendix B.

d. _____ In accordance with §1929(b)(2)(B) of the Act, individuals who meet the test of disability under the State's §1115 waiver which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. Financial eligibility standards for these individuals are specified in Appendix A. Functional disability standards for these individuals are specified in Appendix B.

4. Additional targeting restrictions (specify):

a. _____ Eligibility is limited to the following age groups (specify): _____

State: FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES FOR THE CATEGORICALLY NEEDY

b. _____ Eligibility is limited by the severity of disease or condition, as specified in Appendix B.

c. _____ Eligibility is limited to individuals who have been shown to have a need for one or more of the services elected by the State under this benefit.

5. Standards for financial eligibility are set forth in Appendix A. Each individual served shall meet applicable standards for financial eligibility.

6. Each individual served will meet the test of functional disability set forth in Appendix B.

7. The State will provide for a comprehensive functional assessment for a financially eligible individual who meets the targeting requirements set forth in item 3 of this Supplement. This assessment will be provided at the request of the individual or another person acting on such individual's behalf. The individual will not be charged a fee for this assessment.

8. The comprehensive functional assessment will be used to determine whether the individual is functionally disabled, as defined in Appendix B. Procedures to ensure the performance of this assessment are specified in Appendix D.

9. The comprehensive functional assessment is based on the uniform minimum data set specified by the Secretary. Check one:

a. _____ The State will use the assessment instrument designed by HCFA.

b. _____ The State will use an assessment instrument of its own designation. The assessment instrument to be used is consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by HCFA. A copy of the assessment instrument can be found at Appendix D.

10. The comprehensive functional assessment will be reviewed and revised not less often than every 12 months. Procedures to ensure this review and revision are specified in Appendix D.

11. The comprehensive functional assessment and review will be conducted by an interdisciplinary team designated by the State. Qualifications of the interdisciplinary team are specified in Appendix D.

12. Based on the comprehensive functional assessment or review, the interdisciplinary team will:

a. identify in each such assessment or review each individual's functional disabilities and need for home and community care, including information about the individual's health status, home and community environment, and informal support system; and

State: FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES FOR THE CATEGORICALLY NEEDY

b. based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.

13. The results of the comprehensive functional assessment or review will be used in establishing, reviewing and revising the person's individual community care plan (ICCP).

14. An ICCP will be developed by a qualified community care case manager for each individual who has been determined, on the basis of a comprehensive functional assessment, to be a functionally disabled elderly individual.

15. All services will be furnished in accordance with a written ICCP which:

a. is established, and periodically reviewed and revised, by a qualified community care case manager after a face-to-face interview with the individual or primary care giver;

b. is based upon the most recent comprehensive functional assessment of the individual;

c. specifies, within the amount, duration and scope of service limitations specified in Appendix C, the home and community care to be provided under the plan. The ICCP will specify the community care services to be provided, their frequency, and the type of provider to furnish each service;

d. indicates the individual's preferences for the types and providers of services and documents the individual's free choice of providers and services to be furnished; and

e. may specify other services required by the individual.

A copy of the ICCP format to be used in implementing this benefit is included in Appendix E.

16. Each individual's ICCP will be established and periodically reviewed and revised by a qualified community care case manager, as provided in Appendix E.

17. A qualified community care case manager is a nonprofit or public agency or organization which meets the conditions and performs the duties specified in Appendix E.

18. The State will provide the following home and community care services, as defined, described and limited in Appendix C to the groups specified in items 3, 4, 5 and 6 of this Supplement.

a. _____ Homemaker services

b. _____ Home health aide services

c. _____ Chore services

State: FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES FOR THE CATEGORICALLY NEEDY

d. _____ Personal care services

e. _____ Nursing care services provided by, or under the supervision of, a registered nurse

f. _____ Respite care

g. _____ Training for family members in managing the individual

h. _____ Adult day care

i. _____ The following services will be provided to individuals with chronic mental illness:

1. _____ Day treatment/Partial hospitalization

2. _____ Psychosocial rehabilitation services

3. _____ Clinic services (whether or not furnished in a facility)

j. _____ Other home and community-based services (other than room and board) as the Secretary may approve. The following other services will be provided:

1. _____ Habilitation

A. _____ Residential Habilitation

B. _____ Day Habilitation

2. _____ Environmental modifications

3. _____ Transportation

4. _____ Specialized medical equipment and supplies

5. _____ Personal Emergency Response Systems

6. _____ Adult companion services

7. _____ Attendant Care Services

8. _____ Private Duty Nursing Services

9. _____ Extended State plan services (check all that apply):

A. _____ Physician Services

B. _____ Home health care services

State: FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES FOR THE CATEGORICALLY NEEDY

C. _____ Physical therapy services

D. _____ Occupational therapy services

E. _____ Speech, hearing and language services

F. _____ Prescribed drugs

G. _____ Other State plan services (specify): _____

10. _____ Other home and community based services (specify):

19. The State assures that adequate standards for each provider of services exist and will be met. These provider standards are found at Appendix C-2.

20. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are adversely affected by the determinations of the interdisciplinary team, or who are denied the service(s) of their choice, or the provider(s) of their choice, or who disagree with the ICCP which has been established.

21. FFP will not be claimed for the home and community care services specified in item 18 of this Supplement prior to the development of the ICCP. FFP will not be claimed for home and community care services which are not included in the ICCP.

22. The State provides the following assurances to HCFA:

a. Home and community care services will not be furnished to recipients while they are inpatients of a hospital, NF, or ICF/MR.

b. FFP will not be claimed in expenditures for the cost of room and board, except when provided as part of respite care furnished in a facility which is (1) approved by the State, and (2) not a private residence. Meals furnished under any community care service (or combination of services) will not constitute a "full nutritional regimen" (3 meals a day).

c. FFP will not be claimed in expenditures for the cost of room and board furnished to a provider of services.

d. The agency will provide HCFA annually with information on the amount of funds obligated by the State with respect to the provision of home and community care to the functionally disabled elderly in that fiscal year. These reports will begin with information relative to FFY 1990 and will be provided in the manner prescribed by HCFA. The State assures that it will provide data on its maintenance of effort, as required by section 1929(e) of the Social Security Act, in such format and at such times as are specified by HCFA.

State: FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES FOR THE CATEGORICALLY NEEDY

e. The home and community care provided in accordance with this Supplement and Appendices will meet all requirements for individual's rights and quality of care as are published or developed by HCFA.

1. All individuals providing care are competent to provide such care; and

2. Each provider of services under this benefit will meet the requirements applicable to the provision of home and community care as set forth in Appendix C.

3. Each individual receiving home and community care will be accorded the rights specified in Appendix F.

4. Case managers will comply with all standards and procedures set forth in Appendix E.

23. FFP will not be claimed for the home and community care services specified in item 18 of this Supplement in any quarter to the extent that cost of such care in the quarter exceeds 50 percent of the product of:

a. the average number of individuals in the quarter receiving home and community care;

b. the average per diem rate of Medicare payment for extended care services (without regard to coinsurance) furnished in the State during such quarter; and

c. the number of days in such quarter.

24. Community care settings in which home and community care is provided will meet the requirements set forth in section 1929(g) and (h) of the Act, as applicable to the specific setting. The State assures that the requirements of Appendix G will be met for each setting in which home and community care is provided under this section.

25. The State will refuse to provide home and community care in settings which have been found not to meet the requirements of sections 1929(g) and (h) of the Act.

26. The State will comply with the requirements of section 1929(i), of the Act, regarding survey and certification of community care settings, as set forth in Appendix G.

27. The State will comply with the requirements of section 1929(i) of the Act, regarding the compliance of providers of home and community care and reviews of this compliance, as set forth in Appendix C.

28. The State will provide for an enforcement process for providers of community care, as required by section 1929(j) of the Act. This process is described in Appendix C.

State: FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES FOR THE CATEGORICALLY NEEDY

29. The State assures that payment for home and community care services will be made through rates which are reasonable and adequate to meet the costs of providing care efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

30. Payment will not be made for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under title XIX or title XI of the Social Security Act or for legal expenses in defense of an exclusion or civil money penalty under title XIX or title XI of the Social Security Act if there is no reasonable legal ground for the provider's case.

31. The State will begin provision of services under section 1905(a)(23) of the Social Security Act effective (specify date):

_____

These services will be provided to eligible individuals for a minimum of four calendar quarters, beginning on this date.

32. Services will be provided to eligible recipients for the duration of the period specified in item 31, above, without regard to the amount of Federal financial participation available to the State.

33. The State assures that it will monitor the appropriateness and accuracy of the assessments and reviews. Through its monitoring, the State assures the appropriateness and accuracy of the assessments and periodic reviews. The State assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.

State of Florida
PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.

_____

_____

Regular Post Eligibility

The state applies post-eligibility treatment of income rules to PACE participants who are eligible under section 1902(a)(10)(A)(ii)(VI) of the Act (42 C.F.R. §435.217 of the regulations). Yes _X__ No ____
Post-eligibility for states that have elected to apply the rules to PACE participants

Note: Section 2404 of the Affordable Care Act mandated that, for the five-year period beginning January 1, 2014, the definition of an "institutionalized spouse" in section 1924(h)(1) of the Social Security Act include all married individuals eligible for certain home and community-based services (HCBS), including HCBS delivered through 1915(c) waivers. As of this writing, the ACA provision has been extended through December 31, 2019. This means that married individuals eligible in the eligibility group described at 42 C.F.R. §435.217 must have their post-eligibility treatment-of-income rules determined under the rules described in section 1924(d). Because states that elect to apply post-eligibility treatment-of-income rules to PACE participants may only do so to the same extent the rules are applied to individuals eligibility under 42 C.F.R. §435.217, application of the post-eligibility treatment-of-income rules must be applied to married individuals receiving PACE services consistent with the provisions described herein under "Spousal post-eligibility" so long as the amendment to section 1924 of the Act made by the ACA remains in effect.

1. 1634 and SSI States

The State applies the post-eligibility rules to individuals who are receiving PACE services and are eligible under 42 C.F.R. §435.217 consistent with the rules of 42 C.F.R. §435.726, and, where applicable, section 1924 of the Act. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

1. Allowances for the maintenance needs of the individual (check one):

1.The amount deducted is equal to:
(a) _____The SSI federal benefit rate
(b) _____Medically Needy Income Level (MNIL)
(c) _____The special income level standard for the institutionalized individuals eligible under section 1902(a)(10)(A)(ii)(V) of the Act
(d) _____Percentage of the Federal Poverty Level: _____%
(e) _____Other (specify):_____
2._____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
3.__X___The following formula is used to determine the needs allowance:
For individuals residing in the community (not in an ALF), the personal needs allowance shall be equal to 300% of the SSI Federal Benefit Rate (FBR).
For individuals placed in an assisted living facility (ALF), the personal needs allowance shall be calculated according to the following formula:

Three meals per day and a semi-private room (ALF Basic Monthly Charge)

+20% of Federal Poverty Level
= Personal Needs Allowance

Note: If the amount protected for a PACE enrollee in item 1 is equal to, or greater than, the PACE enrollee's income, enter N/A in items 2 and 3.

2. Allowance for the maintenance needs of the spouse:
The amount deducted for the PACE enrollee's spouse is equal to:
1.____ The SSI federal benefit rate
2.____ Optional State Supplement Standard
3.____ Medically Needy Income Level Standard
4.____ The following dollar amount (provided it does not exceed the amount(s) described in 1-3): $_____
5 .____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
6.____ Not applicable (N/A)

3. Allowance of the maintenance needs of the family (check one):
1.__X__ AFDC need standard

2.____ Medically needy income standard

The amount specified below 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 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

4.____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.

5.____ The amount is determined using the following formula:
_____
_____

6.____ Other

7.____ Not applicable (N/A)

4. Allowance for medical and remedial care expenses, as described in 42 CFR 435.726(c)(4).

2. 209(b) States,

The State applies the post-eligibility rules to individuals who are receiving PACE services and are eligible under 42 C.F.R. §435.217 consistent with the rules of 42 C.F.R. §435.735, and, where applicable, section 1924 of the Act. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

1. Allowances for the maintenance needs of the individual (check one):

1.The amount deducted is equal to:

(a) _____The SSI federal benefit rate

(b) _____Medically Needy Income Level (MNIL)

(c) _____The special income level standard for the institutionalized individuals eligible under section 1902(a)(10)(A)(ii)(V) of the Act

(d) _____Percentage of the Federal Poverty Level: _____%

(e) _____Other (specify):_____

2._____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

3._____The following formula is used to determine the needs allowance:

_____

_____

Note: If the amount protected for a PACE enrollee in item 1 is equal to, or greater than, the PACE enrollee's income, enter N/A in items 2 and 3.

2. Allowance for the maintenance needs of the spouse:

The amount deducted for the PACE enrollee's spouse is equal to:

1.____ The more restrictive income standard established under 42 C.F.R. §435.121
2.____ Optional State Supplement Standard
3.____ Medically Needy Income Level Standard
4.____ The following dollar amount (provided it does not exceed the amount(s) described in 1-3): $_____
5 .____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
6.____ Not applicable (N/A)

3. Allowance of the maintenance needs of the family (check one):

1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below 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 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5.____ The amount is determined using the following formula:

_____

_____

6.____ Other
7.____ Not applicable (N/A)

4. Allowance for medical and remedial care expenses, as described in 42 CFR 435.735 (c)(4).

Spousal Post Eligibility

State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance consistent with the minimum monthly maintenance needs allowance described in section 1924(d), a family allowance, for each family member, calculated as directed by section 1924(d)(1)(C), and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.
Yes __X__ No ____

Note: states must elect the use the post-eligibility treatment-of-income rules in section 1924 of the Act in the circumstances described in the preface to this section.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A).____The following standard included under the State plan (check one):

1. _____SSI
2. _____Medically Needy
3. _____The special income level for the institutionalized
4. _____Percent of the Federal Poverty Level: _____%
5. _____Other (specify):_____

(B).____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C)__X___ The following formula is used to determine the needs allowance:
For individuals residing in the community (not in an ALF), the personal needs allowance shall be equal to 300% of the SSI Federal Benefit Rate (FBR).
For individuals placed in an assisted living facility (ALF), the personal needs allowance shall be calculated according to the following formula:

Three meals per day and a semi-private room (ALF Basic Monthly Charge)

+20% of Federal Poverty Level
= Personal Needs Allowance

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____
_____
_____
_____
_____
_____

II. Rates and Payments

A. The State assures CMS that the capitated rates will be less than the cost to the agency of providing State plan approved services to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the amount the state would have otherwise paid for a comparable population.

1._X__ Rates are set at a percent of the amount that would otherwise been paid for a comparable population.
2.___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3.___ Adjusted Community Rate (please describe)
4.___ Other (please describe)

The following describes the method that is used to develop the amount that would otherwise have been paid (AWOP) for the PACE contracts. Florida uses an actuarial firm to calculate the AWOP.

In order to estimate the AWOP, the services are considered in three separate categories for an equivalent non-enrolled population group:

1. Long-term care (LTC) services covered by Medicaid.
2. Acute care services covered by Medicaid.
3. Dental services covered by Medicaid.

The projected nursing home and home and community-based service components plus the acute care and dental services are blended to establish an AWOP. The Agency may

implement separate AWOP for dual eligible and Medicaid-only PACE enrollees or other sub-groups.

After the AWOP amounts are calculated, the Agency will negotiate with PACE organizations a per-member-per-month (PMPM) payment rate based on a percentage of the PACE AWOP. The final rate(s) will never be equal to or more than the PACE AWOP.

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval, and will include the name, organizational affiliate of any actuary used, and attestation/description of the capitation rates.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

State of __Florida__
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

i. Eligibility

The State determines eligibility for Self-Directed Personal Assistance Services:

A. __X_ In the same manner as eligibility is determined for traditional State Plan personal care services, described in Item 24 of the Medicaid State Plan.

B. __X_ In the same manner as eligibility is determined for services provided through a 1915(c) Home and Community-Based Services Waiver.

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

A. __X__State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.

Only children under 21 years of age, enrolled in the Developmental Disabilities waiver(s) will be self-directing their State Plan personal care services.

B. __X___Services included in the following section 1915(c) Home and Community-Based Services waiver(s) to be self-directed by individuals eligible under the waiver(s). The State assures that all services in the impacted waiver(s) will continue to be provided regardless of service delivery model. Please list waiver names and services to be included.

Service providers will be enrolled with the authorized state agency Fiscal Employer Agent (FEA) designated on behalf of the Consumer Directed Care Plus (CDC+). Providers must attest to the provision of services in order to receive payment for services. All providers must be at least 16 years of age and must satisfy the qualifications, requirements and applicable licensure for the service that is provided. Providers must also comply with the background screening requirements and provisions of the applicable Florida Statutes.

Individual Budgeting (iBudget) Waiver: Life Skills Development, Adult Dental Services, Behavior Analysis Services, Behavior Assistant Services, Personal Supports, Specialized Medical Equipment and Supplies, Dietitian Services, Environmental Accessibility Adaptations, Private Duty Nursing, Occupational Therapy, Personal Emergency Response System, Physical Therapy, Residential Habilitation, Respiratory Therapy, Respite, Skilled Nursing, Special Medical Home Care, Specialized Mental Health Counseling, Speech Therapy, Supported Living Coaching, Transportation, Family and Guardian Training, and Person-Centered Planning.

iii. Payment Methodology

A. __X__ The State will use the same payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. The State uses the same payment methodology for individuals self-directing their State plan personal care services.

B. __X__ The State will use a different payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. Amended Attachment 4.19-B page(s) are attached. The State uses a different payment methodology for individuals self-directing their section 1915(c) Home and Community-Based waiver services.

iv. Use of Cash

A. _____ The State elects to disburse cash prospectively to participants self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

B. __X___ The State elects not to disburse cash prospectively to participants self-directing personal assistance services.

v. Voluntary Disenrollment

The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

A program consumer may elect to discontinue participation in the Consumer-Directed Care Plus (CDC+) program at any time.

In the event disenrollment is requested, the consumer's consultant completes a CDC+ Change Form to disenroll the consumer and forwards the form to program staff. All disenrollments are effective the first day of the month following receipt of the disenrollment form.

Program staff notifies the Agency for Health Care Administration about all disenrollments. Upon disenrollment from CDC+ the consumer may access waiver services through traditional means.

The consumer's consultant is responsible for ensuring the consumer has traditional waiver services in place to begin the first day of the month. Therefore, there will be no lapse in services.

vi. Involuntary Disenrollment

A. The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to the traditional service delivery model are noted below. Consumers may be disenrolled by consultants and CDC+ program directors.

Reasons for involuntary disenrollment include:

- 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;
- Consumer health or safety at risk;
- Consumer can no longer be served safely in the community.
- Admission to a licensed facility (group home, ALF, etc.)

B. The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

In the event disenrollment is required, the consumer's consultant completes a Consumer-Directed Care Plus (CDC+) Change Form to disenroll the consumer and forwards the form to program staff. All disenrollments are effective the first day of the month following receipt of the disenrollment form.
Program staff notifies the Agency for Health Care Administration about all disenrollment. Upon disenrollment from CDC+ the consumer may access waiver services through traditional means.

The consultant is responsible for ensuring the consumer has traditional waiver services in place to begin effective the first day of the month. Therefore, there will be no lapse in services.

vii. Participant Living Arrangement

Any additional restrictions on participant living arrangements, other than homes or property owned, operated, or controlled by a provider of services, not related by blood or marriage to the participant are noted below.

The 1915(c) iBudget waiver allows individuals to live in licensed facilities. Those individuals will not be allowed to participate in the CDC+ program based on this requirement.

viii. Geographic Limitations and Comparability

A. ___X__ The State elects to provide self-directed personal assistance services on a statewide basis.

B. _____ The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe:_____

C. _____ The State elects to provide self-directed personal assistance services to all eligible populations.

D. __X___ The State elects to provide self-directed personal assistance services to targeted populations. Please describe: Eligibility for the program is limited to individuals under 21 years of age enrolled in the iBudget Waiver.

E. __X___ The State elects to provide self-directed personal assistance services to an unlimited number of participants.

F. _____ The State elects to provide self-directed personal assistance services to _____ (insert number of) participants, at any given time.

ix. Assurances

A. The State assures that there are traditional services, comparable in amount, duration, and scope, to self-directed personal assistance services.

B. The State assures that there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for self-directed personal assistance services.

C. The State assures that an evaluation will be performed of participants' need for personal assistance services for individuals who meet the following requirements:

i. Are entitled to medical assistance for personal care services under the Medicaid State Plan; or
ii. Are entitled to and are receiving home and community-based services under a section 1915(c) waiver; or
iii. May require self-directed personal assistance services; or
iv. May be eligible for self-directed personal assistance services

D. The State assures that individuals are informed of all options for receiving self-Directed and/or traditional State Plan personal care services or personal assistance services provided under a section 1915(c) waiver, including information about self-direction opportunities that is sufficient to inform decision-making about the election of self-direction and provided on a timely basis to individuals or their representatives.

E. The State assures that individuals will be provided with a support system meeting the following criteria:
   i. Appropriately assesses and counsels individuals prior to enrollment:
   ii. Provides appropriate counseling, information, training, or assistance to ensure that participants are able to manage their services and budgets:
   iii. Offers additional counseling, information, training, or assistance, including financial management services:
      1. At the request of the participant for any reason; or
      2. When the State has determined the participant is not Effectively managing their services identified in their service plans or budgets.

F. The State assures that an annual report will be provided to CMS on the number of individuals served through this State Plan option and total expenditures on their behalf, in the aggregate.

G. The State assures that an evaluation will be provided to CMS every 3 years, describing the overall impact of this State Plan option on the health and welfare of participating individuals, compared to individuals not self-directing their personal assistance services.

H. The State assures that the provisions of section 1902(a)(27) of the Social Security Act, and Federal Regulations 42 CFR 431.107, governing provider agreements, are met.

I. The State assures that a service plan and service budget will be developed for each individual receiving self-directed PAS. These are developed based on the assessment of needs.

J. The State assures that the methodology used to establish service budgets will meet the following criteria:
   i. Objective and evidence based, utilizing valid, reliable cost data
   ii. Applied consistently to participants
   iii. Open for public inspection

iv. Includes a calculation of the expected cost of the self-directed PAS and supports if those services and supports were not self-directed.
v. Includes a process for any limits placed on self-directed services and supports and the basis/bases for the limits.
vi. Includes any adjustments that will be allowed and the basis/bases for the adjustments.
vii. Includes procedures to safeguard participants when the amount of the limit on services is insufficient to meet a participant's needs.
viii. Includes a method of notifying participants of the amount of any limit that applies to a participant's self-directed PAS and supports.
ix. Does not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.
x. Service Plan

The State has the following safeguards in place, to permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider's influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

Not applicable.

xi. Quality Assurance and Improvement Plan

The State's quality assurance and improvement plan is described below, including

i. How it will conduct activities of discovery, remediation, and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and

The State will conduct activities of discovery, remediation and quality improvement by using tools to collect data, take action and continuously improve the program. The tools developed for CDC+ fit into a complete quality management plan. These tools include: consumer satisfaction surveys, toll-free helpline, Person Centered Planning process (PCP) and the same follow-up instrument for each group, data reports, a Quality Advisory Committee, and monitoring of consultants and consumers.

I. The Consumer Satisfaction Surveys will be distributed on a yearly basis. The surveys will be accompanied by a letter from the program director explaining its importance and that feedback is necessary for continuous program improvement. Confidentiality will be kept on the surveys, however there is an option to include the responders name and appropriate information if the responder feels necessary or would like to be contacted.

Discovery: The survey requests basic information regarding the consumer and respondent such as: the person filling out the survey (consumer or representative) and the city where the consumer resides. Location allows the program office to see how each area rates.

Remediation: Areas with low survey ratings or low submission to program offices will alert the program office to do necessary outreach or training in those particular areas. The performance indicators are listed in the survey. Performance indicators are goals that each program office found important for their particular consumer population. Performance Indicators are questions such as: 1) The training provided by my consultant included a complete user-friendly consumer notebook. 2) I am able to find qualified employees and/or vendors to provide my services. Consideration will be given to those answers in which the majority or a large portion of the consumer population is unhappy with a particular item. For example, if one consumer indicated that he/she is unhappy with the consumer notebook. However, the rest of the consumers were very happy with their notebooks. The program office might decide that changing the notebook in that situation would be unnecessary. The survey asks whether or not each performance indicator is important to the respondent as well as the respondent to rate how they feel about the answer to each question. The rating is a 5-point Likert scale ranging from 1-(Strongly Disagree) to 5-(Strongly Agree). There is also a box labeled "Not applicable" for those respondents who feel that question does not apply to them. Every performance indicator includes a comments/suggestion section. Respondents are asked to explain a rating of 3-(Neither Agree or Disagree) or less.

Quality Improvement: The surveys are compiled into a data system (such as excel) for reporting. The surveys are evolving documents, meaning if a significant percentage of the responders indicate a performance indicator is not appropriate or relevant, then the performance indicator may be removed or changed in the survey document. Also the program office will review performance indicators with a 3 or less that are not being met by 80% or more of the respondents for relevance and appropriateness. The State assures all CMS' assurances listed in this application regarding consumer services, options and support system will be addressed in the survey.

II. The toll-free helpline is provided at the main program office for the Agency for Persons with Disabilities (APD). In addition, APD provides their consumers an e-mail address for questions; the e-mail is answered daily during normal business hours Monday through Friday from 8:00 A.M. until 5:00 P.M. Eastern Standard Time (EST) excluding holidays.

Discovery: The helpline enables consumers, representatives, consultants, members of the general public, etc. to call about anything from requesting general information, payment problem trouble-shooting, or making complaints. The e-mail addresses assists consumers with budget plan issues as well as timesheet and vendor invoice questions.

Remediation: Calls and emails into the helpline and e-mail addresses will be logged, researched and responded to within 48 business hours (Monday through Friday from 8:00 A.M. until 5:00 P.M. Eastern Standard Time [EST] excluding holidays). Resolution does not guarantee that the caller is satisfied with the response of the call but was given an answer to their question or issue.

Quality Improvement: Helpline and e-mail logs will be reviewed on a quarterly basis as part of ongoing quality assurance. The logs will describe the type of caller (consumers or consultants) and how quickly the call was answered or resolved. The logs will aid the program office in quality assurance enabling them to see what issues are facing the callers. For example, prospective consumers may call with reports of false information being distributed concerning the program. This type of information will allow the program office to provide outreach to the public, identify and refute misinformation as well as distribute correct information about the program. Consumers use the helpline and the consumer e-mail addresses to resolve payment issues, questions about budget/purchasing plans, and general program questions. The operating agency also has a current web-site with current information and forms for consumers. The operating agency tracks consumer issues by a "Notes" section on its database and records any issue regarding the consumer. That way any staff member can access a consumer file for current consumer information.

III. The Person Centered Planning (PCP) process will provide waiver support coordinators/consultants with information gathering tools and techniques that are critical to identifying the strengths, abilities, interests and personal goals of individuals with developmental disabilities on the iBudget waiver.

Discovery: The PCP process for the iBudget waiver allows consumers to list their needs and goals and define what services and supports will help them to satisfy their needs and reach their goals. For example a personal goal might be to spend more time with family and friends. The service they can use to reach that goal may include a certain frequency of homemaker hours once a week so the consumer can feel comfortable having visitors.

Remediation: These tools help the consumer decide what services and supports should be listed on their purchasing plan. The PCP process for the iBudget waiver is implemented when the consumer begins the program and at their yearly assessment. A follow-up instrument is completed at the semi-annual visit.

Quality Improvement: The follow-up instrument asks the consumers if their goals have been reached. Questions include: 1) Have you met Goal #1 listed on the PCP Tool? 2) Do you want to change any of your current goals? From this point, the consumer might decide their goals have changed. The follow-up instrument will be conducted no less than once a

year at the consumer's annual reassessment. The follow-up instrument also incorporates a "mini-survey" from consumers concerning health, safety, and welfare, their service needs, and their feelings regarding the program. From the follow-up instrument, the program office can glean pertinent consumer issues for the annual consumer survey.

IV. Consultant services for individuals with developmental disabilities will be provided by certified support coordinators trained to assume the consultant's role and responsibilities. These certification and training requirements will help assure effective and competent consultants and preserve waiver consumers' choice of consultant. Consultants are trained by Consumer-Directed Care Plus (CDC+) program staff in the overall philosophy of self-direction and specifically in the operations of the CDC+ program. To provide services to CDC+ consumers, consultants are required to be Medicaid waiver service providers for consultant services only. Consultants cannot serve as the consumer's representative. Consultants who are not certified case managers/support coordinators will be considered for enrollment on a case-by-case basis and the Agency for Health Care Administration (AHCA) has the final approval authority. Approval will be granted to those individuals who have a valid provider agreement with the Medicaid agency and who must meet the same training and certification provider requirements as those on the iBudget 1915(c) Home and Community-Based Services (HCBS) waiver.

Discovery: Consultant monitoring will include desk reviews and individual participant interviews. Desk reviews will be conducted on a quarterly basis to a random sampling of no less than 10% of all consultants. For consultants serving five or more CDC+ consumers, the desk reviews will include monitoring the consultant file for at least five randomly selected consumers. For consultants serving less than five CDC+ consumers, two files shall be reviewed. The file must include all necessary documentation for that consumer.

Documentation includes items such as: annual Medicaid eligibility determination and a completed and signed Person Centered Planning (PCP) process for the iBudget waiver. The consultant must have monthly contact with the consumer and visit the consumer in their home or community activity no less than once per six-month period. Monthly contact may be in the form of phone calls or in person, whichever is the preferred method of the consumer. Documentation of home visits and monthly contact must be in the consultant files for each consumer.

There is a Monthly Contact Review Form that must be completed by the consultant and includes topics such as: 1) Reviewed Monthly Budget Statement with the consumer and services are purchased along with purchasing plan. 2) Change in service needs due to change in circumstances.

Remediation: The consultant receives a copy of the consumer's Monthly Budget Net Worth Statement from APD for the iBudget consumers. If the consumer is not making purchases in accordance with his/her approved budget/purchasing plan, the consultant must complete a Corrective Action Plan (CAP) with the consumer. Consumers must sign that they

understand the implications of the CAP as well following the required action. The CAP must be implemented immediately and all purchases should reflect the CAP by the next monthly consultant review. If the consumer's purchases are still outside the guidelines of CDC+ and/or the budget/ purchasing plan after 60 days, then the consumer will be disenrolled from the program and returned to the traditional 1915(c) HCBS waiver.

Quality Improvement: At the semi-annual home visit, the consultant must look for indicators of fraud, abuse, neglect or exploitation and must report any findings to the proper authorities within 24 hours of the visit. Failure of the consultant to perform the monitoring duties will terminate the consultant from providing services on the CDC+ program. The program office will immediately assist the consumer in locating a new, local consultant. The operating program office (APD) has a contingency plan for consultant deficiencies. The State assures that all of Centers for Medicare and Medicaid Services (CMS) assurances listed in this application regarding participant safeguards, participant eligibility and budget development will be addressed in the monitoring of consultants.

V. The Quality Advisory Committee (QAC) is comprised of key program stakeholders. . The QAC will serve in an advisory capacity on behalf of APD.

Discovery: All reporting data is shared with the QAC. Along with reviewing data, the QAC will also look at other ways to improve the program and make suggestions to the program offices. The QAC meets on a quarterly basis. The QAC may include consumers, program staff, consultants, consumer-representatives, care-givers, Area Office staff, (AHCA) external reviewers (if applicable), and community advocates. APD will recommend members to the QAC as appropriate, and AHCA will serve as the approval authority.

Remediation: The QAC will consist of a maximum of six members. All members are trained in expectations, roles and responsibilities, federal and state laws and program policies and procedures.

Quality Improvement: The QAC also reviews the Program Self-Assessment (PSA). The QAC will identify and advise the program office of the areas in which the program should improve itself and will aid in setting the priorities for improvement. The QAC reviews all program policies, consultant and consumer brochures and training materials.

VI. The program office is also charged in completing a PSA that assesses the program structure and policies to see if the program is meeting the performance indicators. The PSA is developed using the guidelines created by SCRIPPS' in the Guide to Quality in Consumer Directed Services.

Discovery: The PSA is developed by the program office in assistance with the QAC. The final document must be approved by AHCA. The PSA asks the program office to evaluate itself with statements such as:

1) Consumers, family members and advocates help design, develop, operate and evaluate the program.
2) Can consumers determine which services to use and can they select, hire and dismiss their workers? The main purpose of the PSA is to assist the program office in identifying program goals, having a plan to meet the goals, ensuring the goals are met and aiding the program office in re-assessing itself in an ongoing capacity. The PSA also alerts the program office of unmet goals or issues that the program office might need to address so the program office continues to excel in its efforts.

Remediation: The APD Program Office will work with the QAC on identifying performance indicators to list in the PSA. Performance Indicators will be identified from areas that are listed by the consumer in the satisfaction surveys and areas to be improved upon in consultant training gathered from the monitoring reports, etc.

Quality Improvement: The QAC reviews the PSA and helps the program office to determine what areas the program office is lacking and the priorities for correcting any deficiencies. The QAC also aids the program office in identifying program improvements needed by the program offices. During the QAC meeting, the program office is responsible for updating the QAC on steps taken to meet requirements of the PSA and any future activities related to program improvement.

VII. APD requires monthly bank reconciliation reports from its subagent to balance consumer accounts. The requirement for the monthly bank reconciliation is listed in the contract between APD and its subagent.

Discovery: APD submits Monthly Budget Reports to the consumer, consultant, and program office and keeps a helpline log for calls to their helpline. APD will review Monthly Budget Statements before they are sent out.

Remediation: APD requires copies of all state and federal filing completed by the subagent.

Quality Improvement: The State assures that all of Centers for Medicare and Medicaid Services (CMS) assurances listed in this application regarding provider agreements will be met by the subagent for APD.

i. The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.

Below is a list of the system performance measures, outcome measures and satisfaction measures of all aspects of the Consumer-Directed Care Plus (CDC+) program. Please note that the measures are evolving as they are based on performance indicators for the program.

System Performance Measures: All of the following reports/measures will be compiled from the program office database.

- The program office will submit an annual report to Agency for Health Care Administration (AHCA), which will demonstrate: client demographic data and a statement of future goals and activities. It will include detailed financial data, reports on performance measures and relevant facts about program operations. Among the data reporting is enrollment and disenrollment information and per member cost expenditures.
  - This report will help the program office to establish a baseline for performance indicators and to enhance or modify those indicators as necessary.
- The program office will submit a quarterly evidence report to AHCA with monitoring efforts and results. Also included will be actions taken/proposed to address deficiencies. All monitoring must address CMS assurances.
  - This report will allow AHCA to monitor program office performance and activities and to provide feedback to the program office.
- The yearly Program Self-Assessment (PSA) will be delivered to the Quality Advisory Committee (QAC) and the program office must be in compliance with the performance indicators for the program. If the program office is not in compliance, they must work on program improvement activities with the QAC.
  - This will allow the program office with the assistance of the QAC to monitor program progress as well as modify performance indicators as necessary.
- All consultants must use an incident reporting system as specified in the traditional 1915(c) Home and Community-Based Services (HCBS) waiver and all incident information must be reported to the program office. The incident information will be compiled and included with the annual report to Agency for Health Care Administration (AHCA). The incidents will be logged by type of incident and must include appropriate action taken to remedy the situation.
  - This will aid in monitoring of incident reporting and follow-up as well as possible discovery of abuse or neglect.
- The subagent for APD will maintain a current Medicaid Provider Agreement.
  - This is required in the assurances.
- APD maintains a Government Policies and Procedures Manual which reflects all requirements described in the subagent's Medicaid Provider Agreement and contract. The manual includes policies, procedures and internal controls for all operations tasks. The manual also includes a policy and procedure for staying up-to-date with all federal and state requirements and for updating the manual at least annually and as needed.
  - The manual acts as the "blueprint" for government FEA operations, is a training tool for new government FEA staff and is a key component of a quality management system.

- APD will implement a helpline call log.

  - This aids in monitoring so the program office is made aware of what types of complaints or questions are called in to the APD.

The Outcome Measures listed below are taken from the PCP process for the iBudget waiver and follow-up instrument; there are also quarterly monitoring items:

- The PCP process for the iBudget waiver must be completed before a consumer completes their first budget/purchasing plan.
  - This aids the consumer in identifying their goals and needs in order to input the services and supplies which will help them to complete their goals.
- Each consumer will need to list their personal goals and identify which services or supports will help them to reach those goals.
  - This will help the consumer to identify and achieve their goals. For example: Goal #1 might be to live in their own home and remain as independent as possible. In order to reach that goal, the consumer might need to hire someone during the week days to provide personal assistance.
- The follow-up instrument will be conducted at least every six months.
  - This will aid the consumer in determining if their goals are being met.
- The consumer will also be able to identify if they need to modify their goals at their bi-annual follow-up. All consumers must be able to request a change to their service plan based on a change in needs or health status. Service plans must be reviewed annually, or whenever necessary due to a change in a consumer's needs or health status.
  - This will allow the consumer to identify new goals or change current goals and identify the services and supports that will meet the new goals and include them on their purchasing plan, removing any services or supports that are no longer necessary.
- The consultant file must include the annual Medicaid eligibility document for each consumer. This helps to assure the State that there are not ongoing issues with consumers being ineligible for Medicaid because of a missed meeting or other situation that could have been taken care of by completing a document or attending a meeting.
  - This will aid the program office in ensuring all consumers retain their Medicaid eligibility and all consultants are tracking annual Medicaid meetings for their consumers.

- Every consultant must maintain a signed consent form. The form must be either signed by the consumer or representative, if applicable. The consent form will serve as verification that the consumer is responsible for directing their own care and fully understands the program.

- This will aid the State to ensure all consumers understand and consent to participate in this program.

The following Satisfaction Measures are taken from the Consumer Satisfaction Survey:

- The Budget/Purchasing Plan had clear instructions on how to complete.
  - The program office will verify information and instructions distributed to consumers are user-friendly. At least 80% of the consumers must agree that program materials are user-friendly. All results from the Satisfaction Survey will be given to the Quality Advisory Committee (QAC). The QAC will help determine the priorities for the performance indicators in which the State will need to meet. If the State is falling behind expectations on the performance indicators, the QAC will help determine how to correct or improve the processes.

- Payments for consumers' invoices and timesheets must be made in a timely manner.
  - This will inform the program office if the subagent is performing its duties and in a timely manner. If not, the program office will need to discuss a corrective action plan with the subagent.

- Payment issues were responded to within 48 business hours.
  - While a response is expected within 48 business hours (a response could include situations in which the issue is still being researched), 90% of issues should be resolved within 72 business hours.

- The consumer's net worth/monthly statement must be received every month.
  - This will aid the program office in determining if consumers are indeed receiving their statements. Statements must be received in order for the consumers to reconcile their balances monthly. Also consumers use their statements to ensure their purchases are accurately reflected.

Risk Management

A. The risk assessment methods used to identify potential risks to participants are described below.

Potential risks to the consumer are assessed during the service development process. Strategies to mitigate risk are incorporated into the budget/purchasing plan, subject to consumer needs and preferences. The budget/purchasing plan development process addresses emergency backup plans. Each consumer is screened for capacity to direct their own care and required to identify a representative if indicated.

B. The tools or instruments used to mitigate identified risks are described below.

I. Criminal Background Checks are mandatory for all employees, even family members. Criminal Background Checks are mandated by state law. The Criminal Background Checks are performed at no cost to the consumer but are to be paid by the employee. All individuals who will be rendering care to a consumer enrolled in this program must either:

- Be a Medicaid enrolled provider who received background screening at the time of their enrollment into the Medicaid program (and who remains in good standing with the Medicaid program); or
- Pass a background screening; or
- Provide proof of a State of Florida and/or a Federal background screening completed within six-months prior to employment, the outcome of which was a finding of no disqualifying offenses.

II. Each Consumer-Directed Care Plus (CDC+) consumer is required to develop an emergency back-up plan before starting to manage a budget on CDC+. The emergency backup plan should describe the alternative services delivery methods that will be used under any of the following circumstances: 1) if the primary employees fail to report to work or otherwise cannot perform the job at the time and place required, 2)if the consumer experiences a personal emergency, or 3) if there is a community-wide emergency(e.g., requiring evacuation). The personal emergency portion of the emergency back-up plan will allow the participant to identify circumstances that would cause an emergency for him/her based upon his/her unique needs. The emergency back-up plan must also address ways to assure that the needs of the individual are met should an unexpected shortage of funds occur.

III. The Consumer/Representative Agreement is a written agreement between a consumer and the consumer's representative that sets forth the CDC+ responsibilities of the representative. All consumers have the option of choosing one individual to act as a representative (friend, caregiver, family member or other person, etc.) to assume budget and care management responsibilities. Representatives may not work for the consumer

or be paid by the consumer. Consumers may also receive assistance with their CDC+ responsibilities without appointing a representative; however these individuals cannot sign documents, speak for or otherwise act on behalf of the consumer.

IV. The monthly monitoring of consumers by consultants will be used to assess for risks to the consumer. The consultant will monitor both the consumer's monthly budget to assess the consumer's spending and service utilization in comparison with the purchasing plan and the consultant will also assess the consumer's risk for abuse, neglect or exploitation at the semi-annual home visits.

C. The State's process for ensuring that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated, is described below.

Prior to enrollment in the CDC+ program, each consumer will receive a Home and Community-Based Waiver care/support plan based on an assessment of need that includes an identification of risks and potential mitigation strategies. All consumers in CDC+ must take part in an initial training prior to the development of the budget/purchasing plan. In this training, the consumer is given lists of roles and responsibilities, which provides a detailed description of the roles and responsibilities of the consumer in the program including a detailed description of the roles, responsibilities and support functions of the consultant, and APD staff. This document will be thoroughly reviewed with the consumer and/or the representative to ensure that there is a clear understanding of the responsibilities related to the health and safety and mitigation risks to be assumed by the consumer. The consumer will list all identified risks in the emergency back-up plan including the plan that each individual consumer will use in the case of an emergency. The consumer/representative will develop a purchasing plan to specify how the monthly budget will be used to meet the consumer's care needs, and how other identified needs might be met through generic, community supports, and Medicaid State plan services. Risks will be documented and updated at the consumer's semi-annual home visit or more frequently if needed.

D. The State's process for ensuring that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant's representative, if any, and others from whom the participant may seek guidance, is described below.

The consumer/representative is responsible for developing their own budget/purchasing plan to show how their budget will be spent each month. In that plan, the consumer will identify the risks that were discussed with the consultant during their initial and semi-annual monitoring assessment.

The consumer must identify and manage their personal emergency back-up plan/risk mitigation strategy in their PGS tool. Consultants will provide support and technical assistance in order to facilitate the development of the budget/purchasing plan by the consumer/representative.

Consultants will not assume responsibility for developing the budget/purchasing plan, but will review and approve the plan to ensure that proposed services are adequate, purchases are cost-effective and related to the consumer's needs, and that an emergency back-up plan is in place. The consultant reviews the proposed budget/purchasing plan with the consumer/representative and others identified by the consumer as a method to assess the consumer/representative's ability to assume service management responsibilities and to further generate discussion around risk management.

ii. Qualifications of Providers of Personal Assistance

E. __X__ The State elects to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

F. _____ The State elects not to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

iii. Use of a Representative

G. __X__ The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

i._____ The State elects to include, as a type of representative, a State mandated representative. Please indicate the criteria to be applied.

H. _____ The State elects not to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

iv. Permissible Purchases

I. __X__ The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

J. The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

xvi. Financial Management Services

A. _____The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

i. __X_ The State elects to provide financial management services through a reporting or subagent through its fiscal intermediary in accordance with section 3504 of the IRS Code and Revenue Procedure 80-4 and Notice 2003-70; or

ii. ____The State elects to provide financial management services through vendor organizations that have the capabilities to perform the required tasks in accordance with section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish financial management services, the procurement method must meet the requirements set forth Federal regulations in 45 CFR section 74.40 – section 74.48.)

iii. ____The State elects to provide financial management services using "agency with choice" organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.

B. __X__ The State elects to directly perform financial management services on behalf of participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

1915(i) State plan Home and Community-Based Services

Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for delinquent youth with serious emotional disturbances and their families as set forth below.

1. Services. *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Redirection services:

- Redirection Therapy services
  - Individual therapy
  - Family therapy
  - Group therapy
- Redirection Therapeutic Support services
- Redirection 24 Hour Crisis Therapeutic Support services
- Redirection services Case Coordination

2. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

○	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:	
	○ The Medical Assistance Unit *(name of unit)*:	
	○ Another division/unit within the SMA that is separate from the Medical Assistance Unit *(name of division/unit)* *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*	
⊙	The State plan HCBS benefit is operated by *(name of agency)*	
	The Department of Juvenile Justice	
	A separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

3. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the State assures that):* When the Medicaid agency does not directly conduct an administrative 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. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not

substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☑	☑	☐
2 State plan HCBS enrollment managed against approved limits, if any	☑	☑	☑	☐
3 Eligibility evaluation	☑	☑	☑	☐
4 Review of participant service plans	☑	☑	☑	☐
5 Prior authorization of State plan HCBS	☑	☑	☑	☐
6 Utilization management	☑	☑	☑	☐
7 Qualified provider enrollment	☑	☑	☑	☐
8 Execution of Medicaid provider agreement	☑	☐	☐	☐
9 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
11 Quality assurance and quality improvement activities	☑	☑	☑	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

1. Department of Juvenile Justice (DJJ) or their contracted quality improvement organization.
2. Department of Juvenile Justice (DJJ) or their contracted quality improvement organization.
3. Department of Juvenile Justice (DJJ) or their contracted quality improvement organization.
4. Department of Juvenile Justice (DJJ) or their contracted quality improvement organization.
5. Department of Juvenile Justice (DJJ) or their contracted quality improvement organization.
6. Department of Juvenile Justice (DJJ) or their contracted quality improvement organization.
7. Department of Juvenile Justice (DJJ) or their contracted quality improvement organization.
11. Department of Juvenile Justice (DJJ) or their contracted quality improvement organization.

(By checking the following boxes the State assures that):

4. ☑ **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual

- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

Assessments for Redirection services will be conducted by certified Redirection service providers. These are the only providers in the state that are qualified to conduct these assessments.

The Department of Juvenile Justice will screen recipients using the Positive Achievement Change Tool Assessment (PACT) to determine if they meet target criteria. The PACT is an assessment tool that is utilized in conjunction with a case management process that addresses both criminogenic needs and protective factors from the moment a recipient enters the Florida juvenile justice system until he or she exits. A recipient's Juvenile Probation Officer (JPO) will follow the recipient through the assessment process and will be one of the members of the recipient's multidisciplinary team (MDT).

The evaluations and reevaluations for service eligibility will be performed by the Department of Juvenile Justice or their contracted quality improvement organization.

Assessments to determine the service needs of recipients will be performed by the certified Redirection services provider that will make treatment recommendations.

Person-centered recipient treatment plans will be developed and approved by a multidisciplinary team (MDT). The MDT should include the recipient, the recipient's parents, caregivers, or guardians, the recipient's Redirection services therapist, the Redirection services staff supervisor, a representative from the Department of Juvenile Justice, as well as representation from any other community supports applicable. Recipient treatment plans must be approved by the Department of Juvenile Justice or their contracted quality improvement organization.

The Department of Juvenile Justice will develop and implement a person-centered Youth Empowerment Success (YES) supervision plan with input from the youth and his or her family. The YES plan identifies supervision needs to help the youth successfully meet the conditions stipulated by the court; the provision of services that address the youth's offending behavior, strengths, protective factors and needs; and the coordination of services to assist the youth in choosing positive alternatives to offending behavior and becoming a productive member of his or her community. The YES plan will incorporate the Redirection services treatment recommendations and serves as a case management tool throughout the course of the youth's supervision and treatment. The YES plan will be monitored at required intervals through a case staffing process and includes the participation of the youth, family and Redirection services provider in the process. The youth driven, family-focused YES plan will be updated as needed, and Redirection services are revised or terminated based on youth's and family's needs and progress.

5. ☑ **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

Fair Hearing Policy	
Process	Roles and Responsibilities
The Medicaid Fair Hearing policy and process is detailed in Rule 65-2.042, Florida Administrative Code. Recipients have the right to a Fair Hearing when action has been taken regarding their Medicaid services or eligibility. Actions related to decisions regarding Medicaid eligibility include determinations that an applicant does or does not meet Medicaid financial, clinical, or technical criteria or failure to act in a timely manner for eligibility determination. If services are decreased or re-authorization is not provided, the entity that initiates the action must send notice to the recipient, the recipient's guardian, the recipient's attorney (if one exists), and the recipient's guardian ad litem (if one exists) at least 10 days prior to the service reduction or termination. If a recipient does not agree with this decision, the recipient or his or her authorized representative may ask for a hearing within 21 days of the date of this notice. If this action is a termination, reduction, or suspension of services, those services may continue until a hearing is held, but the recipient must request a Fair Hearing within 10 days of the date of this notice in order to receive continued benefits. Recipients may be requested to repay that portion of the benefits that the hearing decision determines to be invalid. Recipients have the right to be represented by an authorized representative, to review his or her file at a reasonable time before and during the hearing, to review all documents and records to be used by the State at the hearing and to receive copies of all such documents. Recipients may request an interpreter. Fair Hearings may be requested verbally or in writing. No specific form is required. To request a Fair Hearing for financial or clinical eligibility determinations, individuals are directed to contact their local Department of Children and Families' office or to send Fair Hearing requests to: DCF, Office of Hearing Appeals 1317 Winewood Boulevard, Building 5, Room 205 Tallahassee, Florida 32399.	Certified Redirection services providers and the Department of Juvenile Justice or their contracted quality improvement organization will be required to inform recipients of Florida Medicaid's Fair Hearing policy. The Department of Juvenile Justice or their contracted quality improvement organization will verify during annual monitorings that recipients are notified of Florida Medicaid's Fair Hearing policy. The Florida Department of Children and Families will process appeals and Fair Hearing requests and will facilitate Fair Hearings on the behalf of recipients.

6. ☑ **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

7. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the

Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	7/1/13	6/30/14	403
Year 2	7/1/14	6/30/15	**707**
Year 3	7/1/15	6/30/16	**1,010**
Year 4	7/1/16	6/30/17	**1,313**
Year 5	7/1/17	6/30/18	**1,616**

2. ☑ **Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

2. Medically Needy. *(Select one):*

⊙	The State does not provide State plan HCBS to the medically needy.	
○	The State provides State plan HCBS to the medically needy *(select one):*	
	○	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
	○	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*select one*):

○	Directly by the Medicaid agency
⊙	By Other (*specify State agency or entity with contract with the State Medicaid agency*):
	The Department of Juvenile Justice.

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The Department of Juvenile Justice or their contracted quality improvement organization's management evaluation/reevaluation team will have a licensed psychiatrist with competence in diagnosis, and treatment of children and adolescents with serious emotional disturbances and behavioral disorders.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The Department of Juvenile Justice (DJJ) will screen recipients using the Positive Achievement Change Tool Assessment (PACT) to determine if they meet both the target criteria and the needs based eligibility criteria. Recipients within the defined target population will be notified by the Department of Juvenile Justice that they may be eligible for services following their initial and follow-up PACT assessments.

Recommendations for Redirection services will require an evaluation for prior authorization by the Department of Juvenile justice or their contracted quality improvement organization. Reevaluations for continued service authorization will have to be completed no less that every six months.

4. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The following criteria are to be used for the authorization of Redirection services on behalf of eligible Medicaid recipients:

1) All admissions are voluntary.
2) The child or adolescent has age appropriate cognitive ability to benefit from treatment; recipient does not have an organic brain disorder (dementia or delirium) or other psychiatric or neurological

conditions that would produce a cognitive deficit severe enough to prohibit benefit.

3) Home and community based resources do not meet the treatment needs of the recipient or are not available.
   a) To meet this requirement, one of the following shall be established.
      i) A lower level of care will not meet the recipient's treatment needs. Examples of lower levels of care include
         a. Individual and family outpatient therapy
         b. Group therapy
         c. Therapeutic behavioral onsite services
         d. Psychosocial rehabilitation
         e. Behavioral health day treatment
      ii) An appropriate lower level of care is unavailable or inaccessible and a reasonable course of traditional outpatient treatment is unlikely to resolve significant symptoms to permit a safe functioning in the community.
   b) Proper treatment of the recipient's psychiatric condition requires intensive community-based services. To meet this requirement all of the following criteria must be met:
      i) The child or adolescent has a serious impairment of functioning compared to others of the same age due to the psychiatric diagnosis, in one or more major life roles (school, family, interpersonal relations, self-care, etc.) as evidenced by documented presence of
         (a) Deficits in cognition, control, or judgment due to diagnosis(es)
         (b) Circumstances resulting from those deficits in self-care, personal safety, social/family functioning, academic or occupational performance, and
         (c) Prognostic indicators which predict the effectiveness of treatment;
   c) The services can reasonably be expected to improve the recipient's condition within a reasonable timeframe or prevent further regression so that the services will no longer be needed.
      i) The Redirection services provider shall develop with the recipient a treatment plan prescribing the services.
      ii) The treating Redirection services provider shall develop with the recipient a formal aftercare plan.
      iii) Redirection services are expected to result in maintaining or improving the recipient's level of functioning.

Target Group(s). ***(If applicable, specify the target population(s) who will be eligible to receive this State plan HCBS benefit):***

- Under 18 years of age; and
- Who meet the following diagnostic criteria
    - Must have an emotional disturbance or serious emotional disturbance as defined in Chapter 394, F.S.

In order to continue 1915(i) services the Agency for Health Care Administration will need to renew the SPA every five (5) years.

5. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	**NF (& NF LOC waivers)**	**ICF/MR (& ICF/MR LOC waivers)**	**Applicable Hospital* LOC (& Hospital LOC waivers)**
The needs based eligibility criteria are described in #4.	Not applicable as this institutional setting would not be considered for the population served by Redirection services.	Not applicable as this institutional setting would not be considered for the population served by Redirection services.	The following criteria are to be used for admission to a SIPP facility when reimbursement is to be made on behalf of eligible Medicaid recipients: 1. All admissions are non-emergency and voluntary. 2. Medical clearance must be given by a physician prior to admission. 3. The child or adolescent has age appropriate cognitive ability to benefit from treatment. 4. The child or adolescent has the cognitive and developmental ability to benefit from treatment and group setting. 5. CFR 441.152 Federal requirements A, B, and C shall be met for admission to a SIPP. A. Ambulatory care resources available in the community do not meet the treatment needs of the recipient (42 CFR 441.152(a)). A reasonable course of acute inpatient treatment and/or intensive outpatient services has failed to bring about adequate resolution of significant symptoms to permit placement in a less restrictive setting in the community. To meet this requirement, one of the following shall be established. 1) A lower level of care will not meet the recipient's treatment needs. Examples of lower levels of care include a) Family or relative

placement with outpatient therapy
b) Day or after-school treatment
c) Foster care with outpatient therapy
d) Therapeutic foster care
e) Group childcare supported by outpatient therapy
f) Therapeutic group childcare
g) Partial hospitalization
h) Custodial care

2) An appropriate lower level of care is unavailable or inaccessible and a reasonable course of acute inpatient treatment has failed to resolve significant symptoms to permit a safe return to the community.

B. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician (42 CFR 441.152(a)).

To meet this requirement all of the following criteria must be met:

1) A current ICD diagnosis is present and has been established through a documented comprehensive bio-psychosocial diagnostic assessment. The diagnosis must indicate the presence of a psychiatric disorder that is severe in nature and requires more intensive treatment than can be provided on an outpatient basis. As an example, the following diagnoses may indicate the need for SIPP care when acute inpatient treatment has not adequately resolved significant symptoms and behaviors: Major Depressive Disorder, active Post Traumatic Stress Syndrome with continued fragility, and newly

diagnosed psychotic disorders. A concurrent Axis I substance abuse disorder may be present.

2) The rating on DSM IV Axis V at admission is less than 70.

3) The recipient is currently experiencing problems related to the mental disorder diagnosed in B.1 above in one of the following categories designated as a, b, c, or d:

a) Self-care Deficit (not Age Related): Basic impairment of needs or nutrition, sleep, hygiene, rest, or stimulation related to the recipient's mental disorder and severe and long-standing enough to prohibit participation in an available alternative setting in the community, including refusal to comply with treatment (e.g., refuse medications)

OR

b) Impaired Safety (Threat to Self or Others): Evidence of intent to harm self or others caused by the recipient's mental disorder; and unable to function in community setting, provided that such intent does not constitute a clinically emergent situation. Threats to harm self or others accompanied by one of the following:

i. Severely depressed mood
ii. Recent loss
iii. Recent suicide

attempt or gesture or past history of multiple attempts or gestures

iv. Concomitant substance abuse

v. Recent suicide or history of multiple suicides in family or peer group

OR

c) Impaired Thought and/or Perceptual Processes (Reality Testing): Inability to perceive and validate reality to the extent that the patient cannot negotiate his/her basic environment, nor participate in family or school (paranoia, hallucinations, delusions) and it is likely that the recipient will suffer serious harm.

Indicators:

i. Disruption of safety of self, family, peer, or community group

ii. Impaired reality testing sufficient to prohibit participation in any community educational alternative

iii. Not responsive to outpatient trial of medication or supportive care

iv. Requires sub-acute diagnostic evaluation to determine treatment needs

OR

d) Severely Dysfunctional

Patterns: Family, environmental, or behavioral processes, which place the recipient at risk

Indicators (one of the following):

i. Family environment is causing escalation of recipient's symptoms or places recipient at risk.
ii. The family situation is not responsive to available outpatient or community resources and intervention.
iii. Instability or disruption is escalating.
iv. The situation does not improve with the provision of economic or social resources.
v. Severe behavior or established pattern of behavior prohibits any participation in a lower level of care; e.g., habitual runaway, prostitution, repeated substance abuse.

4) The child or adolescent has a serious impairment of functioning compared to others of the same age due to the psychiatric diagnosis, in one or more major life roles (school, family, interpersonal relations, self-care, etc.) as evidenced by documented presence of

a) Deficits in cognition, control, or judgment due to diagnosis(es)
b) Circumstances resulting from those deficits in self-care,

personal safety, social/family functioning, academic or occupational performance

c) Prognostic indicators which predict the effectiveness of treatment

5) The facility requesting prior authorization describes a proposed plan of active treatment based on comprehensive assessment that addresses medical, psychiatric, neurological, psychological, social, educational, and substance abuse needs. Specifically:

a) Services shall be under the supervision of a physician advisor.

b) Intervention of qualified professionals shall be available 24 hours a day.

c) Multiple therapies (group counseling, individual counseling, pre-vocational therapy, family therapy, recreational therapy, expressive therapies, etc.) shall be actively provided to the recipient. Families or surrogates must be involved in the treatment. Family therapy with families or surrogates must be included unless clinically contraindicated, with an expectation of at least one family session per week.

A. The services can reasonably be expected to improve the recipient's condition within a reasonable timeframe of three to six months or prevent further regression so that the services will no longer be needed (42 CFR 441.152(a)).

1) The treating facility shall provide a

			description of the plan for treatment illustrating the required services available at SIPP level of care. 2) The treating SIPP facility shall provide a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan shall include discrete, behavioral, measurable, and time framed discharge criteria. 3) The benefits of SIPP care are expected to result in maintaining or improving the recipient's level of functioning.

*Long Term Care/Chronic Care Hospital

(By checking the following boxes the State assures that):

6. ☑ **Reevaluation Schedule**. Needs-based eligibility reevaluations are conducted at least every twelve months.

7. ☑ **Adjustment Authority**. The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

8. ☑ **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

Services are provided in a family home placement, which may include relative and non-relative homes and licensed foster homes, excluding Specialized Therapeutic Foster Care homes and group settings. Treatment includes provision of clinical services which are psychological, behavioral and psychosocial in orientation and designed to maintain children in their homes and communities. Foster care placements must be licensed in accordance to 65C-13. There should be no more than five children in a licensed home, including the family's own children, without prior approval.

Services are highly supportive, individualized, and flexible and require a "whole family" approach to dealing with all problems affecting the recipient's functioning within the community. The participation of family and/or caretaker, and involvement in the community and school are considered essential to the recipient's successful discharge from this program.

Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:

- An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
- Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
- An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
- An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
- If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
- A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

2. ☑ Based on the independent assessment, the individualized plan of care:

- Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
- Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
- Prevents the provision of unnecessary or inappropriate care;
- Identifies the State plan HCBS that the individual is assessed to need;
- Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

3. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

Face-to-face assessments will be completed by Redirections services practitioners. These practitioners may be a physician or a licensed practitioner of the healing arts.

Licensed practitioners of the healing arts include:

- Clinical social workers licensed in accordance with Chapter 491 F.S.
- Mental health counselors licensed in accordance with Chapter 491 F.S.
- Marriage and family therapists, licensed in accordance with Chapter 491 F.S.
- Psychologists licensed in accordance with Chapter 490 F.S.
- Clinical Nurse Specialist (CNS) with a sub-specialty in Child/Adolescent Psychiatric and Mental Health or Psychiatric and Mental Health licensed in accordance with Chapter 464 F.S.
- Psychiatric ARNP licensed in accordance with Chapter 464 F.S.
- Psychiatric physician assistant licensed in accordance with Chapters 458 and 459, F.S.

Treating practitioners must have a minimum of two years of direct experience working with emotionally disturbed children with criminogenic factors and their families. Practitioners must be employed or under contract with a certified Redirection services provider agency.

4. Responsibility for Plan of Care Development. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

Clinical staff with at least a Bachelor's degree in a human services field, with a minimum of two years of direct experience working with emotionally disturbed children with criminogenic factors, will work with the recipient and the recipient's family to develop an individualized treatment plan. Treatment plans must be authorized by a Medicaid enrolled treating practitioner linked to the certified Redirection services provider agency. A human services field is one in which major course work includes the study of human behavior and development. Non-licensed clinical staff will work under the clinical supervision of a licensed practitioner of the healing arts.

The multidisciplinary team must review the recipient's treatment plan monthly.

5. Supporting the Participant in Plan of Care Development. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The provider will make verbal and written information available to the participant about the person-centered planning process, the opportunity to include others to participate in the planning, and about available services through the program at admission. The participant will be encouraged to participate in the development of individualized treatment plan goals and objectives. The provider will ensure that the participant and identified supports are fully involved in the treatment plan development. Treatment plan meetings are conducted at times and places that are convenient

for the participant and the participant's family. Treatment plans must be developed by one of the following qualified practitioners:

- Physician;
- Psychiatrist;
- Psychiatric physician assistant;
- Psychiatric advanced registered nurse practitioner;
- Licensed Practitioner of the healing arts (LPHA);
- Master's level practitioner; or
- Bachelor's level practitioner.

Practitioners must have a minimum of two years of direct experience working with emotionally disturbed children with criminogenic factors and their families. Practitioners must be employed or under contract with a certified Redirection services provider agency.

Treatment plans must be authorized by a Medicaid enrolled treating practitioners, who must be a physician or a licensed practitioner of the healing arts.

6. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

Redirection services will be available statewide. The Department of Juvenile Justice or their contracted quality improvement organization will publish on its website a list of all certified Redirection services providers that are Medicaid enrolled in each Agency for Health Care Administration (AHCA) area. This list will be made available to participants and their families or legal representatives upon referral to Redirection services. Participants and their families or legal representatives will be afforded the opportunity to choose from certified Redirection services providers.

7. Process for Making Plan of Care Subject to the Approval of the Medicaid Agency. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

The multidisciplinary team with develop the recipient treatment plan. Treatment plans must be authorized by a Medicaid enrolled treating practitioners, who must be a physician or a licensed practitioner of the healing arts. The Department of Juvenile Justice or their contracted quality improvement organization must authorize all individualized treatment plans.

1. Maintenance of Plan of Care Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☐	Operating agency	☐	Case manager
☑	Other (*specify):*	The certified Redirection services provider agency.			

Services

1. 1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Redirection Services
Service Definition (Scope)*:*	

The goal of these services is to "redirect" recipients from juvenile justice facilities to more effective, family-focused, evidence-based treatment options. Redirection services are time-limited intensive community-based services that address the multiple determinants of behavioral disorders in juvenile offenders. Redirection services address the factors associated with delinquency across a recipient's life systems through case coordination and evidence-based treatment and interventions. Services are designed to address the following criminogenic risk factors:

- Records of referrals;
- Family history;
- Mental Health;
- Alcohol and drug use;
- Aggression;
- Relationships;
- Attitudes, behaviors, and skills;
- Current living arrangements;
- Use of free time;
- School performance; and
- Lack of employment.

Certified Redirection services providers are required to demonstrate expertise with the delinquent youth and must utilize specialized treatment approaches including the use of a multidisciplinary team (MDT). The MDT should include the recipient's parents, caregivers, or guardians, the recipient's Redirection Services case coordinator, the recipient's Redirection services therapist, the Redirection services staff supervisor, a representative from the Department of Juvenile Justice, as well as representation from any other community supports applicable.

Redirection services are provided in a home, school, or other community setting. Redirection services utilize an individualized combination of therapy and therapeutic support services.

Redirection Therapy Services:

Individual therapy services include the provision of insight oriented, cognitive behavioral or supportive therapy interventions to an individual recipient, to address criminogenic risk factors.

Family therapy services include the provision of insight oriented, cognitive behavioral or supportive

therapy interventions to a recipient's family, with or without the recipient present, to address criminogenic risk factors. The focus or primary beneficiary of family therapy services must always be the recipient.

Group therapy services include the provision of cognitive behavioral, supportive therapy or counseling interventions to recipients or their families to address criminogenic risk factors. The focus or primary beneficiary of group therapy services must always be the recipient.

A combination of therapy services, aside from Redirection 24 hour crisis therapeutic support services, must be provided at least two times weekly by one of the following qualified practitioners:

- Physician;
- Psychiatrist;
- Psychiatric physician assistant;
- Psychiatric advanced registered nurse practitioner;
- Licensed Practitioner of the healing arts (LPHA); or
- Master's level practitioner.

Practitioners must have a minimum of two years of direct experience working with emotionally disturbed children with criminogenic factors and their families. Practitioners must be employed or under contract with a certified Redirection services provider agency.

Redirection Therapeutic Support Services:

Redirection therapeutic support services combine living and social skills training, support to recipients and their families, housing, pre-vocational and transitional employment rehabilitation training, social support and network enhancement, structured activities to diminish tendencies towards antisocial and criminal behavior, and teaching the recipient and family about symptom management.

Redirection therapeutic support services shall not be available to individuals who are eligible to receive vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Education Act (IDEA).

Redirection therapeutic support services must be rendered at least one time weekly, in addition to therapy services, by one of the following qualified practitioners:

- Physician;
- Psychiatrist;
- Psychiatric physician assistant;
- Psychiatric advanced registered nurse practitioner;
- Licensed Practitioner of the healing arts (LPHA);
- Master's level practitioner; or
- Bachelor's level practitioner.

Practitioners must have a minimum of two years of direct experience working with emotionally disturbed children with criminogenic factors and their families. Practitioners must be employed or under contract with a certified Redirection services provider agency.

Redirection 24 Hour Crisis Therapeutic Support Services:

24 hour therapeutic support services are intended to assist recipients and their families to manage crisis situations. These services must be available 24 hours a day seven (7) days a week. 24 hour therapeutic support services cannot be counted toward weekly therapy and therapeutic support service requirements.

Redirection 24 hour therapeutic support services must be rendered by one of the following qualified practitioners:

- Physician;
- Psychiatrist;
- Psychiatric physician assistant;
- Psychiatric advanced registered nurse practitioner;
- Licensed Practitioner of the healing arts (LPHA);
- Master's level practitioner; or
- Bachelor's level practitioner.

Practitioners must have a minimum of two years of direct experience working with emotionally disturbed children with criminogenic factors and their families. Practitioners must be employed or under contract with a certified Redirection services provider agency.

Redirection Services Care Coordination:

The primary goal of Redirection services care coordination is to optimize the functioning of recipients who have complex needs by coordinating the provision of Redirection treatment and support services in the most efficient and effective manner. Services and service frequency should accurately reflect the individual needs, goals, and abilities of each recipient.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Specify whether the service may be provided by a *(check each that applies):*	☐	Relative
	☐	Legal Guardian
	☐	Legally Responsible Person

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Community Behavioral Health Services group provider (05)		Certified Redirection Services Programs	Redirection services are governed by Title 42, Code of Federal Regulations (CFR), Part 440.130 and through the authority of Chapter 409.906, Florida Statutes (F.S.). The Florida Administrative Code, Chapter 59G, authorizes implementation of Medicaid

			policy for Redirection services.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Community Behavioral Health Services group provider (05)	Agency for Health Care Administration- Bureau of Medicaid Services or designee, and Department of Juvenile Justice or their contracted quality improvement organization.	Annually

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

2. ☐ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the State assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS ; (b) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (*Select one):*

⊙	The State does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. *(Specify criteria):*

2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (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 approach to participant-direction):*

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the State affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. Financial Management. (*Select one):*

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

6. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). (*Select one):*

○	The State does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**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.
	☐	**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.

b. Participant–Budget Authority (individual directs a budget). (*Select one):*

○	The State does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):*
	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):*

Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes,and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of Analysis and Aggregation*
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	**Numerator:** Files reviewed that have evidence that an assessment of the recipient's needs was completed by qualified clinical staff prior to the development of the treatment plan. Denominator: All Redirection services recipient files reviewed.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with a 95% confidence level with a 5% margin of error. This will be required for each program monitoring.	The Department of Juvenile Justice (DJJ) or their contracted quality improvement organization (QIO) will report monitoring results to Florida Medicaid quarterly.	Annually	The DJJ or their contracted QIO will ensure the development of a performance improvement plan within 15 calendar days of the compliance monitoring. The DJJ or their contracted QIO will approve or disapprove the plan within 7 calendar days. The performance improvement plan must be fully implemented within 30 calendar days of approval of the performance improvement plan. The DJJ or their contracted QIO will	The DJJ or their contracted QIO will report monitoring results to Florida Medicaid quarterly. The DJJ or their contracted QIO will monitor provider adherence to performance improvement plans no less than annually.

					conduct a monitoring within 6 months of implementation to ensure performance improvement plan compliance.	
	Numerator: Files reviewed for recipients eligible for services, who participated in services beyond the first 30 days that have evidence that an individualized service plan was completed and authorized by qualified clinical staff. Denominator: All Redirection services recipient files reviewed for recipients who participated in services beyond the first 30 days.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with a 95% confidence level with a 5% margin of error. This will be required for each program monitoring.	The DJJ or their contracted QIO will report monitoring results to Florida Medicaid quarterly.	Annually	The DJJ or their contracted QIO will ensure the development of a performance improvement plan within 15 calendar days of the compliance monitoring. The DJJ or their contracted QIO will approve or disapprove the plan within 7 calendar days. The performance improvement plan must be fully implemented within 30 calendar days of approval of the performance improvement plan. The DJJ or their contracted QIO will conduct a monitoring within 6 months of implementation to ensure performance improvement plan	The DJJ or their contracted QIO will report monitoring results to Florida Medicaid quarterly. The DJJ or their contracted QIO will monitor provider adherence to performance improvement plans no less than annually.

					compliance.	
	Numerator: Files reviewed that contain informed consent, signed by the recipient and his or her parent or guardian, which informs the recipient of other available services and providers. Denominator: All Redirection services recipient files reviewed.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with a 95% confidence level with a 5% margin of error. This will be required for each program monitoring.	The DJJ or their contracted QIO will report monitoring results to Florida Medicaid quarterly.	Annually	The DJJ or their contracted QIO will ensure the development of a performance improvement plan within 15 calendar days of the compliance monitoring. The DJJ or their contracted QIO will approve or disapprove the plan within 7 calendar days. The performance improvement plan must be fully implemented within 30 calendar days of approval of the performance improvement plan. The DJJ or their contracted QIO will conduct a monitoring	The DJJ or their contracted QIO will report monitoring results to Florida Medicaid quarterly. The DJJ or their contracted QIO will monitor provider adherence to performance improvement plans no less than annually.

					within 6 months of implementation to ensure performance improvement plan compliance.	

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of Analysis and Aggregation*
The SMA retains authority and responsibility for program operations and oversight.	Numerator: Number of individual provider compliance monitoring reports and quarterly reports completed by the Department of Juvenile Justice or their contracted quality improvement organization that have been approved by Florida Medicaid. Denominator: Individual provider compliance monitoring reports and quarterly reports completed by the Department of Juvenile Justice	Bureau of Medicaid Services Redirection services contract manager will review all quarterly results.	Florida Medicaid	Ongoing	Florida Medicaid will ensure the development of a corrective action plan within 15 calendar days of notification of non-compliance. Medicaid will approve or disapprove the corrective action plan within 7 calendar days Florida. The corrective action plan must be fully implemented within 30 calendar days of Florida Medicaid's approval of the corrective action plan. Florida Medicaid will conduct monitoring within 3 months of implementation to ensure corrective action plan compliance.	Florida Medicaid will monitor adherence with a corrective action plan on no less than a quarterly basis.

	or their contracted quality improvement organization that were submitted to Florida Medicaid. Numerator: Number of corrective action plans that Florida Medicaid approved within 7 days. Denominator: All corrective action plans that were submitted to Florida Medicaid for approval.					
Providers meet required qualifications.	Numerator: Files reviewed that contain evidence that services were provided by a qualified professional. Denominator: All Redirection services recipient files reviewed.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with a 95% confidence level with a 5% margin of error. This will be required for each program monitoring.	The DJJ or their contracted QIO will report monitoring results to Florida Medicaid quarterly.	Annually	The DJJ or their contracted QIO will ensure the development of a performance improvement plan within 15 calendar days of the compliance monitoring. The DJJ or their contracted QIO will approve or disapprove the plan within 7 calendar days.	The DJJ or their contracted QIO will report monitoring results to Florida Medicaid quarterly. The DJJ or their contracted QIO will monitor provider adherence to performance improvement plans no less than annually.

	Numerator: Redirection services providers with a valid certification from the Department of Juvenile Justice or their contracted quality improvement organization. Denominator: All Redirection services providers.				The performance improvement plan must be fully implemented within 30 calendar days of approval of the performance improvement plan. The DJJ or their contracted QIO will conduct a monitoring within 6 months of implementation to ensure performance improvement plan compliance.	

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of Analysis and Aggregation*
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	The Department of Juvenile Justice or their contracted quality improvement organization agrees to: • Maintain an ongoing management information system to ensure accountability of paid and reimbursed claims; • Maintain accurate records of payment and monitor services delivery; • Maintain, and require providers to maintain, records relevant to these services; • Provide any records to the	Quarterly certification by the Department of Juvenile Justice or their contracted quality improvement organization of each provider and service.	Florida Medicaid	Quarterly	Florida Medicaid will ensure the development of a corrective action plan within 15 calendar days of notification of non-compliance. Florida Medicaid will approve or disapprove the corrective action plan within 7 calendar days. The corrective action plan must be fully implemented within 30 calendar days of Florida Medicaid's approval of the corrective action plan. Florida Medicaid will conduct monitoring within 3 months of implementation to ensure corrective action plan compliance.	Florida Medicaid will monitor adherence with a corrective action plan on no less than a quarterly basis.

	Centers for Medicare and Medicaid Services (CMS) and to Florida Medicaid, when requested for audit purposes; • Void or otherwise pay back any claims that are found to be ineligible for match due to an audit, deferral of denial as deemed appropriate; • Designate an employee to act as liaison with Florida Medicaid for issues related to this agreement. The DJJ or their contracted QIO will provide certification of claims to Florida Medicaid on a quarterly basis. Numerator: The number of claims submitted					

	using the correct rate. Denominator: The number of claims submitted. Numerator: The Number of claims submitted without error. Denominator: The number of claims submitted.					

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of Analysis and Aggregation*
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	The DJJ or their contracted QIO will require providers to report all incidents within 2 hours of the incident occurring or program staff learning of the incident.	The DJJ or their contracted QIO will provide notification of incidents to Florida Medicaid within 48 hours of receipt; and A contract compliance monitoring will be completed for each Redirection Service provider using a sample with a 95% confidence level with a 5% margin of error. This will be required for each program monitoring.	The DJJ or their contracted QIO will monitor providers with oversight from Florida Medicaid.	Annually	Certified Redirection Services providers will be required to report all incidents within 2 hours of the incident occurring or program staff learning of the incident, to the Central Communications Center. Providers are required to immediately respond to critical incidents. The DJJ or their contracted QIO will ensure the development of a performance improvement plan within 15 calendar days of the compliance monitoring. The DJJ or their contracted QIO will approve or disapprove the plan within 7 calendar days. The performance	The DJJ or their contracted QIO will report monitoring results to Florida Medicaid quarterly. The DJJ or their contracted QIO will monitor provider adherence to performance improvement plans no less than annually.

					improvement plan must be fully implemented within 30 calendar days of approval of the performance improvement plan. The DJJ or their contracted QIO will conduct a monitoring within 6 months of implementation to ensure performance improvement plan compliance.	
	Numerator: Files that contain informed consent, signed by the recipient and his or her parent or guardian, which informs the recipient of the provider's role as a mandated reporter in addition to providing the recipient with contact information for the Florida Abuse Hotline.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with a 95% confidence level with a 5% margin of error. This will be required for each program monitoring.	The DJJ or their contracted QIO will monitor providers with oversight from Florida Medicaid.	Annually	Florida Medicaid will ensure the development of a corrective action plan within 15 calendar days of notification of non-compliance. Medicaid will approve or disapprove the corrective action plan within 7 calendar days Florida. The corrective action plan must be fully implemented within 30 calendar days of Florida Medicaid's approval of the corrective action plan.	The DJJ or their contracted QIO report monitoring results to Florida Medicaid quarterly. The DJJ or their contracted QIO will monitor provider adherence to performance improvement plans no less than annually.

	Denominator: All Redirection services recipient files reviewed.				Florida Medicaid will conduct monitoring within 3 months of implementation to ensure corrective action plan compliance.	
	Numerator: Files reviewed that have evidence that any assessed history of trauma, (including abuse, neglect, and exploitation) was considered in the development of the recipient's service plan. Denominator: All Redirection services recipient files reviewed.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with a 95% confidence level with a 5% margin of error. This will be required for each program monitoring.	The DJJ or their contracted QIO will monitor providers with oversight from Florida Medicaid.	Annually	Florida Medicaid will ensure the development of a corrective action plan within 15 calendar days of notification of non-compliance. Medicaid will approve or disapprove the corrective action plan within 7 calendar days Florida. The corrective action plan must be fully implemented within 30 calendar days of Florida Medicaid's approval of the corrective action plan. Florida Medicaid will conduct monitoring within 3 months of implementation to ensure corrective action plan compliance.	The DJJ or their contracted QIO will report monitoring results to Florida Medicaid quarterly. The DJJ or their contracted QIO will monitor provider adherence to performance improvement plans no less than annually.

	Numerator: Files reviewed that have evidence that reported incidents of recipient abuse, neglect, or exploitation were processed in accordance with reporting guidelines. Denominator: All Redirection services recipient files reviewed that have evidence that an incident of recipient abuse, neglect, or exploitation was reported.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with a 95% confidence level with a 5% margin of error. This will be required for each program monitoring.	The DJJ or their contracted QIO will monitor providers with oversight from Florida Medicaid.	Annually	Florida Medicaid will ensure the development of a corrective action plan within 15 calendar days of notification of non-compliance. Medicaid will approve or disapprove the corrective action plan within 7 calendar days Florida. The corrective action plan must be fully implemented within 30 calendar days of Florida Medicaid's approval of the corrective action plan. Florida Medicaid will conduct monitoring within 3 months of implementation to ensure corrective action plan compliance.	The DJJ or their contracted QIO will report monitoring results to Florida Medicaid quarterly. The DJJ or their contracted QIO will monitor provider adherence to performance improvement plans no less than annually

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System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
Contract adherence and the results of compliance monitoring results will be utilized to identify and address area of programmatic concern. The DJJ or their contracted QIO will collect program success data from each certified Redirection Provider and will report these results quarterly to Florida Medicaid. The DJJ or their contracted QIO will collect data on whether or not reportable incidents of recipient abuse, neglect, or exploitation were reported to Florida Abuse Hotline within 24 hours and to the Central Communications Center within 2 hours of the incident occurring or program staff learning of the incident.	The DJJ or their contracted QIO will address quarterly compliance monitoring results and areas of contract noncompliance when developing a corrective plan of action for areas requiring improvement. The corrective action plan must be approved by Florida Medicaid. Florida Medicaid will report compliance monitoring results to the Center for Medicare and Medicaid Services (CMS) annually.	Ongoing	Florida Medicaid will monitor quarterly reports by the Department of Juvenile Justice or their contracted quality improvement organization for data trends to identify performance concerns or areas of noncompliance. When Florida Medicaid identifies performance issues or areas of noncompliance, the DJJ or their contracted QIO will be required to complete a corrective action plan within 15 days. Florida Medicaid will approve or disapprove the corrective action plan within 7 calendar days. If there is not sufficient improvement in performance after the next quarterly report, Florida Medicaid will complete a compliance monitoring and will meet with the administration of DJJ or their contracted QIO to discuss how to address corrective action plan noncompliance from the operating agency itself. Strategies for increasing compliance may include recoupments and provider terminations in addition to referrals to the Fraud Prevention and Compliance Unit or to Medicaid Program Integrity. If there are instances of noncompliance by the operating agency that could not be resolved through corrective action activities, the Florida Medicaid will consult with the CMS when developing a strategy to ensure performance measures are met.

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:

	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

☑	Other Services (specify below) – Redirection Services
	Providers of Redirection services are reimbursed an all-inclusive weekly rate based on a state-developed fee schedule. Redirection services consist of four separate components: Redirection therapy, Redirection therapeutic support, Redirection 24 hour crisis therapeutic support, and Redirection services case coordination. The weekly rate will be paid only if both the Redirection therapy and the Redirection therapeutic support component services are rendered. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Redirection services. The agency's fee schedule rate was set as of 2/18/12 and is effective for services provided on and after that date. All rates are published on the Florida Medicaid web portal, www.mymedicaid-florida.com, under public information for providers, then provider support, then fee schedules.

The Redirection Service rate is based on rates currently set for state plan services. The rates for each Redirection service are multiplied by the anticipated service frequency per week, and are then multiplied by 26 (the number of weeks in an authorization period). The rate results are then averaged and divided by 26 (the number of weeks in an authorization period).

In order to receive reimbursement of the full weekly rate both the Redirection therapy and the Redirection therapeutic support services must be rendered. When both services cannot be provided in the same week, providers can bill for the Redirection therapy service or the Redirection therapeutic support service at an individual service rate. Billing for these services individually should only occur in exceptional situations and providers must verify that recipients remained eligible for this level of service in instances when the weekly service rate is not qualified.

State of Florida

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) X MAT as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

State of Florida

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

i. General Assurance

MAT is covered for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020 and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for Opioid Use Disorder (OUD) that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

iii. Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT.

a. Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

MAT in Opioid Treatment Program (OTP)

MAT services rendered within the scope of an OTP include:

- Medically necessary behavioral health and prescription drug services for the treatment of OUD, including methadone administration, counseling, case review, and medication monitoring.

MAT in Office-Based Opioid Treatment (OBOT)

MAT Behavioral Health Services

MAT behavioral health services for the treatment of OUD includes counseling services such as individual and group counseling sessions.

State of Florida

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

Additional MAT Coverage

Additional MAT Coverage for the treatment of OUD includes medical assessment, and subsequent prescription(s).

For the period of October 1, 2020, through September 30, 2025 Medication Assisted Treatment (MAT) to treat Opioid Use Disorder (OUD) is covered exclusively under section 1905(a)(29).

b. Please include each practitioner and provider entity that furnishes each service and component service.

Opioid Treatment Program (OTP)

OTPs render MAT for opioid addiction delivered under the supervision of a physician or psychiatrist.

Medication administration and monitoring is provided by physicians, physician assistants, nurses, or nurse practitioners licensed in the State of Florida and working within the scope of their practice.

Counseling services are provided by:

- Licensed professionals working within the scope of practice;
- Unlicensed professionals working under the direct supervision of a licensed qualified professional:
  - Registered marriage and family therapy, clinical social work, and mental health counseling interns;
  - Certified master's degree level addiction professionals who are certified by the Florida Certification Board;
  - Certified addictions professionals who are certified by the Florida Certification Board;
  - Certified addiction counselors who are certified by the Florida Certification Board.
  - Certified recovery peer specialists
  - Certified recovery support specialists

Office Based Opioid Treatment (OBOT)

The following providers can deliver all aspects of the MAT for OUD service benefit:

- Physicians, physician assistants, nurses, or nurse practitioners licensed in the State of Florida and working within the scope of their practice.

State of Florida

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

The following providers can provide individual, family, or group counseling:

- Physicians licensed in the State of Florida and working within the scope of their practice.
- Psychiatric advanced practice registered nurses licensed in the State of Florida working within their scope of practice
- Mental health professionals licensed in the State of Florida working within their scope of their practice
- Master's level certified addiction professionals
- Master's level practitioners

The following providers can provide group counseling:

- Psychiatric nurses licensed in the State of Florida working within the scope of their practice
- Bachelor's level practitioners
- Certified addiction professionals

The following providers can deliver MAT for OUD-related services to recipients under the terms of a collaborative pharmacy practice agreement with a licensed physician:

- Pharmacists licensed in the State of Florida and working within their scope of practice.

c. Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

- Physicians licensed in the State of Florida and working within the scope of their practice.
- Psychiatric advanced practice registered nurses licensed in the State of Florida working within their scope of practice.
- Nurses licensed in the State of Florida and working within the scope of their practice.
- Physician assistants licensed in the State of Florida and working within the scope of their practice.
- Mental health professionals licensed in the State of Florida and working within the scope of their practice.
- Pharmacists licensed in the State of Florida and working within their scope of practice.

State of Florida

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

- Registered marriage and family therapy, clinical social work, and mental health counseling interns who:
  - hold a degree from an accredited university or college with a major in counseling, social work, psychology, nursing, rehabilitation, special education, health education, or a related human services field
- Certified master's degree level addiction professionals who:
  - hold a Master's degree from an accredited university or college with a major in counseling, social work, psychology, nursing, rehabilitation, special education, health education, or a related human services field and are certified by the Florida Certification Board;
- Certified addictions professionals who:
  - hold a Bachelor's degree from an accredited university or college with a major in counseling, social work, psychology, nursing, rehabilitation, special education, health education, or a related human services field
  - are certified by the Florida Certification Board;
- Certified addiction counselors who:
  - hold a Bachelor's degree from an accredited university or college with a major in counseling, social work, psychology, nursing, rehabilitation, special education, health education, or a related human services field
  - are certified by the Florida Certification Board.
- Certified recovery peer specialists and certified recovery support specialists who:
  - have a minimum of three (3) years of experience providing recovery support services to individuals with substance use disorders;
  - are certified by the Florida Certification Board.
  - Recovery support specialists and recovery peer specialists are allowed one year from the date of their employment to obtain certification through the Florida Certification Board.

Providers that administer Methadone through MAT must meet the requirements in 42 C.F.R. Part 8 and be certified as an Opioid Treatment Program by the Federal Substance Abuse and Mental Health Services Administration. (other requirements are in (b) above)

iv. Utilization Controls

__X__ The state has drug utilization controls in place. (Check each of the following that apply)

_____ Generic first policy
__X__ Preferred drug lists
__X__ Clinical criteria

State of Florida

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

__X__ Quantity limits

_____ The state does not have drug utilization controls in place.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

MAT Behavioral Health Services

MAT behavioral health services for the treatment of OUD includes counseling and Methadone administration. :

- Services are limited in amount, duration, and scope to:
  - mental health and substance abuse services that are provided for the maximum reduction of the recipient's mental health
  - substance abuse disability and restoration to the best possible functional level.
  - those which are medically necessary and are recommended by a licensed practitioner, psychiatrist, or other physician and included in a treatment plan.

MAT services for the treatment of OUD through an Opioid Treatment Program (OTP) are limited to 52 visits per state fiscal year. Exceptions to these service limitations can be granted with prior authorization based on medical necessity.

MAT for OUD in a non-OTP

Counseling limit is 136 15-minute units per fiscal year of individual counseling; group counseling limit is 174 15-minute units per fiscal year. Exceptions to these service limitations can be granted with prior authorization based on medical necessity.

MAT Prescribed Drugs

MAT medications are reviewed by the State's Pharmaceutical and Therapeutics (P&T) Committee to determine inclusion on the preferred drug list. Age and quantity limits are based on the manufacturer's prescribing information and evaluation of usage by the State and/or the Drug Utilization Review Board, as defined in section 4.26 of this plan.

State of Florida

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on 10/24/2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 68). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: FLORIDA

MEDICAID ELIGIBILITY GROUPS SERVED

a. Home and community care services will be made available to individuals age 65 or older, when the individuals have been determined to be functionally disabled as specified in Appendix B.

b. Individuals served under this provision must meet the following Medicaid eligibility criteria (check all that apply):

1. _____ Age 65 or older who have been determined to be functionally disabled (as determined under the SSI program) as specified in Appendix B.

A. _____ The agency uses the same methodologies for treatment of income and resources as used in the SSI program (or the optional State supplement program which meets the requirements of 42 CFR 435.230, as appropriate). Individuals must be receiving SSI/SSP benefits to be eligible under this provision.

B. _____ The agency uses methodologies for treatment of income and resources that differ from those of the SSI program. These differences result from restrictions applied under section 1902(f) of the Act. The methodologies are described in Supplement 5 to Attachment 2.6-A. Individuals must be eligible for Medicaid under the State's plan to be eligible under this provision.

2. _____ Medically needy, age 65 or older who have been determined to be functionally disabled as specified in Appendix B. In determining the individual's eligibility, the State may, at its option, provide for the determination of the individual's anticipated medical expenses (to be deducted from income). (Check one):

A. _____ The State does not consider anticipated medical expenses.

B. _____ The State considers anticipated medical expenses over a period of _____ months (not to exceed 6 months).

State: FLORIDA

INDIVIDUALS PREVIOUSLY COVERED UNDER A WAIVER

a. _____ The State used a health insuring organization before January 1, 1986, and had in effect a waiver under §1115 of the Act, which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. In accordance with §1929(b)(2)(B) of the Act, the following individuals will be eligible to receive home and community care services. (Check all that apply):

1. _____ Age 65 or older.

2. _____ Disabled, receiving SSI.

These individuals meet the resource requirement and income standards that apply in the State to individuals described in §1902(a)(10)(A)(ii)(V) of the Act.

b. _____ In accordance with §1929(b)(2)(A) the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. This waiver was terminated during the period in which the State furnished home and community care to functionally disabled elderly individuals under its State plan. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

c. _____ In accordance with §1929(b)(2)(A) the Act, individuals age 65 or older, who were served under a waiver granted pursuant to section 1915(d) of the Act on the date on which that waiver was terminated. This waiver was terminated during the period in which the State furnished home and community care to functionally disabled elderly individuals under its State plan. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

State: FLORIDA

FUNCTIONAL DISABILITY

Home and community care services, as defined in this Supplement, are provided to the following classifications of individuals who have been found on the basis of an assessment to be functionally disabled. Services will be limited to individuals who meet the following targeting criteria.

Check all that apply:

a. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with at least two of the following activities of daily living: toileting, transferring, eating.

b. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with each of the following activities of daily living: toileting, transferring, eating.

c. _____ Services are provided to individuals who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, at least 2 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

d. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, (check one):

1. _____ at least 3 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

2. _____ at least 4 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

3. _____ all of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

e. _____ Services are provided to individuals who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are sufficiently cognitively impaired so as to require substantial supervision from another individual because they engage in inappropriate behaviors that pose serious health or safety hazards to themselves or others.

State: FLORIDA

AGE

Check all that apply:

a. _____ Services are provided to individuals age 65 and older.

b. _____ Services are provided to individuals who have reached at least the following age, greater than 65 (specify): _____

c. _____ Services are provided to individuals who meet the criteria set forth in item 3.b. of Supplement 2, as set forth in Appendix B-3, who were 65 years of age or older on the date of the waiver's discontinuance.

d. _____ Services are provided to individuals who meet the criteria set forth in item 3.c. of Supplement 2, as set forth in Appendix B-3, who were served under the waiver on the date of its discontinuance.

e. _____ Services are provided to individuals who meet the criteria in item 3.d. of Supplement 2, who fall within the following age categories (check all that apply):

1. _____ Age 65 and older

2. _____ Age greater than 65. Services are limited to those who have attained at least the age of (specify): _____

3. _____ Age less than 65. Services will be provided to those in the following age category (specify): _____

4. _____ The State will impose no age limit.

State: FLORIDA

INDIVIDUALS PREVIOUSLY SERVED UNDER WAIVER AUTHORITY

a. _____ In accordance with §1929(b)(2)(A) of the Act, the State will discontinue the following home and community-based services waiver(s), approved under the authority of §1915(c) or §1915(d) of the Act. (Specify the waiver numbers):

Waiver Number	Last date of waiver operation
_____	_____
_____	_____
_____	_____
_____	_____

b. For each waiver specified in Appendix B-3-a, above, the State will furnish at least 30 days notice of service discontinuance to those individuals under 65 years of age, and to those individuals age 65 or older who do not meet the test of functional disability specified in Appendix B-1 (except those individuals who will continue to receive home and community-based services under a different waiver program).

c. Individuals age 65 years of age or older, who were eligible for benefits under a waiver specified in Appendix B-3-a on the last date of waiver operation, who would, but for income or resources, be eligible for home and community care under the State plan, shall be deemed functionally disabled elderly individuals for so long as they would have remained eligible for services under the waiver.

d. The financial eligibility standards which were in effect on the last date of waiver operation are attached to this Appendix.

e. The following are the schedules, in effect on the last date of waiver operation, under which individuals served under a waiver identified in Appendix B-3-a were reevaluated for financial eligibility (specify):

Waiver Number	Reevaluation schedule
_____	_____
_____	_____
_____	_____
_____	_____

State: FLORIDA

DEFINITION OF SERVICES

The State requests that the following services, as described and defined herein, be provided as home and community care services to functionally disabled elderly individuals under this program:

a. _____ Homemaker Services. (Check one.)

_____ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities. This service does not include medical care of the client. Hands-on care is limited to such activities as assistance with dressing, uncomplicated feeding, and pushing a wheelchair from one room to another. Direct care furnished to the client is incidental to care of the home. These standards are included in Appendix C-2.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

b. _____ Home Health Aide Services. (Check one.)

_____ Services defined in 42 CFR 440.70 with the exception that limitations on the amount, duration and scope of such services shall instead be governed by the limitations imposed below.

_____ Other Service Definition: _____

State: FLORIDA

DEFINITION OF SERVICES (con't)

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

c. _____ Chore Services. (Check one.)

_____ Services identified in the ICCP which are needed to maintain the individual's home in a clean, sanitary and safe environment. For purposes of this section, the term "home" means the abode of the individual, whether owned or rented by the client, and does not include the residence of a paid caregiver with whom the client resides (such as a foster care provider), or a small or large community care facility.

Covered elements of this service include heavy household chores such as washing floors, windows and walls, removal of trash, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access inside the home for the recipient, and shoveling snow to provide access and egress.

Chore services will be provided only in cases where neither the client, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

State: FLORIDA

DEFINITION OF SERVICES (con't)

Provider qualifications are specified in Appendix C-2.

d. _____ Personal Care Services. (Check one.)

_____ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service includes meal preparation, when required by the individual community care plan (ICCP), but does not include the cost of the meals. When specified in the ICCP, this service also includes such housekeeping chores as bedmaking, cleaning, shopping, or escort services which are appropriate to maintain the health and welfare of the recipient. Providers of personal care services must meet State standards for this service. These standards are included in Appendix C-2.

_____ Other Service Definition: _____

1. Services provided by family members. Check one:

_____ Payment will not be made for personal care services furnished by a member of the recipient's family or by a person who is legally or financially responsible for that recipient.

_____ Personal care providers may be members of the recipient's family. Payment will not be made for services furnished to a minor by the recipient's parent (or stepparent), or to a recipient by the recipient's spouse. Payment will not be made for services furnished to a recipient by a person who is legally or financially responsible for that recipient.

Check one:

_____ Family members who provide personal care services must meet the same standards as other personal care providers who are unrelated to the recipient. These standards are found in Appendix C-2.

_____ Standards for family members who provide personal care services differ from those for other providers of this service. The standards for personal care services provided by family members are found in Appendix C-2.

2. Personal care providers will be supervised by:

_____ a registered nurse, licensed to practice nursing in the State

_____ case managers

_____ other (specify): _____

State: FLORIDA

DEFINITION OF SERVICES (con't)

3. Minimum frequency or intensity of supervision:

_____ as indicated in the client's ICCP

_____ other (specify): _____

4. Personal care services are limited to those furnished in a recipient's home.

_____ Yes _____ No

5. Limitations (check one):

_____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

_____ The State will impose the following limitations on the provision of this service (specify): _____

e. _____ Nursing Care Services Provided By or Under The Supervision of a Registered Nurse.

_____ Nursing services listed in the ICCP which are within the scope of State law, 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. Standards for the provision of this service are included in Appendix C-2.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

State: FLORIDA

DEFINITION OF SERVICES (con't)

f. _____ Respite care. (Check one.)

_____ Services given to individuals unable to care for themselves; provided on a short-term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

_____ Other Service Definition: _____

1. Respite care will be provided in the following location(s):

_____ Recipient's home or place of residence

_____ Foster home

_____ Facility approved by the State which is not a private residence

2. The State will apply the following limits to respite care provided in a facility.

_____ Hours per recipient per year

_____ Days per recipient per year

_____ Respite care will be provided in accordance with the ICCP. There are no set limits on the amount of facility-based respite care which may be utilized by a recipient.

_____ Not applicable. The State does not provide facility-based respite care.

3. Respite care will be provided in the following type(s) of facilities.

_____ Hospital

_____ NF

_____ ICF/MR

_____ Group home

_____ Licensed respite care facility

State: FLORIDA

DEFINITION OF SERVICES (con't)

_____ Other (specify): _____

_____ Not applicable. The State does not provide facility-based respite care.

4. The State will apply the following limits to respite care provided in a community setting which is not a facility (including respite care provided in the recipient's home).

_____ Hours per recipient per year
_____ Days per recipient per year

_____ Respite care will be provided in accordance with the ICCP. There are no set limits on the amount of community-based respite care which may be utilized by a recipient.

_____ Not applicable. The State does not provide respite care outside a facility-based setting.

Qualifications of the providers of respite care services are included in Appendix C-2. Applicable Keys amendment (section 1616(e) of the Social Security Act) standards are cited in Appendix F-2.

g. _____ Training for Family Members in Managing the Individual. (Check one.)

_____ Training and counseling services for the families of functionally disabled elderly individuals. For purposes of this service, "family" is defined as the persons who live with or provide care to a disabled individual, and may include a spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the functionally disabled individual. Training includes instruction about treatment regimens and use of equipment specified in the ICCP and shall include updates as may be necessary to safely maintain the individual at home. This service is provided for the purpose of increasing the ability of a primary caregiver or a member of the recipient's family to maintain and care for the individual at home. All training for family members must be included in the client's ICCP.

_____ Other Service Definition: _____

State: FLORIDA

DEFINITION OF SERVICES (con't)

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

h. _____ Adult Day Care. (Check one.)

_____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the client. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

_____ Other Service Definition: _____

Check all that apply:

1. _____ Physical therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of physical therapy will be included in the rate paid to providers of adult day care services.

2. _____ Occupational therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of occupational therapy will be included in the rate paid to providers of adult day care services.

3. _____ Speech therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of speech therapy will be included in the rate paid to providers of adult day care services.

State: FLORIDA

DEFINITION OF SERVICES (con't)

4. _____ Nursing care furnished by or under the supervision of a registered nurse, and indicated in the individual's ICCP, will be provided by the facility as a component part of this service.

5. _____ Transportation between the recipient's place of residence and the adult day care center will be provided as a component part of this service. The cost of this transportation is included in the rate paid to providers of adult day care services.

6. _____ Other therapeutic activities which will be provided by the facility as component parts of this service. (Specify): _____

Limitations. Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

i. _____ Services for individuals with chronic mental illness, consisting of (Check all that apply):

1. _____ Day Treatment or other Partial Hospitalization Services. (Check one.)

_____ Services that are necessary for the diagnosis or active treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

State: FLORIDA

DEFINITION OF SERVICES (con't)

b. occupational therapy, requiring the skills of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients,

d. drugs and biologicals furnished for therapeutic purposes,

e. individual activity therapies that are not primarily recreational or diversionary,

f. family counseling (the primary purpose of which is treatment of the individual's condition),

g. patient training and education (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

h. diagnostic services.

Meals and transportation are excluded from reimbursement under this benefit. The purpose of this benefit is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

_____ Other Service Definition: _____

Limitations. Check one:

a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

b. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

2. _____ Psychosocial Rehabilitation Services. (Check one.)

State: FLORIDA

DEFINITION OF SERVICES (con't)

_____ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- o Restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- o Social skills training in appropriate use of community services;
- o Development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- o Telephone monitoring and counseling services.

The following services are specifically excluded from Medicaid payment:

Vocational services,
Prevocational services,
Supported employment services,
Educational services, and
Room and board.

_____ Other Service Definition: _____

Psychosocial rehabilitation services are furnished in the following locations (check all that apply):

a. _____ Individual's home or place of residence

b. _____ Facility in which the individual does not reside

c. _____ Other (Specify): _____

State: FLORIDA

DEFINITION OF SERVICES (con't)

Limitations. Check one:

a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

b. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

3. _____ Clinic Services (Whether or Not Furnished in a Facility) are services defined in 42 CFR 440.90.

Check one:

a. _____ This benefit is limited to those services furnished on the premises of a clinic.

b. _____ Clinic services may be furnished outside the clinic facility. Services may be furnished in the following locations (specify): _____

Check one:

a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

b. _____ The State will impose the following limitations on the provision of this service (specify): _____

State: FLORIDA

DEFINITION OF SERVICES (con't)

Qualifications of the providers of this service are found in Appendix C-2.

j. _____ Habilitation. (Check one.)

_____ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully at home or in the community. This service includes:

1. _____ Residential habilitation: assistance with acquisition, retention or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a home or community setting. Payments for residential habilitation are not made for room and board, or the costs of facility maintenance, upkeep, and improvement. 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 routine care and supervision, or for activities or supervision for which a payment is available from a source other than Medicaid. The methodology by which payments are calculated and made is described in Attachment 4.19-B.

2. _____ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the recipient resides. Services shall normally be furnished 4 or more hours per day, on a regularly scheduled basis, for 1 or more days per week, unless provided as an adjunct to other day activities included in the recipient's ICCP. Day habilitation services shall focus on enabling the individual to attain or retain his or her maximum functional level.

_____ Other Service Definition: _____

State: FLORIDA

DEFINITION OF SERVICES (con't)

Check all that apply:

A. _____ Physical therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of physical therapy will be included in the rate paid to providers of habilitation services.

B. _____ Occupational therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of occupational therapy will be included in the rate paid to providers of habilitation services.

C. _____ Speech therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of speech therapy will be included in the rate paid to providers of habilitation services.

D. _____ Nursing care furnished by or under the supervision of a registered nurse, and indicated in the individual's ICCP, will be provided by the facility as a component part of this service.

E. _____ Transportation between the recipient's place of residence and the habilitation center will be provided as a component part of this service. The cost of this transportation is included in the rate paid to providers of habilitation services.

F. _____ Other therapeutic activities which will be provided by the facility as component parts of this service. (Specify):_____

_____

_____

_____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

State: FLORIDA

DEFINITION OF SERVICES (con't)

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Payment will not be made for the following:

Vocational Services;
Prevocational services;
Educational services; or
Supported employment services.

Qualifications of the providers of this service are specified in Appendix C-2.

k. _____ Environmental Modifications. (Check one.)

_____ Those physical adaptations to the home, required by the individual's ICCP, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home.

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies the need for which is identified in the client's ICCP.

Adaptations or improvements to the home which are of general utility, or which are not of direct medical or remedial benefit to the client, such as carpeting, roof repair, central air conditioning, etc., are specifically excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

State: FLORIDA

DEFINITION OF SERVICES (con't)

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

l. _____ Transportation. (Check one.)

_____ Service offered in order to enable individuals receiving home and community care under this section to gain access to services identified in the ICCP. Transportation services under this section shall be offered in accordance with the recipient's ICCP, and shall be used only when the service is not available without charge from family members, neighbors, friends, or community agencies, and when the appropriate type of transportation is not otherwise provided under the State plan. In no case will family members be reimbursed for the provision of transportation services under this section.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

m. _____ Specialized Medical Equipment and Supplies. (Check one.)

_____ Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the ICCP, which enable clients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This

State: FLORIDA

DEFINITION OF SERVICES (con't)

service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and supplies not otherwise available under the State plan. Items which are not of direct medical or remedial benefit to the recipient are excluded from this service. All specialized medical equipment and supplies provided under this benefit shall meet applicable standards of manufacture, design and installation.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

n. _____ Personal Emergency Response Systems (PERS). (Check one.)

_____ PERS is an electronic device which enables certain high-risk clients to secure help in the event of an emergency. The client may also wear a portable "help" button to allow for mobility. The system is connected to the client's phone and programmed to signal a response center once the "help" button is activated. The response center is staffed by individuals with the qualifications specified in Appendix C-2.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

State: FLORIDA

DEFINITION OF SERVICES (con't)

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

o. _____ Adult Companion Services. (Check one.)

_____ Non-medical care, supervision and socialization provided to a functionally disabled adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on medical care. Companion services may include non-medical care of the client, such as assistance with bathing, dressing and uncomplicated feeding. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the client. This service is provided in accordance with a therapeutic goal in the ICCP, and is not merely diversionary in nature.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

3. Services provided by family members. Check one:

A. _____ Payment will not be made for adult companion services furnished by a member of the recipient's family or by a person who is legally or financially responsible for that recipient.

State: FLORIDA

DEFINITION OF SERVICES (con't)

B. _____ Adult companion service providers may be members of the recipient's family. Payment will not be made for services furnished to a minor by the recipient's parent (or stepparent), or to a recipient by the recipient's spouse. Payment will not be made for services furnished to a recipient by a person who is legally or financially responsible for that recipient.

Check one:

1._____ Family members who provide adult companion services must meet the same standards as other adult companion providers who re unrelated to the recipient. These standards are found in Appendix C-2.

2._____ Standards for family members who provide adult companion services differ from those for other providers of this service. The standards for adult companion services provided by family members are found in Appendix C-2.

p. _____ Attendant Care. (Check one.)

_____ Hands-on care, of both a medical and non-medical supportive nature, specific to the needs of a medically stable, physically handicapped individual. This service may include skilled medical care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of the client-based care may also be furnished as part of this activity.

_____ Other Service Definition: _____

Check all that apply:

1. _____ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the ICCP.

State: FLORIDA

DEFINITION OF SERVICES (con't)

2. _____ Supervision may be furnished directly by the client, when the client has been trained to perform this function, and when the safety and efficacy of client-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on observation of the client and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained with the client's ICCP.

3. _____ Other supervisory arrangements: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

q. _____ Private Duty Nursing. (Check one.)

_____ Private Duty Nursing services consist of individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within their scope of practice under State law.

_____ Other Service Definition: _____

Check one:

1. _____ Private duty nursing services are limited to services provided in the individual's home or place of residence.

State: FLORIDA

DEFINITION OF SERVICES (con't)

2. _____ Private duty nursing services are not limited to services provided in the individual's home or place of residence.

Check one:

A. _____ Services may also be provided in the following locations (Specify):

_____
_____
_____

B. _____ The State will not place limits on the site of private duty nursing services.

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____
_____
_____
_____
_____
_____
_____

r. _____ Extended State Plan Services. The following services are available under the State plan, but with limitations. Under this benefit, these services will be provided in excess of the limitations otherwise specified in the plan. Provider standards will remain unchanged from those otherwise indicated in the State plan. When these services are provided as home and community care, the limitations on each service will be as specified in this section.

1. _____ Physician services.

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____
_____
_____
_____

State: FLORIDA

DEFINITION OF SERVICES (con't)

2. _____ Home Health Care Services

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

3. _____ Physical Therapy Services

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

4. _____ Occupational Therapy Services

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

5. _____ Speech, Hearing and Language Services

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

State: FLORIDA

DEFINITION OF SERVICES (con't)

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

6. _____ Prescribed Drugs

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

8. _____ Other services (specify): _____

Provider standards for each "other" services identified are found in Appendix C-2.

State: FLORIDA

PROVIDER QUALIFICATIONS

a. The following are the minimum qualifications for the provision of each home and community care service under the plan.

LICENSURE AND CERTIFICATION CHART

Cite relevant portions of State licensure and certification rules as they apply to each service to be provided.

SERVICE	PROVIDER TYPE	LICENSURE	CERTIFICATION
HOMEMAKER			
HOME HEALTH AIDE			
CHORE SERVICES			
PERSONAL CARE			
NURSING CARE			
RESPITE CARE			
IN HOME			
FACILITY BASED			
FAMILY TRAINING			
ADULT DAY CARE			
DAY TREATMENT/ PARTIAL HOSPITALIZATION			
PSYCHOSOCIAL REHABILITATION			
CLINIC SERVICES			

State: FLORIDA

PROVIDER QUALIFICATIONS (con't)

SERVICE	PROVIDER TYPE	LICENSURE	CERTIFICATION
HABILITATION			
RESIDENTIAL			
DAY			
ENVIRONMENTAL MODIFICATIONS			
TRANSPORTATION			
MEDICAL EQUIPMENT AND SUPPLIES			
PERSONAL EMERGENCY RESPONSE SYSTEMS			
ADULT COMPANION			
ATTENDANT CARE			
PVT DUTY NURSING			

Identify any licensure and certification standards applicable to the providers of "other" services defined in Appendix C-1 on a separate sheet of paper. Attach the paper to this Appendix.

Identify any additional standards applicable to each service on a separate sheet of paper. Attach the paper to this Appendix.

b. ASSURANCE THAT REQUIREMENTS ARE MET

1. The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under this section.

2. The State will require each provider furnishing services under this section to furnish proof that all applicable requirements for service provision, specified in this Appendix, are met prior to the provision of services for which FFP is claimed.

3. The State assures that it will review each provider at least once a year, to ensure that provider requirements continue to be met.

c. PROVIDER REQUIREMENTS APPLICABLE TO ALL SERVICES

In addition to standards of licensure and certification, each individual furnishing services under this section must demonstrate the following to the satisfaction of the State:

1. Familiarity with the needs of elderly individuals. The degree of familiarity must be commensurate with the type of service to be provided.

State: FLORIDA

PROVIDER QUALIFICATIONS (con't)

2. If the provider is to furnish services to individuals with Alzheimer's Disease or to recipients with other mental impairments, familiarity with the course and management of this disease, commensurate with the type of service to be provided.

3. The provider must furnish proof of sufficient ability to communicate with the client or primary caregiver. To be considered sufficient, this ability must be commensurate with the type of service to be provided.

4. Each provider must have received training, appropriate to the demands of the service to be provided, in proper response to emergency situations. This training must include instruction in how to contact the client's case manager.

5. Each provider must be qualified by education, training, experience and/or examination in the skills necessary for the performance of the service.

6. Providers may meet these standards by the following methods:

   A. Education, including formal degree requirements specified in the provider qualifications for the service to be furnished.

   B. Specific course(s), identified in the provider qualifications for the service to be furnished.

   C. Documentation that the provider has completed the equivalent of the course(s) identified in item c.6.B, above.

   D. Training provided by the Medicaid agency or its designee.

      The Medicaid agency or its designee will also make this training available to unpaid providers of service.

      _____ Yes _____ No

   E. Appropriate experience (specified in the provider qualifications for the applicable service) which may substitute for the education and training requirements otherwise applicable.

   F. The provider may demonstrate competence through satisfactory performance of the duties attendant upon the specified service. With regard to particular providers, and particular services, the State may also choose to require satisfactory completion of a written or oral test. Test requirements are included in the provider requirements applicable to the specific service.

Specific standards of education, training, experience, and/or demonstration of competence applicable to each service provided are attached to this Appendix.

d. PROVIDER REQUIREMENTS SPECIFIC TO EACH SERVICE

State: FLORIDA

PROVIDER QUALIFICATIONS (con't)

In addition to the licensure and certification standards cited in Appendix, the State will impose the following qualifications for the providers of each service.

SERVICE	MINIMUM QUALIFICATIONS OF PROVIDERS
HOMEMAKER	
HOME HEALTH AIDE	Providers of Home Health Aide services meet the qualifications set forth at 42 CFR Part 484 for the provision of this service under the Medicare program. Additional qualifications:
CHORE SERVICES	
PERSONAL CARE	
NURSING CARE	
RESPITE CARE IN HOME	
FACILITY BASED	
FAMILY TRAINING	
ADULT DAY CARE	
DAY TREATMENT/PARTIAL HOSPITALIZATION	Day treatment/partial hospitalization services are furnished by a hospital to its outpatients, or by a community mental health center. They are furnished by a distinct and organized ambulatory treatment center which offers care less than 24 hours a day.
PSYCHOSOCIAL REHABILITATION	
CLINIC SERVICES	
HABILITATION GENERAL STANDARDS	
RESIDENTIAL HABILITATION	
DAY HABILITATION	

State: FLORIDA

PROVIDER QUALIFICATIONS (con't)

SERVICE	MINIMUM QUALIFICATIONS OF PROVIDERS
ENVIRONMENTAL MODIFICATIONS	
TRANSPORTATION	
MEDICAL EQUIPMENT AND SUPPLIES	
PERSONAL EMERGENCY RESPONSE SYSTEMS	
ADULT COMPANION	
ATTENDANT CARE	
PVT DUTY NURSING	

Identify the provider requirements applicable to the providers of each "other" service specified in Appendix C-1 on a separate sheet of paper. Attach the paper to this Appendix.

State: FLORIDA

ASSESSMENT

a. The State will provide for a comprehensive functional assessment for a financially eligible individual who meets the targeting requirements set forth in items 3 and 4 of Supplement 2.

b. This assessment will be provided at the request of the individual, or another person acting on the individual's behalf.

c. The individual will not be charged a fee for this assessment.

d. Attached to this Appendix is an explanation of the procedures by which the State will ensure the performance of the assessment.

e. The assessment will be reviewed and revised not less often than (check one):

1. _____ Every 12 months

2. _____ Every 6 months

3. _____ Other period not to exceed 12 months (Specify): _____

f. Check one:

1. _____ The State will use an assessment instrument specified by HCFA.

2. _____ The State will use an assessment instrument of its own specification. A copy of this instrument is attached to this Appendix. The State certifies that this instrument will measure functional disability as specified in section 1929(b) and (c) of the Act. The State requests that HCFA approve the use of this instrument, and certifies that at such time as HCFA may publish a minimum data set (consistent with section 1929(c)(2) of the Act), the assessment instrument will be revised, as determined necessary by HCFA, to conform to the core elements, common definitions, and uniform guidelines which are contained in the minimum data set.

g. In conducting the assessment (or the periodic review of the assessment), the interdisciplinary team must:

1. Identify in each such assessment or review each individual's functional disabilities; and

2. Identify in each such assessment or review each individual's need for home and community care. This identification shall include:

A. Information about the individual's health status;

B. Information about the individual's home and community environment; and

C. Information about the individual's informal support system.

State: FLORIDA

ASSESSMENT (con't)

3. Determine whether the individual is, or continues to be, functionally disabled. This determination will be made on the basis of the assessment or review.

h. The interdisciplinary team conducting the assessment shall furnish the results to the Medicaid agency and to the qualified community care case manager designated by the Medicaid agency (as specified in Appendix E) to establish, review and revise the individual's ICCP.

i. The Medicaid agency will monitor the appropriateness and accuracy of the assessments and periodic reviews on an ongoing basis, and whenever it is informed by a qualified community care case manager that inaccuracies appear to exist in the assessment of an individual. All problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.

State: FLORIDA

INTERDISCIPLINARY TEAM

a. Initial assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. _____ The interdisciplinary teams will be employed directly by the Medicaid agency.

2. _____ The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.

3. _____ The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.

4. _____ The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides community care or nursing facility services.

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting comprehensive functional assessments.

When assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the assessments without the prior written approval of the Medicaid agency.

b. Periodic reviews of assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. _____ The interdisciplinary teams will be employed directly by the Medicaid agency.

2. _____ The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.

3. _____ The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.

4. _____ The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides community care or nursing facility services.

State: FLORIDA

INTERDISCIPLINARY TEAM (con't)

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting periodic reviews of the individuals' comprehensive functional assessments.

When periodic reviews of assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the periodic reviews without the prior written approval of the Medicaid agency.

c. The interdisciplinary teams conducting initial assessments shall consist, at a minimum, of (check all that apply, but at least 2):

1. _____ Registered nurse, licensed to practice in the State
2. _____ Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. _____ Physician (M.D. or D.O.), licensed to practice in the State
4. _____ Social Worker (qualifications attached to this Appendix)
5. _____ Case manager
6. _____ Other (specify): _____

d. The interdisciplinary teams conducting periodic reviews of assessments shall consist, at a minimum, of (check all that apply, but at least 2):

1. _____ Registered nurse, licensed to practice in the State
2. _____ Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. _____ Physician (M.D. or D.O.), licensed to practice in the State
4. _____ Social Worker (qualifications attached to this Appendix)
5. _____ Case manager
6. _____ Other (specify): _____

State: FLORIDA

INDIVIDUAL COMMUNITY CARE PLAN (ICCP)

a. A written individual community care plan (ICCP) will be developed for each individual who has been determined, on the basis of a comprehensive functional assessment performed in accordance with Appendix D, to be a functionally disabled elderly individual, according to the criteria set forth in Appendices A and B.

b. The ICCP will be established, and periodically reviewed and revised, by a Qualified Community Care Case Manager after a face to face interview with the individual or primary caregiver.

c. The ICCP will be based on the most recent comprehensive functional assessment of the individual conducted according to Appendix D.

d. The ICCP will specify, within the amount, duration and scope of service limitations set forth in Appendix C, the home and community care to be provided to such individual under the plan.

e. The ICCP will indicate the individual's preferences for the types and providers of services.

f. The ICCP will specify home and community care and other services required by such individual. (Check one):

1. _____ Yes 2. _____ No

g. The ICCP will designate the specific providers (who meet the qualifications specified in Appendix C-2) which will provide the home and community care. (Check one):

1. _____ Yes 2. _____ No

h. Neither the ICCP, nor the State, shall restrict the specific persons or individuals (who meet the requirements of Appendix C-2) who will provide the home and community care specified in the ICCP.

State: FLORIDA

QUALIFIED COMMUNITY CARE CASE MANAGERS

a. A "Qualified Community Care Case Manager" will meet each of the following qualifications for the provision of community care case management.

1. Be a nonprofit or public agency or organization;

2. Have experience or have been trained in:

A. Establishing and periodically reviewing and revising ICCPs; and

B. The provision of case management services to the elderly.

The minimum standards of experience and training which will be employed by the State are attached to this Appendix;

3. Have procedures for assuring the quality of case management services. These procedures will include a peer review process.

4. The State will assure that community care case managers are competent to perform case management functions, by requiring the following educational or professional qualifications be met. (Check all that apply):

A. _____ Registered nurse, licensed to practice in the State

B. _____ Physician (M.D. or D.O.), licensed to practice in the State

C. _____ Social Worker (qualifications attached to this Appendix)

D. _____ Other (specify): _____

b. When community care case management is provided by a nonprofit, nonpublic agency, the agency providing the community case management will not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides home and community care or nursing facility services and will not furnish home and community care or nursing facility services itself. (Check one):

1. _____ Yes

2. _____ Not applicable. The State will not use nonprofit, nonpublic agencies to provide community care case management.

c. The State will employ procedures to assure that individuals whose home and community care is managed by qualified community care case managers are not at risk of financial exploitation due to such managers. An explanation of these procedures is attached to this Appendix.

State: FLORIDA

QUALIFIED COMMUNITY CARE CASE MANAGERS (con't)

d. The State requests that the requirements of item E-2-b be waived in the case of a nonprofit agency located in a rural area. The State's definition of "rural area" is attached to this Appendix. (Check one):

1. _____ Yes 2. _____ No

3. _____ Not applicable. The State will not use nonprofit, nonpublic agencies to provide community care case management.

State: FLORIDA

COMMUNITY CARE CASE MANAGEMENT FUNCTIONS

a. A qualified community care case manager is responsible for:

1. Assuring that home and community care covered under the State plan and specified in the ICCP is being provided;

2. Visiting each individual's home or community care setting where care is being provided not less often than once every 90 days;

3. Informing the elderly individual or primary caregiver how to contact the case manager if service providers fail to properly provide services or other similar problems occur. This information will be provided verbally and in writing.

4. Completes the ICCP in a timely manner; and

5. Reviews and discusses new and revised ICCPs with elderly individuals or primary caregivers.

b. Whenever a qualified community care case manager has reason to believe that an individual's assessment or periodic review (conducted under Appendix D) appears to contain inaccuracies, the community care case manager will bring these apparent discrepancies to the attention of the agency which has performed the assessment or review. If the assessors and the community care case manager are unable to resolve the apparent conflict, the case manager shall report the situation to the component of the Medicaid agency which is responsible for monitoring the program.

1. _____ Yes 2. _____ No

c. Whenever a qualified community care case manager is informed by an elderly individual or primary caregiver that provider(s) have failed to provide services, or that other similar problems have occurred, the community care case manager shall take whatever steps are necessary to verify or disprove the complaint. If a problem is confirmed by this monitoring, the community care case manager shall address the problem in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted. This may include reporting the situation to the component of the Medicaid agency which is responsible for monitoring the program.

1. _____ Yes 2. _____ No

d. Whenever a qualified community care case manager is informed by a provider of service (whether paid or unpaid) that there has been a change in the individual's condition, or that a problem may have arisen which is not currently being addressed, the community care case manager shall take whatever steps are necessary to verify or disprove the information. If a problem is confirmed by this monitoring, the community care case manager shall address it in an appropriate and timely manner, consistent with the nature and severity of the situation.

1. _____ Yes 2. _____ No

State: FLORIDA

COMMUNITY CARE CASE MANAGEMENT FUNCTIONS (con't)

e. Community care case managers shall verify the qualifications of each individual or agency providing home and community care services prior to the initiation of services, and at such intervals as are specified in Appendix C, thereafter. (Check one):

1. _____ Yes 2. _____ No

f. Where the provision of services in an individual's ICCP is not governed by State licensure or certification requirements, the community care case manager shall verify the qualifications of the individual or entity furnishing the services, and as necessary, provide or arrange for the training specified in Appendix C-2. (Check one):

1. _____ Yes 2. _____ No

3. _____ Not applicable. All services are governed by State licensure or certification requirements.

g. Community care case managers shall inform each elderly individual for whom an ICCP is established of the person's right to a fair hearing should the individual disagree with the contents of the ICCP.

State: FLORIDA

RIGHTS SPECIFIED IN THE STATUTE

The State assures that home and community care provided under the State plan will meet the following requirements:

a. Individuals providing care are competent to provide such care. The State will maintain documentation to show that each provider of care meets or exceeds the applicable minimum qualifications specified in Appendix C-2.

b. Individuals receiving home and community care shall be assured the following rights:

1. The right to be fully informed in advance, orally and in writing, of the following:

a. the care to be provided,

b. any changes in the care to be provided; and

c. except with respect to an individual determined incompetent, the right to participate in planning care or changes in care.

2. The right to voice grievances with respect to services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances, and to be told how to complain to State and local authorities. A description of the procedures which the State will utilize to ensure this right is attached to this Appendix.

3. The right to confidentiality of personal and clinical records.

4. The right to privacy and to have one's property treated with respect.

5. The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

6. The right to education or training for oneself and for members of one's family or household on the management of care.

7. The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in the individual's ICCP.

8. The right to be fully informed orally and in writing of the individual's rights.

State: FLORIDA

ADDITIONAL RIGHTS

The State assures that home and community care provided under the State plan will meet the following additional requirements:

a. The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community care services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities. Copies of these standards are maintained at the Medicaid agency.

b. In the case of an individual who has been adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the individual are exercised by the person appointed under State law to act on the individual's behalf.

c. In the case of an individual who resides in his or her own home, or in the home of a relative, when the individual has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the individual's rights to the extent provided by State law. In addition, all rights to be informed of the care to be provided, and to have input into the development of the ICCP specified in Appendix F-1-b shall be extended to the principal caregiver.

d. In the case of an individual who resides in a community care setting, and who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the individual's rights to the extent provided by State law.

State: FLORIDA

GUIDELINES FOR PROVIDER COMPENSATION

a. The following advisory guidelines are provided for such minimum compensation for individuals providing home and community care. These guidelines will be used to assure the availability and continuity of competent individuals to provide such care for functionally disabled individuals who have functional disabilities of varying levels of severity.

1. For services which are the same as, or similar (in content, complexity and provider qualifications) to those provided under the approved Medicaid State plan, the State will compensate the providers on the same basis as that which is approved as part of the plan.

A. _____ Yes B. _____ No

2. For services which are the same as, or similar (in content, complexity and provider qualifications) to those provided under another program funded and operated by the State, the State will compensate the providers on a basis which is equivalent to that used by the other publicly funded program.

A. _____ Yes B. _____ No

3. For services which are dissimilar to those provided under the plan or another program funded and operated by the State, the State will develop methods of compensation which are sufficient to enlist an adequate number of providers, taking into account the number of individuals receiving the service and their geographic location.

A. _____ Yes B. _____ No

b. The State assures that it will comply with these guidelines.

1. _____ Yes 2. _____ No

c. The methods by which the State will reimburse providers are described in attachment 4.19-B.

State: FLORIDA

COMMUNITY CARE SETTINGS-GENERAL

a. Definitions.

1. Small residential community care setting. A small residential community care setting is defined as a facility in which between 3 and 8 unrelated adults reside, and in which personal services (other than merely board) are provided in conjunction with residing in the setting. To qualify as a small residential community care setting, at least one resident must receive home and community care under this benefit.

2. Small nonresidential community care setting. A small nonresidential community care setting is defined as a facility in which an organized program is operated (by the facility or on the premises of the facility) which serves between 3 and 8 individuals, at least one of which receives home and community care under this benefit at the setting.

3. Large residential community care setting. A large residential community care setting is a facility in which more than 8 unrelated adults reside, and in which personal services are provided in conjunction with residing in the setting. To qualify as a large residential community care setting, at least one resident must receive home and community care under this benefit.

4. Large nonresidential community care setting. A large nonresidential community care setting is defined as a facility in which an organized program is operated (by the facility or on the premises of the facility) which serves more than 8 individuals, at least one of which receives home and community care under this benefit at the setting.

5. Unrelated adults. Unless defined differently under State law, for purposes of this benefit, unrelated adults are individuals who are 18 years of age or older, and who do not have any of the following relationships to other adults resident in the facility: spouses, parent (including stepparent) or child (including stepchild), or siblings.

6. Personal services. Personal services are those services provided to the individual by the setting, which are intended to compensate for the absence, loss, or diminution of a physical or cognitive function. Personal services, as defined here, are not equated with personal care services available under either 42 CFR 440.170, or personal care services provided under the home and community care benefit.

b. The State will provide home and community care to individuals in the following settings:

1. _____ Nonresidential settings that serve 3 to 8 people.

2. _____ Residential settings that serve 3 to 8 people, and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

3. _____ Nonresidential settings that serve more than 8 people.

State: FLORIDA

COMMUNITY CARE SETTINGS-GENERAL

4. _____ Residential settings that serve more than 8 people, and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

5. _____ Not applicable. The State will not provide services in these types of community care settings.

c. The State assures that the requirements of sections 1929(g) and (h) of the Act (as applicable to the specific setting) will be met for each setting in which home and community care is provided under this section.

d. FFP will not be claimed for home and community care which is provided in settings which have been found not to meet the requirements of sections 1929(g) and (h) of the Act.

State: FLORIDA

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to small nonresidential community care settings.

The State will require that small nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed -

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

State: FLORIDA

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

11. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

12. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A small nonresidential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the client's individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

State: FLORIDA

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

State: FLORIDA

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

g. Each small nonresidential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each small nonresidential community care setting must meet any applicable State and local certification or license, zoning, building and housing codes, and State and local fire and safety regulations.

i. Each small nonresidential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients.

j. Nothing in this section shall be construed to require a small nonresidential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the facility.

k. Except to the extent dictated otherwise by State law, a small nonresidential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

State: FLORIDA

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

The requirements of this Appendix shall apply to small nonresidential community care settings.

The State will require that small nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed -

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups. This shall not be construed to require the setting to furnish a private bedroom for the individual.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

State: FLORIDA

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to receive notice before the room or the roommate of the resident in the setting is changed.

11. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

12. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

13. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A small residential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

State: FLORIDA

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

State: FLORIDA

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

g. Each small residential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each small residential community care setting must meet any applicable State and local, certification, licensure, zoning, building and housing codes, and State and local fire and safety regulations.

i. Each small residential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of residents.

j. Nothing in this section shall be construed to require a small residential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the setting.

k. Except to the extent dictated otherwise by State law, a small residential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

State: FLORIDA

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to large nonresidential community care settings.

The State will require that large nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed -

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the

State: FLORIDA

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

health or safety of the individual or other clients would be endangered.

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

11. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

12. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plans of remedial action in effect with respect to the facility.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A large nonresidential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

State: FLORIDA

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

c. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

d. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

State: FLORIDA

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

e. Each large nonresidential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

f. Each large nonresidential community care setting must be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients, personnel and the general public.

g. Nothing in this section shall be construed to require a large nonresidential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the facility.

h. Except to the extent dictated otherwise by State law, a large nonresidential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

i. A large nonresidential community care setting must be licensed or certified under applicable State and local law.

j. A large nonresidential community care setting must meet such provisions of the most recent edition of the Life Safety Code of the National Fire Protection Association as are applicable to the type of setting.

1. The State requests that HCFA waive certain provisions of this Code, which if rigidly applied would result in unreasonable hardship upon a setting. The State certifies that such a waiver would not adversely affect the health and safety of clients or personnel. The specific request for waiver and supporting documentation are attached.

_____ Yes _____ No

2. The State certifies to HCFA that there is in effect a fire and safety code, imposed by State law, which adequately protects clients and personnel in certain types of nonresidential community care settings. The specific types of settings are identified in attached documentation. The State requests that the provisions of the State code be substituted for those of the Life Safety Code of the National fire Protection Association for those particular settings.

_____ Yes _____ No

k. Each large nonresidential community care setting must disclose persons with an ownership or control interest (including such persons as defined in section 1124(a)(3) of the Social Security Act) in the setting.

State: FLORIDA

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

1. A large nonresidential community care setting may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under Medicaid or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard, or to have failed to meet the requirements of this Appendix.

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The requirements of this Appendix shall apply to large residential community care settings.

The State will require that large residential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed -

   A. to ensure the physical safety of the individual or other clients served in the setting, and

   B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients) until such an order can reasonably be obtained.

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups. This shall not be construed to require the setting to furnish a private bedroom for the individual.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

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8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to receive notice before the room or the roommate of the resident in the setting is changed.

11. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

12. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

13. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A large residential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

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4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(ii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

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3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

g. Each large residential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each large residential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients, personnel and the general public.

i. Nothing in this section shall be construed to require a large residential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the setting.

j. Except to the extent dictated otherwise by State law, a large residential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

k. A large residential community care setting must be licensed or certified under applicable State and local law.

l. A large residential community care setting must meet such provisions of the most recent edition of the Life Safety Code of the National Fire Protection Association as are applicable to the type of setting.

1. The State requests that HCFA waive certain provisions of this Code, which if rigidly applied would result in unreasonable hardship upon a setting. The State certifies that such a waiver would not adversely affect the health and safety of clients or personnel. The specific request for waiver and supporting documentation are attached.

_____ Yes _____ No

2. The State certifies to HCFA that there is in effect a fire and safety code, imposed by State law, which adequately protects clients and personnel in certain types of residential community care settings. The specific types of settings are identified in attached documentation. The State requests that the provisions of the State code be substituted for those of the Life Safety Code of the National fire Protection Association.

_____ Yes _____ No

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m. Each large residential community care setting must disclose persons with an ownership or control interest (including such persons as defined in section 1124(a)(3) of the Social Security Act) in the setting.

n. A large residential community care setting may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under Medicaid or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard, or to have failed to meet the requirements of this Appendix.