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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiverï¿½s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Major Changes

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

Addition of provider types eligible to perform waiver services (Appendix C)

Clarification of Participant Rights to Fair Hearings and Grievances (Appendix F)

Clarification of Participant Safeguards in reporting Critical Incidents (Appendix G)

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

1. Request Information (1 of 3)

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

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

Familial Dysautonomia Waiver

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: FL.40205
Waiver Number:FL.40205.R04.00
Draft ID: FL.015.04.00

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

Model Waiver

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

01/01/25

Approved Effective Date: 01/01/25

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☒ **Hospital**

Select applicable level of care

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

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155**

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

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

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

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

1. Request Information (3 of 3)

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

Select one:

- (●) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

- [ ] **Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I**
- [ ] **Waiver(s) authorized under section 1915(b) of the Act.**

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

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

- [ ] **section 1915(b)(1) (mandated enrollment to managed care)**
- [ ] **section 1915(b)(2) (central broker)**
- [ ] **section 1915(b)(3) (employ cost savings to furnish additional services)**
- [ ] **section 1915(b)(4) (selective contracting/limit number of providers)**

- [ ] **A program operated under section 1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

- [ ] **A program authorized under section 1915(i) of the Act.**
- [ ] **A program authorized under section 1915(j) of the Act.**
- [ ] **A program authorized under section 1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

- [ ] **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

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

This waiver serves participants diagnosed with Familial Dysautonomia (FD). The waiver services are support coordination, respite services, non-residential support services, consumable medical supplies, durable medical equipment, behavior services, and dental services. This waiver is managed through the Bureau of Medicaid Policy of the Florida Agency for Health Care Administration (AHCA). Providers that are in good standing and currently providing services to participants of the Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services (HCBS) Waiver administered by the Florida Agency for Persons with Disabilities (APD) are invited to provide services to the participants of this waiver. Services are accessed at the individual's local level in their own community or neighboring community. Services provided under this waiver are monitored by AHCA. The goal of this waiver is to delay or prevent institutionalization and allow eligible participants to live at home in their community instead of hospital placement.

3. Components of the Waiver Request

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

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

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

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

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

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

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ◉ **No**

○ **Yes**

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

◉ **No**

○ **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified

provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

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

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

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

I. Public Input. Describe how the state secures public input into the development of the waiver:

The Agency provided public notice as specified in 42 CFR 441.304(f) to solicit meaningful input from recipients, providers and all stakeholders on waiver amendments or renewals at least 30-days prior to submission. The statements of public notice included: publication in the Florida Administrative Register, an update to the Agency's website, tribal notices, and a provider alert. Additionally, all support coordinators were provided a copy of the waiver document to share with their clients. The Agency posted the waiver renewal request and a summary of the changes to the Agency Web site for public review and comment. All statements of public notice included Agency contact information (phone and email) where interested parties could request a copy of the waiver document in print by mail.

The public-comment period for this renewal request was held from 3:00 p.m. EDT on September 4, 2024, to 3:00 p.m. EDT on October 3, 2024. No comments were received regarding the renewal request from any source.

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

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

7. Contact Person(s)

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

Last Name: Owens

First Name: Meagan

Title: AHC Administrator

Agency: Agency for Health Care Administration

Address: Bureau of Medicaid Policy

Address 2: 2727 Mahan Drive, Mail Stop #20

City: Tallahassee

State: **Florida**

Zip: 32308

Phone: (850) 412-4232 **Ext:** ☐ **TTY**

Fax: (850) 414-1721

E-mail: Meagan.Owens@ahca.myflorida.com

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Florida**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

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

Signature: Brian Meyer

State Medicaid Director or Designee

Submission Date: Dec 11, 2024

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

Last Name: Meyer

First Name: Brian

Title: Deputy Secretary for Medicaid

Agency: Agency for Health Care Administration

Address: 2727 Mahan Drive

Address 2: Mail Stop #8

City: Tallahassee

State: **Florida**

Zip: 32308

Phone:

(850) 412-4118 **Ext:** ☐ **TTY**

Fax:

(850) 488-2520

E-mail:

Brian.Meyer@ahca.myflorida.com

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:

   Division of Medicaid/Bureau of Medicaid Policy/Federal Authorities Section

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

   Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding

(MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the Stateâs quality improvement strategy, provide information in the following fields to detail the

Stateâs methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percentage of case file reviews completed by the Medicaid staff on an annual basis that comply with state requirements. Numerator: Number of case file reviews completed by the Medicaid staff on an annual basis that comply with state requirements. Denominator: Number of case files.

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

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

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

Data Aggregation and Analysis:

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

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

When reviewing case files, Medicaid staff reviews the following elements:

CARES 603 Form- The recipient's level of care must be re-evaluated annually by the Comprehensive Assessment and Review for Long-Term Care Services (CARES) staff at the Department of Elder Affairs (DOEA) and the re-determination is documented and placed in the recipient's case record. Completed annually.

Support Plan- Supports Plans should be developed by the waiver support coordinator within 30 days of the recipient's enrollment in the FD Waiver and 90 days prior to the activation of the annual renewal of the plan. The 90 days will allow time for the development of and submission to Medicaid staff for approval. The Support Plan is updated at least annually during a scheduled review of the recipient's needs, preferences, goals, and health status. Completed annually.

Beneficiary Surveys- Conducted by the waiver support coordinators and completed annually.

Interviews with waiver participants/their families- These interviews are exploratory in nature, designed to gather feedback and input. Information gained will be used to improve system performance and quality of care. The information will also be used to identify, address, and prevent discrepancies between the services that the Cost Plan and Support Plan specify and services that the waiver participants are receiving. During these interviews, Medicaid staff also educates recipients and guardians on how to report concerns or incidences of abuse, neglect, and exploitation. Due to the small total enrollment, Medicaid staff is interviewing 100% of FD Waiver participants annually.

Fiscal Review- Prior to yearly reviews of FD Waiver case files, all recipient FD Waiver billing data shall be pulled to review usage patterns for recipients and providers. If unusual patterns are uncovered, providers are referred to the Office of the Inspector General or the Bureau of Medicaid Program Integrity for review of possible fraud and abuse. Completed annually.

Physician Referral & Diagnosis Confirmation Form- This is submitted upon application.

Application Form- This is submitted upon application.

Department of Children and Families (DCF) Certification of Enrollment Status Form- This is submitted upon application.

Informed Consent Form - This is submitted upon application.

Periodic waiver support coordinator conference call meetings- These conference call meetings serve various functions of quality management. Training is always provided as part of the meeting. Topics such as expectation for client contact and Support Plan procedures have been reviewed. These meetings also serve as an opportunity for waiver support coordinators to obtain technical assistance from Medicaid staff as necessary. The calls also serve as a course for identifying, addressing, and preventing problems with participant access to waiver services. Conducted periodically.

Support Coordination Accreditation Review- A Waiver Support Coordinator (WSC) must be certified by APD, the DCF Adult Services Program, or DOEA. A WSC must also have a bachelor's degree and a minimum of three years professional experience in developmental disabilities, special education, mental health, counseling, guidance, social work, or health and rehabilitative services. Review completed annually by Medicaid staff.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the Stateâs method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The WSC conducts interviews with FD recipients to complete the level of care assessment, eligibility worksheet and support plan on a continuous and ongoing basis. The WSC sends the completed documents to Medicaid staff for review on an annual basis. Medicaid staff reviews 100% of documents to identify problems or concerns. Any problems or concerns identified are discussed at periodic status meetings between Medicaid staff and the WSCs, and Medicaid staff follows-up with the WSCs to ensure the issues are satisfactorily resolved.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☒ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☒	Medically Fragile	3	64	☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Diagnosis of Familial Dysautonomia; Hospital Level Of Care; Medicaid Eligible

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

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

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

Specify:

With improved medical care, the life expectancy of individuals with FD is increasing, and about 50 percent live to the age of 30. The average life expectancy for individuals with FD is 20-40 years old, making cases of participants aging out of the waiver at age 65 infrequent. The waiver support coordinator (WSC) will assist the participant in transitioning to a new waiver in the event the participant reaches the maximum age limit. The WSCs may assist the participant in applying for the Long-Term Care Waiver. The WSCs are counseled to assist participants as necessary.

Appendix B: Participant Access and Eligibility

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

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

○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible

individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

◉ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

The FD Waiver is designed for individuals living in their own homes or at home with their family (or foster family).

The State Medicaid Agency holds periodic phone calls with the waiver support coordinators of the waiver participants. Updates are received and the health and safety of participants is closely monitored during these calls. Utilization of services is evaluated monthly. A referral would be made to another waiver if an individual could no longer be safely maintained within the FD waiver cost limit. At this time, no individuals have needed to transition to another waiver due to individual cost limit issues.

Should an individual exceed the cost limit and be disenrolled from the waiver, the individual or their family representative can request a fair hearing.

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

◉ **The following dollar amount:**

Specify dollar amount: 20900

The dollar amount *(select one)*

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

Specify the formula:

◉ **May be adjusted during the period the waiver is in effect. The state will submit a waiver**

amendment to CMS to adjust the dollar amount.

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Based on Physician referral and Diagnosis Confirmation to Determine Level of Care.

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	

Waiver Year	Unduplicated Number of Participants
	15
Year 2	15
Year 3	15
Year 4	15
Year 5	15

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

the waiver.

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

The state established policies governing the selection of individuals for entrance to the waiver are based on objective criteria and do not violate the requirement that otherwise eligible individuals have comparable access to all services offered in the waiver. All FD Waiver participants must be 3 to 64 years old. The FD Waiver utilizes a first-in-time-first-in-line method for entrance to the waiver. Capacity is specified as fifteen (15) participants diagnosed with Familial Dysautonomia. Participants must apply for FD Waiver services, be determined eligible for the waiver and be determined Medicaid eligible. The Physician Referral and Diagnosis Confirmation to Determine Level of Care must indicate that the participant may require hospitalization in the absence of home and community-based services.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a *(select one)*:

- (●) **Section 1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- ( ) **No**
- (●) **Yes**

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

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

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☐ **Optional state supplement recipients**

☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

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

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

Specify percentage:

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

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

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

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

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

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

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

Specify:

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

○ **Use spousal post-eligibility rules under section 1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

◉ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under**

§ 435.735 (209b State)
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

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

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

The state uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

○ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

○ **Other standard included under the state plan**

Specify:

○ **The following dollar amount**

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

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

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which includes income that is placed in a Miller trust.

○ **Other**

Specify:

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

◉ **Not Applicable (see instructions)**
○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

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

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

Specify:

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

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

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

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

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified

in 42 §CFR 435.726:

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

Select one:

- (●) **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The state does not establish reasonable limits.**
- ( ) **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

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

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

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

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

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

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- (●) **The following standard included under the state plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional state supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

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

      Specify the percentage:
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage:
  - ( ) **Other standard included under the state plan**

    Specify:

- ( ) **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

  Specify:
- ( ) **Other**

  Specify:

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

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

  Specify:

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

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

  Specify dollar amount: If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  Specify:

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

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

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

  Specify:
- **Other**

  Specify:

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

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

Select one:

- **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant,*

not applicable must be selected.

- ○ **The state does not establish reasonable limits.**
- ◉ **The state establishes the following reasonable limits**

Specify:

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

Specify percentage:

- ○ **The following dollar amount:**

Specify dollar amount:

☐ If this amount changes, this item will be revised

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

Specify formula:

○ **Other**

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

○ **The state does not establish reasonable limits.**

◉ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

reasonable indication of the need for services:

i. Minimum number of services.

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

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

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

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

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

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- (●) **Other**

Specify:

Comprehensive Assessment Review and Evaluation Services (CARES) unit of the Florida Department of Elder Affairs and review by the Agency for Health Care Administration. The reevaluation process is the same as for evaluations.

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

The Comprehensive Assessment and Review for Long Term Care Services (CARES) Unit under the jurisdiction of the State of Florida Department of Elder Affairs is designated by state statute to perform Level of Care evaluations for all Medicaid Nursing Home Admissions and Conversions. (Chapter 409.985, Florida Statutes, and 59G-13.080(6)(d)and (e), Florida Administrative Code.)

The CARES Unit, which is composed of a physician (M.D. or D.O.), a registered nurse (licensed in Florida), and a social worker, completes the Level of Care Evaluation based on an assessment form completed by the case manager and a physician referral. The Level of Care Notification form (DOEA- CARES Form 603) is signed by a physician (M.D. or D.O.).

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

The assessment interviews for waiver applicants are conducted by CARES program staff based upon DOEA-Form 701A and DOEA-Form 701B. The completed assessment forms are reviewed to determine level of care and prioritization for waiver services, and CARES program staff complete the Level of Care Notification form (DOEA CARES Form 603) to document whether waiver applicants meet level of care requirements. The Medicaid Agency is not involved in supervision of this function or in the development of LOC policies specific to this waiver.

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

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

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

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

The assessment interviews for waiver applicants are conducted by CARES program staff based upon DOEA-Form 701A and DOEA-Form 701B. The completed assessment forms are reviewed to determine level of care and prioritization for waiver services, and CARES program staff complete the Level of Care Notification form (DOEA CARES Form 603) to document whether waiver applicants meet level of care requirements. The reevaluation process is the same as for evaluations.

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

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

Specify the other schedule:

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

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**

Specify the qualifications:

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

The Comprehensive Assessment and Review for Long Term Care Services (CARES) unit under the Department of Elder Affairs uses a computerized management system which generates a monthly listing of individuals due for reevaluation in the subsequent month. This system ensures that reevaluation takes place in a timely manner. In addition to the CARES system, the participants support coordinator shall track this due date as a part of case management to ensure timely reevaluation.

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

Waiver support coordinators (WSCs) must maintain a central file for each participant. All evaluations and reevaluations must be included in the participants central file. WSCs will maintain written copies of evaluations and reevaluations in the participants central file. This requirement will be monitored by the Agency for Health Care Administration.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percentage of applicants receiving a level of care determination prior to enrollment. Numerator: Number of applicants receiving a level of care determination prior to enrollment. Denominator: Number of applicants.

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

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percentage of initial level of care determinations that were accurately completed in accordance with state policies and procedures. N: Number of initial level of care determinations that were accurately completed in accordance with state policies and procedures. D: Number of initial level of care determinations.

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

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

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

Data Aggregation and Analysis:

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

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

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

CARES 603 Form- The recipient's level of care must be re-evaluated annually by CARES staff and the re-determination is documented and placed in the recipient's case record. Completed annually.

Beneficiary Surveys- Conducted by WSCs. Completed annually.

Interviews with waiver participants/their families- These interviews are exploratory in nature, designed to gather feedback and input. Information gained will be used to improve system performance and quality of care. The information will also be used to identify, address, and prevent discrepancies between the services that the Cost Plan and Support Plan specify and services that the waiver participants are receiving. During these interviews, Medicaid staff also educates recipients and guardians how to report concerns or incidence of abuse, neglect, and exploitation. Due to the small total enrollment, Medicaid staff is interviewing 100% of FD Waiver participants annually.

Physician Referral & Diagnosis Confirmation Form- This is submitted upon application.

Department of Children and Families (DCF) Certification of Enrollment Status Form- This is submitted upon application.

Informed Consent Form - This is submitted upon application.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the Stateâs method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Medicaid staff works closely with the WSCs to ensure all level of care assessments are completed prior to enrollment into the waiver and timely and accurately after waiver enrollment has been completed. Medicaid staff and the WSCs will follow up with CARES staff as necessary to ensure any issues are satisfactorily resolved.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Individuals who have been diagnosed with Familial Dysautonomia (FD) and their families or guardian will be notified through DCF of their opportunity to apply to participate in the FD Home and Community-Based Services (HCBS) Waiver in Florida. If the individual is interested in enrolling in the FD Waiver, the DCF will refer the applicant to the Florida Agency for Health Care Administration. Medicaid staff with the Florida Agency for Health Care Administration is responsible for sending the individual the forms for enrollment in the FD Waiver. The Florida Agency for Health Care Administration will maintain the completed enrollment forms and the documented determination by the CARES office regarding the individual's eligibility and election of choice to participate in the FD Waiver as an HCBS option.

The waiver support coordinator has the individual complete a yearly eligibility worksheet that documents choice to receive community-based supports and services as opposed to institutional services.

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

The signed and returned Application for Participation for the FD Waiver services will serve as documentation of the individuals and their families' choice. If the individual and their family decide to participate in the FD Waiver, the application will be maintained in their central file by the participant's waiver support coordinator.

The waiver support coordinator has the individual complete a yearly eligibility worksheet that documents choice to receive community-based supports and services as opposed to institutional services.

Appendix B: Participant Access and Eligibility

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

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

Because of the small population of individuals diagnosed with FD, it is not believed that translations will be requested. However, translated forms and communications can be provided upon request for individuals and their families. If the Florida Agency for Health Care Administration does not have staff available that can provide translations as necessary, arrangements will be made to make translations available.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Respite**		
Statutory Service	**Support Coordination**		
Extended State Plan Service	**Adult Dental Services**		
Extended State Plan Service	**Durable Medical Equipment**		
Other Service	**Behavioral Services**		
Other Service	**Consumable Medical Supplies**		
Other Service	**Non-Residental Support Services**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: 09 Caregiver Support

Sub-Category 1: 09012 respite, in-home

Category 2: 09 Caregiver Support

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

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition *(Scope):*

Services provided to individuals unable to care for themselves, furnished on a short-term basis for a planned absence or need for relief of those persons normally providing their care. If a nurse is needed to provide respite services, then a prescription from a physician, ARNP, or physician assistant is required. Respite care may be provided in the participant's own home or family home.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Registered Nurse
Individual	Licensed Practical Nurse
Individual	Homemaker/Sitter/Companion
Individual	Nurse Registry

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Homemaker/Sitter/Companion

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Nurse Registry

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Support Coordination

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Support Coordination

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:

Agency

Provider Type:

Support Coordination

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by the Agency for Persons with Disabilities.

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Persons with Disabilities

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Adult Dental Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Covers dental treatments and procedures that are not otherwise covered by Medicaid State Plan services or covered by the FD participant’s Medicaid managed care dental plan.

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

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

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

This waiver service is limited to individuals over age 21.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Dental Services
Agency	Dental Services

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Dental Services

Provider Qualifications

License *(specify):*

In accordance with Chapter 466, F.S.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency For Health Care Adminstration

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Dental Services

Provider Qualifications

License *(specify):*

In accordance with Chapter 466, F.S.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Adminstration

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Durable Medical Equipment

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Durable medical equipment includes specified prescriptive equipment required by the participant. Durable medical equipment generally meets all of the following requirements: a) can withstand repeated use; b) is primarily and customarily used to serve a medical purpose; c) is generally not useful to a participant absent of a disability; and d) is appropriate for use in the home.

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

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

This waiver service is limited to individuals over age 21.

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pharmacy
Agency	Home Health Agency
Agency	Retail Stores
Agency	Medical Supply Companies and Durable Medical Equipment Suppliers
Agency	Assistive Technology Suppliers and Technology Practitioners

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Durable Medical Equipment

Provider Category:

Agency

Provider Type:

Pharmacy

Provider Qualifications

License *(specify):*

In accordance with Chapter 465, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Adminstration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Durable Medical Equipment

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Adminstration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Durable Medical Equipment

Provider Category:

Agency

Provider Type:

Retail Stores

Provider Qualifications

License *(specify):*

In accordance with Chapter 205, F.S.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Durable Medical Equipment

Provider Category:

Agency

Provider Type:

Medical Supply Companies and Durable Medical Equipment Suppliers

Provider Qualifications

License *(specify):*

In accordance with Chapter 205, F.S.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Adminstration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Durable Medical Equipment

Provider Category:

Agency

Provider Type:

Assistive Technology Suppliers and Technology Practitioners

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10010 mental health assessment
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Behavioral services are provided to assist a participant in learning new behavior, to increase existing behavior, to reduce existing behavior, and to emit behavior under precise environmental conditions. Behavior analysis includes the design, implementation, and evaluation of systematic environmental modification for the purpose of producing socially significant improvements and understanding of human behavior based on the principles of behavior identified through the experimental analysis of behavior. It includes the identification of functional relationships between behavior and environment.
Training for parent, caregivers and staff is also part of behavior analysis services when these persons are integral to the implementation or monitoring of a behavior analysis services plan.
These services may be provided in the provider's office, the participant's home or anywhere in the community including settings relevant to the behavior problems being addressed.

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

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

Waiver services are limited to individuals over age 21.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Psychologist
Individual	Psychologist
Agency	Marriage and Family Therapist
Agency	Behavior Analyst
Individual	Clinical Social Worker

Provider Category	Provider Type Title
Individual	Behavior Analyst
Individual	Mental Health Counselor
Individual	Behavior Assistant
Agency	Behavior Assistant
Agency	Mental Health Counselor
Agency	Clinical Social Worker
Individual	Marriage and Family Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:

Agency

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

In accordance with Chapter 490, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

In accordance with Chapter 490, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:

Agency

Provider Type:

Marriage and Family Therapist

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:

Agency

Provider Type:

Behavior Analyst

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In accordance with Chapter 393, F.S.

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:

Individual

Provider Type:

Clinical Social Worker

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:

Individual

Provider Type:

Behavior Analyst

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In accordance with Chapter 393, F.S.

Other Standard *(specify):*

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

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

Level 3: Board or Florida Certified Associate Behavior Analyst or a Florida Certified Behavior Analyst with bachelors or high school diploma, regardless of experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:

Individual

Provider Type:

Mental Health Counselor

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:

Individual

Provider Type:

Behavior Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavioral Services

Provider Category:

Agency

Provider Type:

Behavior Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:

Agency

Provider Type:

Mental Health Counselor

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:

Agency

Provider Type:

Clinical Social Worker

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:

Individual

Provider Type:

Marriage and Family Therapist

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumable Medical Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Consumable medical supplies are those non-durable supplies and items that enable participants to increase their ability to perform activities of daily living. Consumable medical supplies are of limited usage and must be replaced on a frequent basis. Supplies covered must meet all of the following conditions: a) be related to a participant's specific medical condition, b) not be provided by any other program, c) be the most cost-beneficial means of meeting the participant's need, and d) not primarily for the convenience of the participant, caregiver, or family.

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

Supplies covered are:
1. Diapers, including pull-ups, adult diapers or adult disposable briefs.
2. Wipes.
3. Disposable gloves.
4. Surgical masks, when prescribed by a physician.
5. Disposable or washable bed or chair pads and adult sized bibs.
6. Ensure or other food supplements when determined necessary by a licensed dietitian. Participants that require nutritional supplements must have a dietitians assessment documenting such need. The assessment shall include documentation of weight fluctuation. Total parenteral nutrition (TPN) is available through the Medicaid Durable Medical Equipment and Supplies Program.
7. Feeding tubes and supplies not covered by Medicaid State Plan and prescribed by a physician. Excludes supplies for a participant who qualifies for food supplements under the Florida Medicaid Durable Medical Equipment and Supplies Program.
8. Dressings, not covered by Medicaid, required for a caregiver to change wet to dry dressing over surgical wounds or pressure ulcers, and prescribed by a physician.
9. Hearing aid batteries, cords and routine maintenance and cleaning prescribed by an audiologist.
10. Bowel management supplies purchased under the waiver are limited to $150.00 every three months. These supplies include laxatives, suppositories and enemas determined necessary for bowel management by the participants physician.

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

This waiver service is limited to individuals over age 21.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Medical Supply Companies and Durable Medical Equipment Suppliers
Agency	Retail Stores/ Independent Vendors
Agency	Pharmacy

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumable Medical Supplies

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Adminstration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumable Medical Supplies

Provider Category:

Agency

Provider Type:

Medical Supply Companies and Durable Medical Equipment Suppliers

Provider Qualifications

License *(specify):*

In accordance with Chapter 205, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumable Medical Supplies

Provider Category:

Agency

Provider Type:

Retail Stores/ Independent Vendors

Provider Qualifications

License *(specify):*

In accordance with Chapter 205, F.S.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Adminstration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumable Medical Supplies

Provider Category:

Agency

Provider Type:

Pharmacy

Provider Qualifications

License *(specify):*

In accordance with Chapter 465, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Administration

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Residental Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04070 community integration
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

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

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

Service Definition *(Scope):*

Non-residential support services (NRSS) are individualized training activities provided to an adult or child in integrated, non-residential settings. This service is provided for the express purpose of providing access to community-based activities that cannot be provided by natural or other unpaid supports and are defined as activities most likely to result in increased ability to access community resources without paid supports. These training activities are age-appropriate and geared to enhancing the acceptable individual behaviors, increasing the participant's ability to control the environmental and emphasizing those qualities, which are integrative and normative in nature. These training activities can include activities such as: volunteering, job exploration and shadowing; developing control and choice over valued daily routines; accessing generic public resources; participation and membership in places of worship and social organizations; developing acquaintances, friendships and other social supports; and supporting connections with family members and other social supports that promote health, safety and well-being.

Transportation is not included as a component of this service.

Personal care/assistance may be included as a component of this service and is included in the rate paid to providers for Non-Residential Support Services.

Meals are not included as a component of this service.

For enrollees who still attend school and have not graduated from high school, these services may not be provided in a school setting. They may not replace or duplicate the provision of comprehensive education and related services to individuals with disabilities who are covered under IDEA mandate requirements.

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Vendor
Agency	Agency Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Residental Support Services

Provider Category:

Individual

Provider Type:

Independent Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Adminstration

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Residental Support Services

Provider Category:

Agency

Provider Type:

Agency Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency for Health Care Adminstration

Frequency of Verification:

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

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All waiver providers must undergo a criminal history and/or background investigation prior to becoming a Medicaid provider. Providers are systematically precluded from entry into the Medicaid system without the requisite background screenings. Applications are transmitted by the Medicaid Agency for processing through the Florida Department of Law Enforcement. Processing with the Florida Department of Law Enforcement includes a national background investigation with the Federal Bureau of Investigation (FBI). Founded abuse complaints will be identified as part of the background screening.

All providers must submit to and clear level one and level two background screenings. Level one is a local level background check of the provider's name with local law enforcement. Level two is a State level background check with the Florida Department of Law Enforcement and the Federal Bureau of Investigations databases of the provider's fingerprints. All providers with ownership, management duties, or direct participant contact must submit to level one and two background screening.

The State of Florida has developed a statewide Clearinghouse to process criminal history background checks of direct service providers. The purpose of the Clearinghouse is to provide a single data source for background screening results of persons required to be screened by law for employment in positions that provide services to children, the elderly and disabled individuals. The results of criminal history checks are shared among state agencies when a person has applied to volunteer, be employed, be licensed, or enter into a contract that requires a state and national fingerprint-based criminal history check.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ◉ **No. The state does not conduct abuse registry screening.**
- ○ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

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

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

- [ ] **Self-directed**
- [ ] **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- (●) **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ( ) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- ( ) **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

AHCA staff works with the Agency for Persons with Disabilities (APD) to solicit current Developmental Disabilities Home and Community-Based Services Waiver providers in good standing to provide services to the Familial Dysautonomia population. Interested providers must submit a request to AHCA to add a designated specialty code to their Medicaid provider number in order to bill for their services. AHCA accepts applications for new FD waiver providers on a continuous basis.

All willing and qualified providers have the opportunity to apply to be a FD waiver service provider. The State Medicaid Agency has a provider enrollment unit to assist interested providers in the enrollment process. An online application as well as the phone number for provider enrollment is posted on the Florida Medicaid Web Portal.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
Number and percentage of new licensed providers satisfying waiver service provider qualifications prior to delivering services. Numerator: Number of new licensed providers satisfying waiver service provider qualifications. Denominator: Number of new licensed providers.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percentage of FD waiver providers continuously qualified on an annual basis. Numerator: Number of providers continuously qualified as FD providers on an annual basis. Denominator: Number of providers enrolled as FD providers.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
Number and percentage of new non-licensed/non-certified providers satisfying waiver service provider qualifications prior to delivery of services. Numerator: Number of non-licensed/non-certified provider applicants that meet provider qualifications prior

to delivery of services. Denominator: Number of new non-licensed/non-certified providers.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

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

Performance Measure:
Number and percentage of non-licensed/non-certified providers satisfying waiver service provider qualifications continually. Numerator: Number of non-licensed/non-certified providers satisfying waiver service provider qualifications continually. Denominator: Number of non-licensed/non-certified providers.

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

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

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

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
Number and percentage of providers, with staff mandated to report abuse, neglect and exploitation, which have received the appropriate training. Numerator: Number of providers with staff mandated to report abuse, neglect and exploitation, that have received the appropriate training. Denominator: Number of providers with staff who are mandated reporters.

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the Stateâs method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Providers are required to remediate all deficiencies. Medicaid staff works with providers on a one-to-one basis to facilitate problem resolution to completion.

Providers who do not continually meet required training, license, certification, or other standards will be notified by the Medicaid staff in writing of non-compliance.

If the appropriate credentials are not provided within 30 days, the provider will be disenrolled and any claims billed will be subject to recoupment.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

Waiver enrollees reside in their personal residence (setting owned or leased by the enrollee or a family member) and receive services as described in Appendix C-1/C-3: Service Definitions. These can include the personal residence, provider office (Adult Dental Services, Behavioral Services) or other community settings (Non-Residential Support Services).

As noted in the HCBS Settings Statewide Transition Plan (October 2022), the State has determined that recipients in the Familial Dysautonomia Waiver receive services in the recipient's home and community-based service locations that are accessible to individuals receiving HCBS to the same degree as individuals not receiving HCBS and are therefore compliant with the HCB Settings Rule requirements. Recipients in waiver programs who live in private homes of their own or the home of their family member, are in compliance with the HCBS Final Rule. Per SMD 19-001, individual, privately-owned homes (privately owned or rented home and apartments in which the individual receiving Medicaid-funded HCBS lives independently or with family members, friends or roommates) are presumed to be in compliance with the regulatory criteria of the home and community-based setting.

The State's statutory and administrative regulatory requirements, managed care contract requirements, waiver and state plan program monitoring processes and remediation activities demonstrate full compliance with the settings rule.

Monitoring is conducted at least annually through a review of enrollee case folders by staff of the Division of Medicaid.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Support Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Waiver support coordinators (WSCs) work with the participant and the participant's family or guardian in advance of the scheduled support plan meeting to gather information for the development of a support plan based on the needs of the participant. Information regarding available services in the community, through natural supports, by the Medicaid State Plan, and waiver services are made available. This allows the participant to be familiar with opportunities they may not have considered. The participant and the participant's family or guardian helps determine who is present during the development of the service plan. The participant may invite anyone they feel appropriate to the service plan meeting.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Waiver support coordinators (WSCs) work with the participant and the participant's family or guardian to develop a support plan based upon the needs of the participant. The planning meeting to develop the plan occurs at least sixty days prior to effective date of the support plan. The participant and the participant's family or guardian determines who is present during the development of the service plan. The participant may invite anyone they feel appropriate to the support plan meeting. The participant's needs, preferences, goals, and health status are discussed and service needs are determined based upon the discussion. It is the responsibility of the support coordinator to inform the participant and the participant's family or guardian of the available services. It is also the responsibility of the WSC to work with other available resources in the community, through natural supports, and the Medicaid State Plan to provide services in coordination with waiver services. During the planning provider responsibilities are reviewed and report deadlines are provided.

The WSCs work with the participant and the participant's family or guardian on a monthly basis and are able to monitor the changing needs of the participant. The support plan is updated at least annually during a scheduled review of the participant's needs, preferences, goals, and health status. Any changes that require a change in services are to be reported to the Agency for Health Care Administration for approval of a change in the service plan within 15 days after need is determined.

The WSCs work closely with the participant and their representative during the development of the service plan and throughout the year. Monthly contact with the participant and the participant's family and quarterly face-to-face meetings help to identify possible risk factors thereby reducing or eliminating those factors from the participant's daily life. The service plan reflects the participant's health concerns and the impact on the person, assistive or adaptive equipment, and a list of current medications with the purpose and any side effects or problems noted.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the scheduled support plan meeting and throughout the year, the waiver support coordinator (WSC) needs to remain aware of possible risks that threaten the health, safety, and welfare of the participant. Monthly contact with the participant and the participant's family or guardian and quarterly in-person meetings (not virtual/electronic) will help identify possible risk factors thereby reducing or eliminating those factors from the participant's daily life.

Each participant's WSC is required to develop an emergency back-up plan as part of their annual support plan. The emergency backup plan should describe the alternative service delivery methods that will be used under any of the following circumstances: 1) if the primary provider fails to report to work or otherwise cannot perform the job at the time and place required, 2) if the participant experiences a personal emergency, or 3) if there is a community-wide emergency (e.g., requiring evacuation). The personal emergency portion of the emergency-backup plan will allow the participant to identify circumstances that would cause an emergency for him/her based upon his/her unique needs. The support plan identifies critical services that affect the participant's health, safety, and welfare. Those identified critical services should be addressed specifically by the WSC in the support plan annually, with backup supports identified.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Medicaid staff will provide information about qualified waiver support coordinators (WSC) to participants and the participant's family or guardian to review so that an informed choice may be made. The WSC choice is based on interviews by the participant and/or their parent or guardian. The WSCs assist participants in making choices regarding providers of other services. Qualified providers for each service are reviewed with the participant and/or their parent or guardian by the WSC. Choice is based upon interviews with the provider by the participant and/or their parent or guardian.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

Support plans should be developed by the waiver support coordinator (WSC) within 30 days of the participant's enrollment on the FD Waiver and 90 days prior to the activation of the annual renewal of the plan. The 90 days will allow time for the development of and submission to the Agency for Health Care Administration for approval. The engagement of additional support services or providers should also take place within the 30 days of the participant's enrollment or within the 90 day renewal period.

The WSCs work closely with the participant and the participant’s family or legal guardian on a monthly basis and are able to monitor the changing needs of the participant. In addition, the State Medicaid Agency holds periodic phone calls with the WSCs to receive updates on each waiver participant and to monitor the health and safety of participants. All service plans are received and reviewed by the State Medicaid Agency. The plans are reviewed and allowable services are approved. If any discrepancies are noted the Medicaid staff will contact the WSC and provide technical assistance.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Waiver support coordinators (WSCs) work with the participant and the participant's parent or guardian to develop and monitor the participant's Support Plan. Support Plans are reviewed annually in a scheduled meeting of the WSC and the participant and the participant's parent or guardian. The participant and the participant's parent or guardian may invite any other interested parties including other service providers to the annual Support Plan meeting.

During this support plan meeting, the WSC verifies that participant has access to waiver services identified in their service plan, that the participant exercises free choice of providers, and that services meet participant needs. The WSC also reviews state plan services with the participant and their parent or guardian during this meeting. An emergency back-up plan must be established during the support planning to ensure the health and safety of the participant. It is often necessary to involve alternate providers who may be invited to participate in the planning process. The WSC is responsible for including natural and generic resources to Support Plans to include community activity, state plan medical services and non-paid supports.

At the end of the Support Plan meeting the WSC documents any identified problems and develops a remediation goal to address them within 60 calendar days. If changes in service needs occur, access to services becomes problematic or if provider changes are necessary, the support plan may be updated between annual Support Plan meetings if circumstances with the participant change and warrant a change in the Support Plan.

During annual file monitoring, the Medicaid program analyst for the FD Waiver reviews the central record from the WSC to ensure support plan meeting case notes are current and complete, and that waiver documents requiring participant or guardian signature are included. The program analyst also conducts interviews with participants or guardians to verify that they have been afforded choice of providers, access to services that meet identified needs, and to assess the participant's satisfaction with services. Medicaid staff reviews the Support Plan to determine that required services, backup plans, and natural non-paid resources are in place, and that state plan Medicaid services are clearly identified in the plan. Any issues or problems resulting from monitoring are addressed by Medicaid staff by initiating corrective action with the WSC and regular follow up with participant, guardians or providers as needed. The Agency receives annual reports of quality errors related to all waiver service providers, including WSC's, and takes corrective action as needed.

b. Monitoring Safeguards. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participantsâ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number and percentage of participants with support plans documenting personal goal setting and community integration goal setting. Numerator: Number of participants support plans documenting personal goal setting and community integration goal setting. Denominator: Number of support plans.

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

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participantâs needs.***

Performance Measures

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

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

Performance Measure:
Number and percentage of participants with support plans that are updated/revised at least annually consistent with assessed needs. Numerator: Number of support plans that are updated/revised at least annually consistent with assessed needs. Denominator: Total number of support plans.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of participants' support plans that were updated/revised when there were changes in the participants' needs. Numerator: Number of participants' support plans that were updated/revised when there were changes in the participants' needs. Denominator: Total number of support plans indicating a significant change.

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

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

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Number and percentage of participant services delivered according to the support plan as to service type, scope, amount, duration, and frequency. Numerator: Number of participant services delivered according to the support plan as to service type, scope, amount, duration, and frequency. Denominator: Total number of records.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percentage of recipients afforded choice of services and service providers. N: Number of recipients afforded choice of services and service providers. D: All service plans.

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

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

Data Aggregation and Analysis:

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

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

Recipient's records will be requested annually. A desk review will take place, which will include a review of the waiver support coordination (WSC) provider records for the recipient for the prior year's activities. The record review will be conducted covering WSC documentation; waiver services Support Plans, Cost Plans, service coordination and completion of beneficiary surveys. The review will end with the completion of a summary of the preliminary findings, including any immediate concerns and/or actions required. A written report shall be provided to the provider from Medicaid staff, which will include any quality improvement plan requirements or recommendations.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the Stateâs method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

A written report shall be provided to the provider from Medicaid staff, which will include any quality improvement plan requirements or recommendations.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR ?431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

When a waiver applicant seeks enrollment, the Department of Children and Families (DCF) has the responsibility to determine whether they meet financial eligibility requirements for Florida Medicaid. In compliance with 42 CFR Part 431, Subpart B, DCF's Office of Hearings and Appeals conducts fair hearings for waiver applicants contesting adverse eligibility determinations.

The applicant receives a Notice of Case Action (HRS-AA Form 2266) from DCF which contains the following statement: "If you have reason to believe this action is incorrect, your eligibility specialist will be glad to discuss it with you. You also have the right to request a hearing before a State Hearing Officer. A request for a hearing should be made within 90 days from the date at the top of this notice. You can bring with you or be represented at the hearing by a lawyer, relative, or person designated by you."

Waiver applicants who receive a Notice of Case Action from the Department denying their Medicaid eligibility can request a fair hearing by contacting the Department's Office of Hearings and Appeals using the information contained in the Notice of Case Action. The Office of Hearings and Appeals sends the applicant and all other parties hearing notices informing them of the hearing date and time and their right to have representation at the hearing. Upon conclusion of the fair hearing, the Fair Hearing Officer will consider the evidence presented, review the applicable Medicaid regulations and notify the recipient and the other parties of the final order. The DCF maintains notices of fair hearings regarding eligibility.

Eligibility Fair Hearings are conducted by DCF. They may be requested verbally or in writing. No specific form is required. To request a fair hearing for financial eligibility determinations, applicants contact:

By Phone: (850) 488-1429
By email: appeal.hearings@myflfamilies.com
By Mail: Office of Hearings and Appeals
2415 N Monroe St, Ste 400-I
Tallahassee, FL 32303-1490

Waiver Services (Denial, Termination, Reduction or Suspension)
Recipients and legal representatives, if applicable, receive fair hearing rights information from their WSC during the initial visit to develop the waiver person-centered care plan. Written notice of a denial, termination, reduction, or suspension of a waiver service will be provided to the recipient/or his/her designee if services were already being provided. This letter informs the recipient that services will continue during the period while the recipient appeal is under consideration. Instructions will provide how to request a fair hearing by a State Hearings Officer. The Agency for Health Care Administration maintains notices of fair hearings regarding waiver services.

Service-related Fair Hearings are conducted by AHCA. They may be requested by phone, fax, email or in writing. No specific form is required.

By Phone: 877-254-1055
By Fax: 239-338-2642
By email: Medicaidhearingunit@ahca.myflorida.com
By Mail: Office of Fair Hearings
P.O. Box 60127
Fort Myers, FL 33906

Level of Care (LOC) Eligibility Denials
When the Bureau of CARES receives a referral for the Familial Dysautonomia (FD) Waiver, the medical information provided by the applicant's physician in Form FD-1 is reviewed and then a face-to-face comprehensive needs assessment (Form 701B) is conducted with the applicant. Based on these steps, CARES will make LOC determination. If the applicant is not found to meet the LOC required for the waiver, the applicant receives a Notice of Case Action from DCF, which explains the applicant's right to a Fair Hearing through AHCA.

All notices of adverse actions and the right to request a Fair Hearing are maintained in the enrollee's central record.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

AHCA maintains an enrollee and provider complaint hub. Enrollees and providers access the complaint hub through the AHCA web site or a toll-free telephone number. Complaints are reviewed and resolved by AHCA staff. Hub metrics are maintained by AHCA and reviewed periodically.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

For the complaint hub, enrollees and providers access AHCA's website, complete an on-line complaint form, and submit the electronic complaint to AHCA. Enrollees and providers may also contact the Helpline (phone and TDD) and a Helpline staff member will complete the complaint form for them. Complaint hub staff contact Agency units responsible for the complaint area and seek direction on the resolution of the complaint or, if necessary, AHCA subject matter specialists are contacted to resolve the complaint. All complaints can be addressed through the complaint hub, including accessing services, service locations, fraud, billing, or any other concerns.

Participants are informed that neither Complaints nor Grievances are a pre-requisite or substitute for a Fair Hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

TFD service providers are required to report to the Agency for Health Care Administration headquarters within 24 hours if any of the following events occur: 1. death of a participant due to any means; 2. participant injury or illness that requires emergency medical treatment that was sustained due to an accident, act of abuse, neglect or other incident; 3. allegation of sexual battery; 4. elopement; 5. financial exploitation. The Critical Incident form should be faxed to Medicaid Central office.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Training and information concerning abuse, neglect, and exploitation is provided to participants by waiver support coordinators in face-to-face visits. Detailed information is provided about what a critical incident is and how to report the incident. Waiver support coordinators are required to provide FD participants and family members the information regarding Floridas toll-free abuse hotline (1-800-96-ABUSE) at the annual Support Plan meeting.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

FD service providers are required to report to the Agency central office within 24 hours if any of the following events occur: 1. death of a participant due to any means; 2. participant injury or illness that requires emergency medical treatment that was sustained due to an accident, act of abuse, neglect or other incident; 3. allegation of sexual battery; or 4. elopement.

Waiver support coordinators are responsible for informing the Agency headquarters of the status of all critical events or incidents. Waiver support coordinators will be required to submit reports to the Agency regarding critical incidents affecting waiver participants. A critical event form is provided to all enrolled providers by Medicaid staff for the purpose of reporting critical events or incidents.

The length of the internal investigation varies from case to case. Investigations of incidents which are conducted by the Agency may take up to 90 days to complete. Investigations conducted are for internal use only and may result in disciplinary actions upon providers, changes in providers, etc. There are no established timeframes for informing a provider or relevant parties of the investigation results.

The Florida Department of Children and Families is responsible for investigating all calls to the Florida's toll-free abuse hotline (1-800-96-ABUSE). The Florida Department of Children and Families is responsible for informing Florida Medicaid of critical events or incidents including those from the confidential report compiled from toll-free abuse hotline calls.

The Agency will inform the participant (or the participant's family or legal representative as appropriate) and other relevant parties (e.g., waiver providers, licensing and regulatory authorities, the Agency) in writing of the investigation results within 7 business days of investigation completion.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

AHCA is responsible for the monitoring and oversight of responses to critical incidents or events. All critical incidents are subsequently addressed as appropriate with the nature of the incident. Aggregate data is compiled and analyzed by AHCA, and trending and analysis of this data helps prevent and/or reduce the occurrence of incidents in the future.

In addition, the Department of Children and Families and the Florida Department of Law Enforcement are responsible for overseeing the reporting of and response to critical incidents or events for all Floridians. AHCA collaborates with the Department of Children and Families – Adult Protective Services and other State agencies. AHCA fosters increased oversight of providers regarding critical incidents and other health, safety and welfare sub-assurances required for the successful operation of the waiver. The State has developed performance measures for capturing and reporting critical incidents. These performance measures may be found in Appendix G (Quality Improvement) of the waiver application.

Enrollees will be monitored for service provision and health and safety issues. Providers and Support Coordinators must assist with services necessary to address health, safety and welfare needs as well as plan of care services.

Oversight of critical incident reporting is conducted on a continuous basis.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Allegations of prohibited use of restraints or seclusion by an FD Waiver provider may be reported by a provider or participant directly to the local Florida Department of Children and Families Office and to the Florida Medicaid Agency's Central Office. The Agency will be required to keep a log of any use of seclusion and restraint and staff will review logs on a monthly basis. The State monitors the unauthorized use of restraints through annual provider reviews conducted by Agency staff and during conference calls with the waiver support coordinators.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

Allegations of prohibited use of restrictive interventions by a FD Waiver provider may be reported directly to the local Florida Department of Children and Families Office and to the Florida Medicaid Agency's Central Office. The Agency will be required to keep a log of any use of seclusion and restraint, and staff will review logs on a monthly basis. The State monitors the unauthorized use of restrictive interventions through annual provider reviews conducted by Agency staff and during conference calls with the waiver support coordinators.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Allegations of prohibited use of restraints or seclusion by a waiver provider may be reported by provider or participant directly to the local Florida Department of Children and Families' office and to the Florida Medicaid Agency's central office. Agencies will be required to keep a log of any use of seclusion and restraint and staff will review logs on a monthly basis. The State monitors the unauthorized use of seclusion through annual provider reviews conducted by Agency staff and during conference calls with the waiver support coordinators.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

○ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percentage of participants with substantiated reports of abuse neglect, or exploitation that had appropriate follow-up by WSC. Numerator: Number of participants with substantiated reports of abuse, neglect or exploitation that had appropriate follow-up by WSC. Denominator: Number of participants with substantiated reports of abuse, neglect or exploitation where a follow-up was required.

Data Source (Select one):
Presentation of policies or procedures
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of waiver support coordinators who have completed Zero Tolerance training as required on recognizing and preventing instances of abuse, neglect, and exploitation N: Number of waiver support coordinators who have completed Zero Tolerance training as required on recognizing and preventing instances of abuse, neglect, and exploitation D: Number of records.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of participants reporting they received information/education about how to report abuse, neglect, exploitation and other critical incidents. Numerator: Number of participants reporting they received information/education about how to report abuse, neglect, exploitation and other critical incidents. Denominator: Number of participants receiving FD services.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number and percentage of critical incident reports received by the Medicaid agency that document appropriate action and follow-up. Numerator: Number of critical incident reports received by the Medicaid agency that document appropriate action and follow-up. Denominator: Total number of critical incidents.

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

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

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of critical incidents reported within 24 hours of observing or learning of the critical incident. Numerator: Number of critical incidents reported within 24 hours of observing or learning of the incident. Denominator: Number of critical incidents that occurred in the reporting period.

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Number and percentage of participants who did not have an incident where prohibited restraint and/or seclusion was used. Numerator: Number of participants who did not have an incident where prohibited restraint and/or seclusion was used. Denominator: Number of participant records.

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

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

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

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
Number and percentage of participants whose special health requirements or safety needs are met as documented in the person-centered support plan. Numerator: Number of recipients whose special health care requirement or safety needs are met as documented in the person-centered support plan. Denominator: Total number of participants with special health care requirements.

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

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the Stateâs method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

A written report shall be provided to the provider from Medicaid staff, which will include any quality improvement plan requirements or recommendations.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target

population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Home and Community-Based Services Waiver for individuals with Familial Dysautonomia currently has six (6) recipients enrolled. Utilization data for the last period available (WY3, 1/1/2022 - 12/31/2022), showed seven (7) unduplicated waiver recipients with $12,724 billed for consumable medical supplies, $5,037 billed for non-residential support services, and $11,758 for waiver support coordination as the only three (3) waiver services utilized.

Medicaid staff utilizes multiple oversight activities to ensure that waiver assurances are met. Oversight activities include: inspection of records, interviews with waiver participants and their families, and periodic waiver support coordinator conference call meetings.

All file reviews are conducted for all recipients on an annual basis. Files are monitored for the following items:
- Physician Referral & Diagnosis Confirmation Form
- Application Form
- CARES 603 Form
- DCF Certification of Enrollment Status Form
- Informed Consent Form
- Current Cost Plan
- Current Support Plan

For files missing any of these documents, waiver support coordinators were contacted to supply a copy from the recipients' central record. In addition, historical and miscellaneous documents (correspondences, detailed medical information, etc.) were reviewed. File reviews will be conducted annually for all recipients, with specific attention being paid to the Support Plan and Cost Plan.

In addition, Medicaid staff conduct periodic waiver support coordinator conference call meetings. These conference call meetings serve various functions of quality management. Training is always provided as part of the meeting. Topics such as expectation for client contact and Support Plan procedures have been reviewed. These meetings also serve as an opportunity for waiver support coordinators to obtain technical assistance from Medicaid staff as necessary. The calls also serve to identify, address, and prevent problems with participant access to waiver services. Waiver support coordinator conference call meetings are an integral part of our ongoing, systematic oversight of the FD Waiver.

Quality improvement reports are compiled annually by the Bureau of Quality. Results of these reports are communicated to waiver providers as deficiencies are detected, and will be provided to enrollees, family members, and other stakeholders upon request. The overall QIS for this waiver is updated upon waiver renewal, and any operational changes within the state agency that affect the operation of this waiver.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☒ **Other** Specify: Bi-Monthly

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Medicaid Agency holds monthly management meetings to discuss program successes and changes that may be needed.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Medicaid Agency holds monthly management meetings to discuss program successes and changes that may be needed.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Financial accountability for the FD Waiver is managed through the Agency for Health Care Administration. Financial accountability is assured through the State's automated management accounting system and the accounting procedures manuals, which include federal reporting requirements. All participant, provider, and service utilization/payment data will be available through the approved federally certified Florida Medicaid Management Information System (FMMIS) that is designed and operated by a contracted entity and managed by the Agency for Health Care Administration.

The Agency for Health Care Administration is responsible for initial and ongoing monitoring of providers. During the monitoring process, providers' qualifications to render services and the documentation required to maintain in their files is reviewed. The documentation includes level of care assessment, plan of care, documentation of service delivery, and billing claims. The monitoring occurs on an annual basis and looks at 100% of the providers and 100% of the participants.

Medicaid Program Integrity (MPI) within the Agency for Health Care Administration conducts the periodic independent audit of the waiver program and does comprehensive reviews of providers to identify fraud, waste, and abuse. Potential identification of fraud is referred to the Office of the Attorney General, Medicaid Fraud Control Unit. Waste and abuse are investigated by MPI. The MPI audit is a comprehensive, more in-depth audit of the provider's practice and must be defensible in an Administrative Hearing. MPI reviews compliance with federal and state laws, rules and promulgated Medicaid policy, including qualifications of all staff, service documentation, and comparison of both eligibility and documentation to billing and reimbursement. MPI identifies overpayments and applies sanctions to the provider.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
Number and percentage of claims paid for services that match the provider's support plan. Numerator: Number of claims paid for services that match the provider's support plan. Denominator: Total number of claims paid.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percentage of claims adhering to reimbursement methodology in the FD waiver. Numerator: Number of claims adhering to reimbursement methodology in the FD waiver. Denominator: Total number of claims.

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

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

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
Number and percentage of claims paid at the correct rate, in accordance with policy requirements and the rate in the fee schedule. N: Number of claims paid at the correct rate, in accordance with policy requirements and the rate in the fee schedule. D: Number of total claims paid.

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

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

Data Aggregation and Analysis:

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

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

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

The integrity of payments are ensured through AHCA's claim system for the Medicaid program, the Florida Medicaid Management Information System (FMMIS).

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the Stateâs method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

Financial Audits are conducted by AHCA and the Auditor General's Office.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

From the first approval of the FD Waiver in 2006, provider rates were historically set in alignment with rates established for similar services in the Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services Waiver. The iBudget provider rates are established in Florida Administrative Code through the State of Florida rulemaking process. The rulemaking process included an opportunity for providers and interested stakeholders to attend advertised public rulemaking workshops and hearings to provide input into rulemaking process. Service rates for the FD Waiver are posted on the State Medicaid Agency's website at https://ahca.myflorida.com/medicaid/home-and-community-based-settings-rule/familial-dysautonomia-waiver. If a waiver participant requests a hard copy, one will be sent via U.S. Mail.

FD Waiver rates were last updated according to this process in 2014. Beginning in 2025, the State will work to establish a rate-setting methodology independent of the iBudget Waiver, using a contracted third-party actuarial vendor or the agency's internal rate-setting process, and the same rulemaking and public-input process as described above, and will maintain this process at least every five years.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

The Florida Medicaid Management Information System (FMMIS) system has recipient eligibility and provider subsystems. The recipient subsystem is updated as part of the eligibility redetermination process. When a recipient is enrolled in this waiver it will be reflected on his/her eligibility file. A file in the provider subsystem is established upon enrollment of a provider. Payments will be reflected on the provider's file. Edits in FMMIS are designed to ensure that payments for waiver services are made only for authorized waiver services to eligible recipients rendered by enrolled providers.

Service providers receive service authorizations from the Waiver Support Coordinator and deliver the services. After delivering the services, service providers send their claims using CMS 1500 billing forms to the Medicaid Fiscal Agent for processing in the approved Florida Medicaid Management Information System (FMMIS).

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

◉ ***No. state or local government agencies do not certify expenditures for waiver services.***

○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services***

and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The Florida Medicaid Management Information System (FMMIS) system has edits to ensure that, prior to generating a payment, the participant is currently eligible for Medicaid in an eligibility category approved for the waiver and is enrolled in this waiver. In addition, support plan monitoring will include review of payments to ensure that services were provided and were included in the participants approved support plan and cost plan.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures

on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- (●) ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ( ) ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- (●) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ( ) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

- ( ) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***

○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not

voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

Check each that applies:

- [ ] ***Health care-related taxes or fees***
- [ ] ***Provider-related donations***
- [ ] ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- (●) ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ( ) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Hospital

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	8751.33	56446.38	65197.71	241339.45	1.00	241340.45	176142.74
2	8751.33	59607.38	68358.71	254854.46	1.00	254855.46	186496.75
3	8751.33	62945.39	71696.72	269126.31	1.00	269127.31	197430.59
4	8751.33	66470.33	75221.66	284197.38	1.00	284198.38	208976.72
5	8751.33	70192.67	78944.00	300112.44	1.00	300113.44	221169.44

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	*Total Unduplicated Number of Participants (from Item B-3-a)*	*Distribution of Unduplicated Participants by Level of Care (if applicable)*
		Level of Care:
		Hospital
Year 1	*15*	*15*
Year 2	*15*	*15*
Year 3	*15*	*15*
Year 4	*15*	*15*
Year 5	*15*	*15*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Average days of waiver enrollment is 365 days for calendar years 2021-2023. Source for WY2 and WY3 is CMS372 report. Source for WY4 is FMIS/DSS recipient enrollment tables. The number of years that a participant will remain on the waiver is unknown due to the complexity of the Familial Dysautonomia (FD) diagnosis. Continued medical advancements related to FD are resulting in participants living longer.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

All waiver year estimates are based on the premise that a maximum of 15 unduplicated participants will be served. The average units and average cost per unit is based upon the average experience of this waiver and Medicaid programs serving similar populations during calendar years 2021-2023. Estimates for the services Support Coordination, Non-Residential Supports, and Personal Care Items are the average of three years of waiver utilization. Dental services are estimated at full utilization (4 units per year at $100 per unit). Durable Medical Equipment (DME) estimates are based on the average state plan utilization of DME services of waiver recipients for the period CY2021, CY2022, and CY2023. Estimates for Behavioral Services is the 3 year average utilization of state plan Behavioral Analysis services for non-waiver individuals with a diagnosis of Riley-Day syndrome. Estimates for respite is the 3 year average utilization of all respite services for non-waiver individuals with a diagnosis of Riley-Day syndrome.
No inflation factor was utilized. The State elected not to apply a growth rate to Factor D based on flat historical service rates, and anticipated waiver utilization.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

D prime (Non-Waiver costs) are derived from the average non-waiver costs for waiver recipients for calendar years 2021-2023. Cost estimates for D prime were increased by 3.7% and 7.4% to account for growth between the years WY4 to WY5 and WY5 to WY1 respectively. Cost growth for WY1 through WY5 is estimated at 5.6% per year.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these*

estimates is as follows:

The Factor G estimates are based on the average cost of all Medicaid State Plan inpatient hospitalization claims for calendar years 2021-2023. The source for the inflation for costs is the National Health Expenditure Projections 2022-2031, Forecast Summary, June 2023, Medicaid payer analysis. Cost estimates for D prime and G factor were increased by 3.7% and 7.4% to account for growth between the years WY4 to WY5 and WY5 to WY1 respectively. Cost growth for WY1 through WY5 is estimated at 5.6% per year. Inpatient hospital is considered to be all-inclusive, no estimate amount for non-institutional services (G prime).

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Since hospitalization is paid based on an all-inclusive per diem rate, there are no other Medicaid State Plan costs incurred; therefore, Factor G' is zero.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Respite	
Support Coordination	
Adult Dental Services	
Durable Medical Equipment	
Behavioral Services	
Consumable Medical Supplies	
Non-Residental Support Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Respite Total:						***13201.65***
Respite	*15 Minutes*	*2*	*1333.50*	*4.95*	***13201.65***	
Support Coordination						***23000.92***
				GRAND TOTAL:		***131269.95***
				Total Estimated Unduplicated Participants:		***15***
				Factor D (Divide total by number of participants):		***8751.33***
				Average Length of Stay on the Waiver:		*365*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Support Coordination	Month	15	9.50	161.41	23000.92	
Adult Dental Services Total:						800.00
Adult Dental Services	Procedure	2	4.00	100.00	800.00	
Durable Medical Equipment Total:						3900.47
Durable Medical Equipment	Purchase	2	14.30	136.38	3900.47	
Behavioral Services Total:						47373.90
Behavioral Services	15 Minutes	2	1785.00	13.27	47373.90	
Consumable Medical Supplies Total:						32432.90
Consumable Medical Supplies	Purchase	9	20.30	177.52	32432.90	
Non-Residental Support Services Total:						10560.10
Non-Residental Support Services	15 Minutes	4	570.20	4.63	10560.10	
				GRAND TOTAL:		131269.95
				Total Estimated Unduplicated Participants:		15
				Factor D (Divide total by number of participants):		8751.33
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						13201.65
Respite	15 Minutes	2	1333.50	4.95	13201.65	
Support Coordination Total:						23000.92
Support Coordination	Month	15	9.50	161.41	23000.92	
				GRAND TOTAL:		131269.95
				Total Estimated Unduplicated Participants:		15
				Factor D (Divide total by number of participants):		8751.33
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Dental Services Total:						**800.00**
Adult Dental Services	Procedure	2	4.00	100.00	**800.00**	
Durable Medical Equipment Total:						**3900.47**
Durable Medical Equipment	Purchase	2	14.30	136.38	**3900.47**	
Behavioral Services Total:						**47373.90**
Behavioral Services	15 Minutes	2	1785.00	13.27	**47373.90**	
Consumable Medical Supplies Total:						**32432.90**
Consumable Medical Supplies	Purchase	9	20.30	177.52	**32432.90**	
Non-Residental Support Services Total:						**10560.10**
Non-Residental Support Services	15 Minutes	4	570.20	4.63	**10560.10**	
				GRAND TOTAL:		**131269.95**
				Total Estimated Unduplicated Participants:		**15**
				Factor D (Divide total by number of participants):		**8751.33**
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**13201.65**
Respite	15 Minutes	2	1333.50	4.95	**13201.65**	
Support Coordination Total:						**23000.92**
Support Coordination	Month	15	9.50	161.41	**23000.92**	
Adult Dental Services Total:						**800.00**
Adult Dental Services					**800.00**	
				GRAND TOTAL:		**131269.95**
				Total Estimated Unduplicated Participants:		**15**
				Factor D (Divide total by number of participants):		**8751.33**
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Procedure	2	4.00	100.00		
Durable Medical Equipment Total:						**3900.47**
Durable Medical Equipment	Purchase	2	14.30	136.38	**3900.47**	
Behavioral Services Total:						**47373.90**
Behavioral Services	15 Minutes	2	1785.00	13.27	**47373.90**	
Consumable Medical Supplies Total:						**32432.90**
Consumable Medical Supplies	Purchase	9	20.30	177.52	**32432.90**	
Non-Residental Support Services Total:						**10560.10**
Non-Residental Support Services	15 Minutes	4	570.20	4.63	**10560.10**	
				GRAND TOTAL:		**131269.95**
				Total Estimated Unduplicated Participants:		**15**
				Factor D (Divide total by number of participants):		**8751.33**
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**13201.65**
Respite	15 Minutes	2	1333.50	4.95	**13201.65**	
Support Coordination Total:						**23000.92**
Support Coordination	Month	15	9.50	161.41	**23000.92**	
Adult Dental Services Total:						**800.00**
Adult Dental Services	Procedure	2	4.00	100.00	**800.00**	
Durable Medical Equipment Total:						**3900.47**
				GRAND TOTAL:		**131269.95**
				Total Estimated Unduplicated Participants:		**15**
				Factor D (Divide total by number of participants):		**8751.33**
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Durable Medical Equipment	Purchase	2	14.30	136.38	3900.47	
Behavioral Services Total:						47373.90
Behavioral Services	15 Minutes	2	1785.00	13.27	47373.90	
Consumable Medical Supplies Total:						32432.90
Consumable Medical Supplies	Purchase	9	20.30	177.52	32432.90	
Non-Residental Support Services Total:						10560.10
Non-Residental Support Services	15 Minutes	4	570.20	4.63	10560.10	
				GRAND TOTAL:		131269.95
				Total Estimated Unduplicated Participants:		15
				Factor D (Divide total by number of participants):		8751.33
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						13201.65
Respite	15 Minutes	2	1333.50	4.95	13201.65	
Support Coordination Total:						23000.92
Support Coordination	Month	15	9.50	161.41	23000.92	
Adult Dental Services Total:						800.00
Adult Dental Services	Procedure	2	4.00	100.00	800.00	
Durable Medical Equipment Total:						3900.47
Durable Medical Equipment	Purchase	2	14.30	136.38	3900.47	
				GRAND TOTAL:		131269.95
				Total Estimated Unduplicated Participants:		15
				Factor D (Divide total by number of participants):		8751.33
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Services Total:						**47373.90**
Behavioral Services	15 Minutes	2	1785.00	13.27	**47373.90**	
Consumable Medical Supplies Total:						**32432.90**
Consumable Medical Supplies	Purchase	9	20.30	177.52	**32432.90**	
Non-Residental Support Services Total:						**10560.10**
Non-Residental Support Services	15 Minutes	4	570.20	4.63	**10560.10**	

GRAND TOTAL:	**131269.95**
Total Estimated Unduplicated Participants:	**15**
Factor D (Divide total by number of participants):	**8751.33**
Average Length of Stay on the Waiver:	365