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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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:
The Agency for Health Care Administration (AHCA), the State Medicaid Agency, updated the number of unduplicated recipients within Appendix B-3, Number Served, and Appendix J-2, Derivation of Estimates. The Waiver Year 1 estimate was based on a population growth factor of approximately 3.5% from the 16/17 372 unduplicated count of 31,334 as reported in the 372 report, and projected forward. Waiver Years 2-5 utilized an estimated growth factor of 1,500 recipients per waiver year, based on trends reported by the Operating Agency, the Agency for Persons with Disabilities (APD).

Additionally, the State Medicaid Agency, the Operating Agency, and the Contracted Vendor conducted an extensive review of all performance measures. Performance measures and the applicable remediations were updated in Appendices A, B, C, D, and G.

The AHCA removed the Comprehensive Transitional Education Program (CTEP) as a provider type, due to the closing of the only CTEP facility within the state.

The waiver effective date was updated to April 1, 2019 to align with standardized reporting timeframes, and a temporary extension from March 15, 2019 through March 31, 2019 is being requested.

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

1. Request Information (1 of 3)

- **A.** The **State** of **Florida** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- **B.** **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
  Developmental Disabilities Individual Budgeting Waiver
- **C.** **Type of Request: renewal**

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

  ○ **3 years** ◉ **5 years**

  Draft ID: **FL.027.02.00**
- **D.** **Type of Waiver** *(select only one)*:
  Regular Waiver
- **E.** **Proposed Effective Date:** *(mm/dd/yy)*
  04/01/19

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The Developmental Disabilities Individual Budgeting Waiver is a Medicaid home and community-based services waiver for persons with developmental disabilities living in their own home, family home, licensed home, or other home-like setting in the community. The waiver is operated by the Florida Agency for Persons with Disabilities (APD) under the administration of the Agency for Health Care Administration (AHCA), the single state Medicaid Agency. This waiver reflects the use of an individual budgeting model. The flexibility of the model allows recipients more opportunities to participate in determining service choices. Each recipient and their parent or guardian will be involved in the budget process to the extent of choosing their array of services, choosing their providers, and having the flexibility to make changes as their needs change, without additional authorization from the operating agency or from the contracted prior authorization vendor.

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

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

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

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

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

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the

approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

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

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

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

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

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

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

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

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
The APD has a longstanding relationship of community involvement. Stakeholders in Florida (self-advocates, family members, providers, and policymakers) are involved in policy development with the APD. Several meetings and conference calls were held to formulate the policies and processes included in this waiver. Staff from the State Medicaid Agency were involved in finalizing recommendations from the stakeholder group.

The State Medicaid Agency will provide 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. The statements of public notice include: publication in the Florida Administrative Register, an update to the Agency's Web site to post the waiver amendment or renewal request and a summary of the changes, and a provider alert.

Additionally, the APD will issue the State Medicaid Agency's notice to waiver support coordinators and issue Provider Advisories to inform waiver support coordinators and other providers that the waiver is up for amendment or renewal. The APD will draft a letter to recipients and have waiver support coordinators share it with those on their caseloads, and send the notice to the APD's list serve.

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

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

2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name: Dalton

First Name: Ann

Title: AHC Administrator

Agency: Agency for Health Care Administration

Address: 2727 Mahan Drive

Address 2: Mail Stop #20

City: Tallahassee

State: **Florida**

Zip: 32308

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

Fax: (850) 414-1721

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

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

Last Name: Lorena

First Name: Fulcher

Title: Senior Management Analyst Supervisor

Agency: Agency for Persons with Disabilities

Address: 4030 Esplande Way

Address 2: Suite

City: Tallahassee

State: **Florida**

Zip: 32310

Phone: (850) 488-5998 **Ext:** ☐ **TTY**

Fax: (850) 410-0665

E-mail: Lorena.Fulcher@apdcares.org

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Kidder

First Name: Beth

Title: Deputy Secretary for Medicaid

Agency: Agency for Health Care Administration

Address: 2727 Mahan Drive

Address 2: Mailstop #8

City: Tallahassee

State: **Florida**

Zip: 32308

Phone: (850) 412-4006 **Ext:** ☐ **TTY**

Fax:

(850) 488-2520

E-mail:

Beth.Kidder@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.

I. Purpose

The purpose of this waiver specific transition plan is to ensure that individuals receiving HCBS in the Developmental Disabilities Individual Budgeting (iBudget) Waiver are integrated in and have access to supports in the community including opportunities to seek employment, work in competitive integrated settings, engage in community life, and control personal resources. The iBudget Transition Plan describes how the state will assess, determine compliance, remediate and monitor continued compliance with the HCB settings requirements. The transition plan outlines the State's process with timeframes that will be used to ensure compliance with the HCB Setting Rule.

II. Overview

The iBudget Waiver is managed by the Florida Agency for Health Care Administration (Agency). The Florida Agency for Persons with Disabilities (APD) is responsible for monitoring certain activities under this waiver to ensure compliance with all state and federal requirements. The iBudget Waiver is being assessed to ensure individuals receiving HCBS have access to a home-like environment and community inclusion, and that all HCBS settings are in compliance with the HCB Setting Rule requirements specified in 42 CFR 441.301(c)4.

The waiver specific transition plan includes:

• An overall programmatic assessment;

- A regulatory assessment;
- A residential settings assessment;
- A non-residential settings assessment;
- A description of the public notice process;
- A timeline of transition plan milestones;
- A state rules and regulations crosswalk;
- The HCB Characteristics Review Tool for Residential Facilities; and
- The HCB Characteristics Review Tool for Non-Residential Settings.

III. Compliance Assessment

A. Overall Programmatic Assessment
To assess the level of compliance with the HCB setting requirements, Florida assessed the State's regulatory requirements for iBudget facilities and the iBudget monitoring process. The assessment was conducted to determine whether the facilities:

- fully align with the Federal requirements,
- do not comply with the federal requirements and will require modifications,
- cannot meet the federal requirements and require removal from the program and/or the relocation of individuals, or
- are presumed to be institutional as specified in 42 CFR 441.301(c)(5).

Based upon this preliminary analysis completed June 15, 2014, the State has determined the State does not have any significant barriers that would impede the iBudget Waiver program's compliance with the HCB setting requirements. The State has initiated the development of a thorough review and monitoring process to ensure it optimizes compliance with the federal requirements including a process for the assessment and monitoring of impacted residential and non-residential provider sites.

B. Service Assessment
To determine the level of compliance with the HCB setting requirements specified in 42 CFR 441.301(c)4, Florida first assessed the services offered under the iBudget Waiver. Based upon this analysis, the State has determined the waiver services are delivered in locations where the HCB Setting Rule applies. The State will continue to monitor the waiver operations to ensure individuals continue to receive services in compliant settings.

The State is developing a comprehensive assessment, remediation and monitoring process to ensure impacted provider sites are in compliance with the HCB Settings Rule.

C. Regulatory Assessment
As part of the preliminary assessment of current state regulations, standards, and policy, the State has determined that the State does not have any significant barriers that would impede the iBudget Waiver program's compliance with the HCB setting requirements. To assess regulatory requirements, the State reviewed all applicable state rules and statutes and determined their compliancy with federal regulation.

To ensure continued compliance, the State will monitor on an on-going basis all changes to future state statutes, regulations, standards, and policy each year.

D. Residential Setting Assessment
Residential facilities were initially assessed by a provider self-assessment for compliance with the HCBS settings requirements using the HCB Characteristics Residential Tool. The assessment tool is designed by the State to determine whether residential providers are compliant with the HCBS settings requirements: home-like environment, and community inclusion. Facility reviewers are instructed to employ multiple assessment tactics when analyzing each standard including independent observation, record and file review, provider questions, and resident/recipient questions as appropriate.

In June 2014, APD e-mailed a link to an electronic self-assessment containing the HCB Characteristics Residential tool to all licensed residential facilities. This survey was intended to assess existing levels of compliance with the new waiver requirements. As of August 2014, 917 providers (54%) responded to the survey out of 1,691. An initial analysis of the assessment results reveal that the majority of residential providers are either already meeting the new federal standards or should be able to achieve full compliance with the implementation of minor programmatic changes. A random sample of the completed self-assessments will be reviewed by the State to ensure the validity of the responses. The State will conduct a complete assessment of all residential settings (in which waiver services are being rendered) in order to determine full compliance.

The residential self-assessment tool is designed to measure home and community-based services (HCBS) providers' level of compliance with the HCBS Settings Rule and provide a framework for assisting providers with any necessary steps to come into compliance. The main areas of assessment are the setting, room/privacy, meals, activities/community integration, respect/rights/choice, and a miscellaneous category of other items to assess. Comments can be entered for clarification or verification. Whether the standard is met is delineated with a check box for met or not met. Methods for verification of the standard

are also listed in the tool that gives the provider or evaluator a way to assess the standard.

The State will continue assessing the residential monitoring tool and provider training in accordance with its findings and stakeholder input.

E. Non-Residential Setting Assessment
The State has developed an assessment tool to evaluate the non-residential settings to ensure compliance with the federal requirements. The State's Operating Agency will conduct in-person assessments of contracted providers for compliance.

IV. Remediation
The State will develop a comprehensive remediation strategy that optimizes cooperation and consultation between the State and providers while minimizing any potential negative impact on individuals who receive services in these settings. The strategy will allow ample time for providers to rectify deficiencies in order to comply with the rule. Remediation plans will be highly individualized and provider-driven based on the individual provider assessments.

The State will determine compliance and necessary remediation actions through its assessment process. Based on its assessment results, the State will determine which CMS-provided compliance category a setting falls into by determining whether it:
• Fully aligns with the federal requirements,
• Does not comply with the federal requirements and will require modifications,
• Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals, or
• Is presumed to be institutional as specified in 42 CFR 441.301(c)(5).

For sites that are determined to be fully aligned with federal requirements, the State will ensure continued compliance through routine monitoring and evaluation of the site.

For sites that do not comply with the federal requirements and will require modifications, the State will initiate the following remediation steps:
• The Agency, or its delegate will send written findings and a determination of compliance to the provider based on the site survey or monitoring.
• The provider will have a given timeframe in which to respond to the Agency, or its delegate, with a remediation action plan and engage in further discussion.
• The Agency, or its delegate will approve the provider remediation plan and monitor its implementation progress. The plan may be modified with approval, throughout the implementation process.
• The Agency, or its delegate will reassess the provider site at the end of the implementation period to ensure compliance.
• The suitable course of action for provider sites that remain non-compliant will be determined on a case-by-case basis.

Options will include:
• Continuing to collaborate with the provider to remediate outstanding issues.
• The Agency, or its delegate, sending a final compliance order detailing how, and when, it expects the provider to come into compliance.
• Terminating the provider from the program and transitioning recipients to compliant settings.

For sites that are presumed to be institutional, the State will implement a case-by-case heightened scrutiny process. This process will include convening with stakeholder and advocacy groups in order to determine if the site in question has qualities of an institution. If the site is determined to be of institutional quality, the State will provide written notice that the site will be terminated from the program and recipients will be transitioned into a compliant setting. If the site is determined to be compliant with the HCB Settings Rule and not of institutional quality, the State will submit evidence and a recommendation to CMS.

Transitioning of HCBS Recipients
In the event remediation attempts have proved unsuccessful, it will be necessary to transition impacted individuals to a setting that meets the requirements of the rule.

The State will develop a comprehensive transition protocol to operationalize how it will transition individuals into compliant settings as necessary in a manner that minimizes the impact on the individual while optimizing their personal choice and care coordination. The protocol will include the following steps:
• The Agency, or its delegate will send impacted HCBS recipients a written notice explaining the need for transition, including alternate provider options and outlining options to helpful resources.
• Waiver support coordinators/case managers will work with impacted individuals, providers and the individuals support group to develop an individualized transition plan that is approved by the individual or their representative.
• Individuals will be monitored during transition and after completing transition to ensure their new service provider maintains compliance with the HCBS Settings Rule and that their services continue to meet waiver standards and requirements.
• Individuals who do not want to change providers and receive services in a compliant setting will be counselled as to the consequences and will be disenrolled from the applicable waiver.

V. Continued Compliance
The State will develop an annual monitoring program that focuses on individual recipient feedback, provider monitoring and overall program and regulatory monitoring. The State is developing monitoring tools that address each aspect to ensure ongoing compliance.

The State will implement a process to evaluate the individual's person-centered plan and seek feedback from the recipient and the recipient's family or representative. The focus of this annual review will be to guarantee the recipient has the opportunity to be active in the community, reside in a home-like living environment and make personal choices.

The HCB Characteristics Tool will be used to determine compliance for the provider sites. A representative sample of residential and non-residential settings will be reviewed by the State. The residential and non-residential review tools will be updated based on provider and reviewer feedback. Updating the tools will ensure accurate results and better determine the remediation actions necessary to ensure continued compliance.

The State will also monitor all changes to state laws, rules, regulations, standards, and policy each year. To ensure on-going compliance of the HCBS programs with the provisions of the HCB Settings Rule, the Agency has established following monitoring principles that will guide the development of its monitoring plan:
• The Agency will assure continued compliance with the HCB Settings Rule prior to the submission of waiver or state plan amendments and renewals.
• Waiver case managers and support coordinators will ensure recipients do not receive services in a setting that does not comply with the HCB Settings Rule.
• The Agency will ensure on-going monitoring of residential and non-residential provider sites.
• The Agency will continue to modify its monitoring activities based on its continuing assessment and public input to ensure full compliance with the HCB Settings Rule.

VI. Communication and Education
The Agency has implemented an outreach strategy for sharing information about the HCB Settings Rule with recipients, providers, interested parties and stakeholders. It is the Agency's goal to promote transparency regarding implementation actions and procedures by disseminating direct, clear and timely communication of information relating to applicable programs, waiver services and the State's HCB Settings Rule implementation activities.

All updates relating to the rule can be found on the Agency website at
http://ahca.myflorida.com/Medicaid/hcbs_waivers/index.shtml. The website is a resource open to recipients, providers and other stakeholders and includes general information about the rule, the State's HCBS programs and any updates to the waivers. This website will be updated when new information becomes available.

The Agency has also established an email inbox and encourages all interested parties to submit comments regarding its HCB settings transition plan, waiver applications, waiver amendments and waiver renewals
(FLMedicaidWaivers@ahca.myflorida.com). Comments are logged and taken into consideration when finalizing these documents and prior to submission to CMS.

Additionally, APD has established methods of communicating with the individuals, providers and stakeholders they serve and will utilize those processes in conjunction with the Agency.

A. Recipient Outreach
The Agency will employ a direct approach to communicating information with recipients through their support coordinator or case manager accordingly. The Agency believes this personal approach will help to engage recipients in the implementation process and facilitate a greater understanding of its actions.

B. Provider Outreach
The primary method of communication to providers is through provider alerts. These alerts are distributed to all waiver and state plan providers and contain relevant information regarding updates to the HCBS programs. A phone number and email address are provided in the alerts so that providers may contact the Agency if they have any questions or concerns.

C. Stakeholder Outreach
The Agency prioritizes effective communication to its many stakeholder groups. The primary method of communication is the Agency's provider alert system in which many stakeholder participate. Additionally, the Agency publicly notices its public comment periods and public meetings in the Florida Administrative Register (FAR).

In order to ensure proper and collaborative implementation of the rule, the Agency has established an interagency workgroup that consists of staff members from each of its impacted sister agencies. These meetings occur once weekly and have participants from each agency. The workgroup includes subject matter experts and other stakeholders.

D. Education and Training
The Agency strives to ensure all of its stakeholders are well informed about the HCB Settings Rule and its implementation activities. The Agency developed an introductory training plan to introduce the rule and its requirements. These trainings were held during the summer of 2014 and consisted of a webinar presentation and a Q&A session. A copy of the "HCBS Rule Overview and Transition Planning 2014" presentation can be located on the Agency's HCBS website.

The Agency is developing a comprehensive, progressive, training and education program designed to reach all stakeholders that address its implementation activities.

VII. Public Notice Process
The State is required to have a 30-day public comment period to allow for meaningful public comment prior to submission of this transition plan. The State provided two statements of public notice on the transition plan. The Agency summarized all comments received during that public comment period and described how the issues were addressed in the transition plan prior to submission to CMS.

Statements of Public Notice
• The Agency will publish a notice of the comment period and a link to the waiver specific transition plan on Florida's Administrative Register and the Agency website. The statements of public notices will provide information on the upcoming public comment period for the transition plan, a link to the plan, and the locations and addresses where public comments may be submitted.
• The Agency will notice iBudget providers through the distribution of a provider alert.
• In addition, the Agency will send notice to the support coordinators who will distribute the public notice to share with their recipients.

Please Note: The Agency will also notify the Florida Federally Recognized Tribes.
Written comments and suggestions may be mailed to:

Agency for Health Care Administration
Attention: HCBS Waivers
2727 Mahan Drive, MS #20
Tallahassee, Florida 32308

Electronic comments may be emailed to: FLMedicaidWaivers@ahca.myflorida.com

iBudget Services Crosswalk1
Service—Settings
Residential Habilitation—Residential Facility
Respite—Residential Facility, Recipient Home/Community
Support Coordination—Residential Facility, Recipient Home/Community
Adult Dental Services—Recipient Home/Community
Occupational Therapy—Residential Facility, Recipient Home/Community
Physical Therapy—Residential Facility, Recipient Home/Community
Private Duty Nursing—Recipient Home/Community
Respiratory Therapy—Residential Facility, Recipient Home/Community
Skilled Nursing—Residential Facility, Recipient Home/Community
Specialized Medical Equipment and Supplies—Residential Facility, Recipient Home/Community
Specialized Mental Health Counseling—Residential Facility, Recipient Home/Community
Speech Therapy—Residential Facility, Recipient Home/Community
Transportation—Recipient Home/Community
Behavior Analysis Services—Residential Facility, Recipient Home/Community
Behavior Assistant Services—Residential Facility, Recipient Home/Community
Dietitian Services—Residential Facility, Recipient Home/Community
Environmental Accessibility Adaptations—Recipient Home/Community
Life Skills Development 1, 2, 3—Non-Residential Setting, Recipient Home/ Community
Personal Emergency Response System—Recipient Home/Community
Personal Supports—Residential Facility, Recipient Home/Community
Residential Nursing—Residential Facility
Supported Living Coaching—Residential Facility, Recipient Home/Community
Special Medical Home Care—Residential Facility
1Recipient Home/Community settings are equally accessible to individuals not receiving HCBS waiver services.

Attachment I
Implementation Action Plan
Subject—Description/Action—Start—End—Resource(s)—Status

Operational Assessments, Development and Implementation
HCB Settings Rule Assessment—Determine elements of rule and categorize. —3/5/14—3/5/14—AHCA Policy—Completed
Preliminary Operational Assessment—Determine affected waivers, review impacted service descriptions, applicable settings and regulations. —3/5/14—5/30/14—AHCA Policy, APD—Completed
Stakeholder Training – HCB Settings Rule—Develop initial stakeholder training re. new HCB settings rule requirements—5/15/14—6/30/14—AHCA Policy, APD, Stakeholders—Completed
Programmatic Preliminary Assessment—Overall preliminary assessment from operating/programmatic agencies—6/18/14—8/25/14—AHCA Policy, APD—Completed
Stakeholder Training – New HCB Settings Rule—Conduct webinar series for interested stakeholders re. HCB Settings Rule requirements and initial State transition plans—7/1/14—9/30/14—AHCA Policy—Completed
Statewide Transition Plan—Develop statewide transition plan, hold public comment and submit to CMS—8/25/14—3/17/15—AHCA Policy, APD, Stakeholders—Completed
Stakeholder Training – HCB Settings Rule Implementation—Develop ongoing, progressive, training re. State implementation activities—2/1/15—4/30/15—AHCA Policy, APD, Stakeholders—Completed
Regulatory and Policy Assessment—Assess impacted state rules (Florida Administrative Code) and policy documents. Recommend amendments as necessary—4/1/15—6/30/15—AHCA Policy, APD—Completed
Systems Assessment—Determine and develop any required changes to State IT system requirements—5/1/16—7/31/16—AHCA Policy, APD—Not Started
Amend Waiver to Submit Updated Waiver Specific Transition Plan—Fully develop waiver specific transition plan, hold public comment and submit to CMS—10/1/16—1/15/17—AHCA Policy, APD, Stakeholders—Not Started
Regulation and Policy Updates—Promulgate recommended changes affected FAC's, amend policy documents —7/1/15—8/30/16—AHCA Policy, APD, Stakeholders—In Progress
Systems Changes—Implement recommended State IT systems changes—8/1/16—5/31/17—AHCA Policy, APD—Not started
Site Assessment and Determination
Residential Assessment Tool—Develop residential setting tool—5/1/14—6/16/14—AHCA Policy, APD—Completed
Residential Assessment Tool—Implement residential tool for monitoring activity—6/17/14—Ongoing—DOEA—Completed
Residential Provider Self-Assessment Period—Disseminate and collect data from residential providers. —6/20/14—7/25/14—APD—Completed
Non-Residential Assessment Tool—Develop non-residential tool—1/15/15—2/19/15—AHCA Policy, APD, Stakeholders—Completed
Non-Residential Provider Self-Assessment Period—Disseminate assessment and collect data from non-residential provider sites—6/22/15—7/22/15—AHCA Policy, APD, Providers—In process
Residential and Non-Residential Assessment Tools—Update tools based on self-assessment experiences and stakeholder feedback—3/1/15—7/23/15—AHCA Policy, APD—Completed
Assessment Data—Analyze self-assessment data—5/1/15—5/15/15—AHCA Policy, APD—Completed
Residential and Non-Residential Site Assessment Process—Develop assessment process and plan—5/1/15—7/31/15—AHCA Policy, APD—Completed
Onsite Residential and Non-Residential Provider Assessment—State validates provider self-assessment responses and determines individual site compliance—8/1/15—7/31/16—AHCA Policy, APD—In Progress
Remediation, Enhanced Scrutiny and Transition
Provider Remediation and Termination Protocol—Develop provider remediation and termination process—1/1/16—4/30/16—AHCA Policy, APD, Stakeholders—Completed
Recipient Transition Process—Develop transition process and plan for recipients in non-compliant facilities—5/1/16—8/30/16—AHCA Policy, APD—Completed
Provider Site Remediation Period—Work with providers to remediate site deficiencies—7/1/16—6/30/17—AHCA Policy, APD, Stakeholders-In progress
Provider Continuation/Termination Determination—Determine provider sites that can/will not meet setting standards and terminate from program—7/1/17—12/31/17—AHCA Policy, APD, Stakeholders—In progress
Recipient Transition Period—Transition recipients receiving services from non-compliant providers—10/1/17—3/1/18—AHCA Policy, APD, Stakeholders—Not started
Monitoring
Program Monitoring—Develop process to monitor waiver operations, policies for continued compliance with the HCB Settings Rule—5/1/15—6/30/15—AHCA Policy, APD—Completed
Provider Monitoring—Develop provider monitoring process to ensure continued compliance—7/1/15—12/31/15—AHCA Policy, APD—Completed
Program Monitoring—Monitor waiver operations, policies to ensure compliance with the HCBS Settings Rule. —1/1/16—Ongoing—AHCA Policy, APD—In progress
Site Monitoring—Monitor provider sites for compliance with HCB Settings Rule—7/1/16—Ongoing—AHCA Policy, APD, Stakeholders—In progress

Attachment II
State Rules and Regulations Crosswalk
State Regulatory Requirement—Description—Settings Impacted—Compliance with Rule—Action Steps

393.062 Florida Statutes (F.S.)—Legislative Findings and Declaration of Intent—Residential and non-residential settings—No conflict—Ongoing monitoring
393.067 F.S.—Developmental Disabilities, Facility license—Foster Homes, Group Homes, Residential Habilitation Facilities—No conflict—Ongoing monitoring
393.13 F.S.—Treatment of Persons with Developmental Disabilities—Residential and non-residential settings—No conflict—Ongoing monitoring
419.001 F.S.—Community Residential Homes—Assisted Living Facilities—No conflict—Ongoing monitoring
Chapter 408, Part II F.S.—Health Care Licensing: General Provisions—Assisted Living Facilities—No conflict—Ongoing monitoring
Chapter 429, Part I F.S.—Assisted Living Facilities—Assisted Living Facilities—No conflict—Ongoing monitoring
429.24(2) F.S.—Private/Semi Private Room Choice, Choice of Roommate, Locking Door to Living Unit, Eating and Snack Preparation Schedule, Participation in Facility and Community Activities, Maintaining a Personal Sleeping Schedule—Assisted Living Facilities—No conflict—Ongoing monitoring
429.28 F.S. —Access to Telephone and Usage Length, Unlimited Visitation, Snacks as Desired—Assisted Living Facilities—No conflict—Ongoing monitoring
429.24(2) F.S.—Private/Semi Private Room Choice, Choice of Roommate, Locking Door to Living Unit, Eating and Snack Preparation Schedule, Participation in Facility and Community Activities, Maintaining a Personal Sleeping Schedule—Assisted Living Facilities—No conflict—Ongoing monitoring
Chapter 58A-5, Florida Administrative Code (F.A.C.)—Assisted Living Facilities—Assisted Living Facilities—No conflict—Ongoing monitoring
Chapter 58T-1 F.A.C.—Training Requiring Provider and Curriculum Approvals—Assisted Living Facilities—No conflict—Ongoing monitoring
Chapter 59A-35 F.A.C.—Health Care Licensing Procedures—Assisted Living Facilities—No conflict—Ongoing monitoring
Chapter 59G—Florida Medicaid Handbooks: Coverage and Limitation Policy—Residential and non-residential settings—1) Review further to determine necessary changes to ensure rule compliance
2) Develop internal agency group to develop revisions
3) Make and implement revisions
4) Monitor continued compliance
Chapter 65G-2 F.A.C.—Licensure of Residential Facilities—Foster Homes, Group Homes, Residential Habilitation Facilities, Comprehensive Transitional Education Program—1) Add definition of lease
2) Reference the lease or legally enforceable agreement in sections related to client choice issues
Chapter 65G-3 F.A.C.—Termination, Suspension, or Reduction of Client Services by Service Providers—Foster Homes, Group Homes, Residential Habilitation Facilities, Comprehensive Transitional Education Program—1) Replace minimum time frame for termination notices to 30 days
Chapter 65G-4 F.A.C.—Service Delivery Practice and Procedure—Foster Homes, Group Homes, Residential Habilitation Facilities, Comprehensive Transitional Education Program—1) Preliminarily determined to be compliant
2) To be further reviewed pending outcome of iBudget Handbook promulgation
APD OP 04-003—Uniform Procedures for the Determination of Residential Habilitation Services and the Submission of Prior Service Authorization Packages—Group Homes, Residential Habilitation Centers, Comprehensive Transitional Education Program, Foster Care Homes, Assisted Living Facilities—No conflict—Ongoing monitoring
Chapter 65G-5 F.A.C.—Supported Living Services—Residential and non-residential settings—No conflict—Ongoing monitoring
Chapter 65G-8 F.A.C.—Reactive Strategies—Residential and non-residential settings—No conflict—Ongoing monitoring
APD OP 10-002—Incident Reporting and Risk Prevention for Individuals Living in the Community—Residential and non-residential settings—No conflict—Ongoing monitoring

Brief description of the HCB Characteristics Review Tool-Non-Residential Settings (referenced in Attachment IV)
The non-residential self-assessment tool is designed to measure HCBS providers' current level of compliance with the HCBS Settings Rule and provide a framework for assisting providers with any necessary steps to come into compliance. The main areas of assessment are community integration and respect/rights/choice and employment. Comments can be entered for clarification or verification. Whether the standard is met is delineated with a check box for met or not met. Methods for verification of the standard are also listed in the tool that gives the provider or evaluator a way to assess the standard.

Summary of Public Comments – iBudget Waiver Transition Plan
The State conducted a 30-day public comment period on the draft iBudget Waiver Transition Plan to solicit meaningful public input prior to finalizing the plan for submission to the Centers for Medicare and Medicaid Services. The public comment period began on February 3, 2015 and ended on March 5, 2015.

The public could submit comments by phone, or in writing to the Agency's designated email box or by regular mail. The following is the list of stakeholders that submitted comments by phone or in writing:

• MacDonald Training Center, Inc.
• Parents Planning Programs (for the Developmentally Disabled of Florida, Inc.)
• United Cerebral Palsy of South Florida

• Florida ARF (Association of Rehabilitation Facilities)
• The ARC of Florida
• Disability Rights Florida
• Florida Developmental Disabilities Council, Inc.
• Individual Consumer
• Florida Department of Education

The following table provides a summary of the comments received, change included or not included in the plan with justification and location where change can be found in the transition plan.

Summary of Comments on the iBudget Waiver Transition Plan
Public Comment Received—Included in the Plan Yes / No—Not Applicable—Justification—Location of Change

Inadequate Rates
• Many unfunded mandates will likely follow implementation of the HCBS rules contingent upon how the new HCBS standards are applied. The rates must be adjusted to cover the additional and/or new requirements if the cost is to be passed on to providers.
• In order for the HCBS initiative to occur, the current room and board requirements will have to be revised.
• We recommend that AHCA rethink its policies regarding overpayments and denial of payments for Medicaid services provided under the iBudget Waiver
• The room and board rate system must be revised to reflect an individual's ability to spend a varied portion of their personal funds on choices such as private rooms, selected activities, or desired food when the choice is different from group home options.
• To achieve compliance, providers need additional funding to upgrade facilities and an increase in rates to recruit and retain qualified staff and stabilize the workforce.
• There must be action steps that address the cost of upgrading facilities such as reinstating Group Home loan programs, including forgiveness of loan after 5 years.
• Supported Living should have an increased stipend to truly make choice available to all recipients. Stipends should be weighted to account for an individual not having earned income or having the additional expense of childcare.
• "Is the cost of choice to be borne by the individual making the choice decisions?" If the answer is no, then HCBS reimbursement rates and service options must cover the cost of the enhanced expectations.———Not applicable—Service rates and related reimbursement issues are not a part of the transition plan. HCB Settings Rule did not authorize additional funding.—

Individual Lease Agreements:
• How will health and safety considerations weigh against a required lease or legal document?
• How specific can providers be when developing agreements that assure individual rights while also protecting other individuals residing in the home?
• Exactly how does the lease or enforceable agreement relate to Room and Board only or Residential Habilitation services provided through the iBudget Waiver?—Yes———The State will continue to review the state regulations regarding individual lease agreements. The State will provide training through webinars to assist providers regarding lease agreements.—Attachments I and II were revised to include training. Attachment I was revised to extend the time period of the State's regulatory review.

Staffing/Compliance Oversight
• The current staffing levels and rates do not support a 1-to-1 staff–to-resident ratio for varying individual choice decisions.
———Not applicable—Service staffing levels were not a part of the transition plan.—
• Greater detail and direction are needed on how and when AHCA and APD can ensure compliance from providers.——No——As the Agency moves forward with implementation of the HCB Settings Rule, greater detail about compliance oversight will be provided.—

Person Centered Planning
• iBudget transition plan does not speak to the process of Person Centered Planning.
• When residential settings are being considered, self-advocates and families want to have information available as to where all openings are and want to visit those openings prior to making a decision.
• Improved assistance with making choices; developing new and innovative goals (not just asking me what I want to do, but teaching me about my community and options so I have better information to design my goals).
• Being able to have friends and family over for meals wherever a person may live.
• Require mandatory comprehensive training for providers, consumers, families, and legal representatives in the specifics and the requirements of the Person Centered Planning Process as well as improved monitoring of person center planning by contracted vendor and agency.
• Require consultation with family &/or legal representatives regarding any assessment process which may lead to modifications of the person centered service plan, include access to documents in consumer's central file.
• Describe individuals served in each setting, review their person centered plans and determine compliance with the requirements of a person centered planning process.—Yes———Person center planning is a core component of the waiver and should not be addressed in the transition plan. The Agency will include recipient interviews in the assessment process.—Section VI Communication and Education was added to the transition plan to specify the State's outreach strategy for sharing information with stakeholders and

obtaining public input.

Individuals controlling their personal account
• Does the individual control their individual personal resources?———Not applicable—The HCB Settings Rule encourages the individual to choose their residential setting based upon their identified needs and personal resources. This rule does not impact an individual's control of person resources.—See Attachment III. HCB Characteristics Review Tool – Non-Residential Settings of the transition plan. Standard 1.1 addresses personal resources.

HCB Characteristic Review Tool
• The Tool used to assess and determine settings compliance with the new rule – the questions and interpretive guidelines are very minimal and do not adequately capture the information needed to determine if the HCBS rule characteristics are present.
• Does the setting support individuals receiving services in the community? The tool does not include any questions regarding employment or meaningful day employment.
• A separate tool should be developed for nonresidential settings with a set of questions and interpretive guidelines.
• The results of the June 2014 Residential Self-Assessment Survey process were underwhelming and discomforting: due to low number of respondents and only the "majority" of those respondents who were in compliance or likely to be in compliance with minor changes. APD and AHCA need to obtain 100% compliance by providers and then send surveys to all stakeholders for input on all facilities.
• No timeframe in plan on how long the programmatic changes discussed regarding residential settings would begin, how long they would take, or the time needed to complete the needed changes.
• Non-Residential Settings Assessment must be further developed to be meaningful.
• AHCA's monitoring scope and scale are not defined outside of the table that shows annual monitoring, and does not identify who will monitor the residential and non-residential settings. The HCB Characteristics Review Tool in Attachment III of the Plan requires further detail.
• CMS developed a list of exploratory questions to assist states in assessing HCBS settings.
• State should detail steps for future initial assessments of new providers or services from existing providers and must rely heavily on APD staff input and timely follow-up by surveying consumers.
• Address employment, additional probing questions needed. Question whether the individual experiences isolation in the setting rather than if the setting isolates. Concentrate on the individual's experience—Yes———CMS will review the State revised HCB Characteristic Review Tool as part of the approval process and the Agency will address any deficiencies. Stakeholder input will be considered as the review tools are revised. The Agency will include recipient interviews in the assessment process.—Attachment IV contains the HCB Characteristics Review Tool – Non-Residential Settings. Section VI Communication and Education was added to the transition plan to specify the State's outreach strategy for sharing information with stakeholders and obtaining public input.

Attachments
• Provide clarification in Attachment II, The Agency has determined the program complies with the HCB setting requirements.
—Yes———The Agency has determined there is no conflict between the various provisions in state regulations and the HCB Settings Rule.—Attachments I and II were revised to extend the time period of the State's regulatory review.
• Attachment III Standard 1.1 – Why is the word "institutional" used here when the new CMS rule is addressing a 1915c Home and Community Based Services Medicaid Waiver?———Not applicable—Attachment III's Interpretive Guidelines use institutional to distinguish between residential and institutional characteristics.—Please note reference to 42 CFR 441.301(c)(5) was added.
• The Attachment III seems to be very "facility "based.———Not applicable—The purpose of the HCB Characteristic Review Tool is to distinguish between residential and institutional characteristics.—

Statutes and Regulation
• Florida's compliance in regard to the Regulatory Assessment falls far short of what is needed. Florida Statutes and state regulations governing AHCA and APD should be reviewed for conflict with the new federal regulations.
• AHCA and APD are encouraged to further examine the statutes of Chapter 393, in regards to "Guidance on Settings That Have the Effect of Isolating Individuals Receiving HCBS from the Broader Community," which identifies two characteristics that may meet the criteria for having the effect of isolating individuals.
• CMS' Guidance, mentioned earlier, defines a presumptively institutional setting as one that "is designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities." Florida's only CTEP meets these criteria and should have been identified as presumptively institutional.
• There are rule conflicts that require action. The following rules chapters were noted: 65G-5, 65G-2, 65G-3 and 65G-4, F.A.C.
—Yes———The State's preliminary regulatory assessment reviewed the affected Florida Statutes and rules to determine if any conflict exists with the HCB Settings Rule. Further review of affected statutes will be performed and revisions recommended to policy makers as necessary.—Attachments I and II were revised to extend the time period of the State's regulatory review. Section IV Remediation was added to the transition plan that includes the process for heightened scrutiny of facilities presumed to be institutional.

Services
• State is encouraged to develop iBudget services, including "Life Skills Development" which encompasses three distinct services in

three distinct settings: Companion, Supported Employment, and Adult Day Training. The services should not be bundled for compliance purposes, but should be examined independently to ensure accurate results for each setting.
• Remediation steps are unclear as to what notice – including form of notice, timing of notice, and any protections that would attach as a resident of that facility— will be provided to residents of/consumers in settings when compliance has not been met.
—Yes———The transition plan was not designed to address specific program services or their utilization. The State will continue to review the services identified to determine the necessity to unbundle them.—Section IV Remediation was added to the transition plan that includes the process for heightened scrutiny of facilities presumed to be institutional.

Public Process/ Recipient Outreach
• Once reviews have begun, compliance reports should be put into a publicly-available database for providers, support coordinators, consumers, families, and other stakeholders to have access to without having to make a public records request pursuant to Florida Statutes Chapter 119.
• There has been little to no communication with consumers or their guardians.
• Provide outreach with information and training to all individuals who may contribute to the person centered planning process.
• Recognize individuals may have chosen to be friends with other individuals with disabilities. They may not want to be pressured into interacting with individual they are not comfortable with or forced to engage in non-preferred activities.—Yes———The Agency complied with the public input requirements of the HCB Settings Rule. The Interested parties are encouraged to request training and reports related to the rule implementation. All documents will be made available as any other public record. The Agency will include recipient interviews in the assessment process.—Section VI Communication and Education was added to the transition plan to specify the State's outreach strategy for sharing information with stakeholders and obtaining public input. Additional communication and outreach efforts will be considered as the rule is implemented.

State Assurance

The state assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

   Specify the division/unit name:
   The Florida Agency for Persons with Disabilities (APD)

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   Oversight by the State Medicaid Agency is achieved through an interagency agreement with the Operating Agency, the APD. Delegated functions include: determination of eligibility and enrollment for iBudget Waiver recipients; management of the recipient waitlist; making appropriate approved decisions on behalf of and under the oversight of AHCA; and ensuring qualified providers are enrolled and providing oversight for those providers.

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

Appendix A: Waiver Administration and Operation

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

   - (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
     Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
     The State Medicaid Agency utilizes a Contracted Vendor (CV) for statewide quality assurance for the Developmental Disabilities Individual Budgeting Waiver.
   - ( ) **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

   - (●) **Not applicable**
   - ( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
     Check each that applies:
     - [ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Agency for Health Care Administration is responsible for assessment of performance of the Contracted Vendor for statewide quality assurance for the Developmental Disabilities Individual Budgeting Waiver.

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

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

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

Where possible, include numerator/denominator.

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

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

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

		Confidence Interval = 95%+/-5
☑ **Other** Specify: Contracted Vendor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%+/-5
☑ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

Contracted Vendor		
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Florida's Medicaid Agency staff and the Operating Agency staff are in on-going communications via telephone or face to face to identify and address waiver issues.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
(A-1) The Contracted Vendor conducts PCRs on a continuous and ongoing basis. The Contracted Vendor sends them to the State Medicaid Agency for review on a monthly basis. The State Medicaid Agency reviews a representative sample to identify problems or concerns. Any problems or concerns identified are discussed at periodic status meetings between the Medicaid Agency, the Operating Agency, and the Contracted Vendor. Issues that are not able to be resolved are advanced to upper management.

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

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

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

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

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §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 SubGroup	Minimum Age	Maximum Age: Maximum Age Limit	Maximum Age: No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☑ **Intellectual Disability or Developmental Disability, or Both**					
	☑	**Autism**	3		☑
	☑	**Developmental Disability**	3		☑
	☑	**Intellectual Disability**	3		☑
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

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

*The individual's primary disability is an intellectual disability with an intelligence quotient (IQ) of 59 or less.
*The individual's primary disability is an intellectual disability with an IQ of 60-69 inclusive, and has at least one of the following handicapping conditions:

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

*The individual's primary disability is mental retardation with an IQ of 60-69 inclusive, and has severe functional limitations in at least three of the major life activities specified below.

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

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

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

- ◉ **Not applicable. There is no maximum age limit**
- ○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

○ **Other**

Specify:

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

- [ ] **The participant is referred to another waiver that can accommodate the individual's needs.**
- [ ] **Additional services in excess of the individual cost limit may be authorized.**

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

- [ ] **Other safeguard(s)**

  Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	34742
Year 2	36242
Year 3	37742
Year 4	39242
Year 5	40742

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	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
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)*:

- (selected) **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)*:

- (selected) **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:

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**
2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (●) **Yes**

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

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

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

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

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

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

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: ☐

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

Specify dollar amount: ☐

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
☐ **Aged and disabled individuals who have income at:**

Select one:

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

Specify percentage amount: ☐

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 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 five-year period beginning January 1, 2014, 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 December 31, 2018.

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

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

(*select one*):

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

  Specify the percentage:

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

  Specify dollar amount:

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

  Specify percentage:

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

  Specify:

- **The following dollar amount**

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

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

  Specify:

- **Other**

  Specify:

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

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

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

Specify:

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs

allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

(●) **The following standard included under the State plan**

Select one:

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

(*select one*):

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

Specify the percentage:

( ) **A dollar amount which is less than 300%.**

Specify dollar amount:

( ) **A percentage of the Federal poverty level**

Specify percentage:

( ) **Other standard included under the State Plan**

Specify:

( ) **The following dollar amount**

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

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

Specify:

( ) **Other**

Specify:

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

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

Specify:

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

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

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

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

Specify:

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

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

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

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

Specify:

- ○ **Other**

Specify:

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

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

Select one:

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

Specify:

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:
- ○ **The following dollar amount:**

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

  Specify formula:

○ **Other**

Specify:

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

Select one:

◉ **Allowance is the same**
○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

  Specify the entity:

- ○ **Other**

  Specify:

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

Support Coordinators or APD staff employed by the state shall meet the following minimum qualifications: 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 work or health and rehabilitative services. A master's degree can substitute for one year of the required experience.

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

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

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

I. Level of Care Eligibility: An individual who has applied for developmental disability Medicaid waiver services who meets one of the following criteria and is eligible to receive the services provided in an ICF/DD. Check all criteria that are met.
Option A. ____The individual's primary disability is intellectual disability with an intelligence quotient (IQ) of 59 or less.
Option B. ____The individual's primary disability is intellectual disability with an IQ of 60-69 inclusive and the individual has at least one of the following handicapping conditions OR individual's primary disability is mental retardation with an IQ of 60-69 inclusive and the individual has severe functional limitations in at least three of the Major Life Activities. Please check all handicapping conditions and major life activities that apply.
Option C. ____The individual is eligible under the category of autism, cerebral palsy, Down syndrome, spina bifida, Phelan McDermid syndrome or Prader-Willi syndrome and the individual has severe functional limitations in at least three of the major life activities. Please check all handicapping conditions and major life activities that apply.

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

Major Life Activities
____Self Care

____Understanding and use of language
____Learning
____Mobility
____Self Direction
____Capacity for independent living

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

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

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

APD staff or support coordinators will evaluate an individual's level of care on an annual basis as a part of the support planning process. During that process, the individual is asked to make a choice between institutional and community-based services in addition to a reevalution of the level of care.

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

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

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

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

○ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

◉ **The qualifications are different.**
Specify the qualifications:

Solo providers and supervisors from waiver support coordination agencies shall meet the following minimum qualifications: a bachelor's degree from an accredited college or university and three years of professional experience in developmental disabilities, special education, mental health, counseling, guidance, social work or health and rehabilitative services. A master''s degree can substitute for one year of the required experience.

Waiver Support Coordinators employed by waiver support coordination agencies shall meet the following minimum qualifications: 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 work or health and rehabilitative services. A master's degree can substitute for one year of the required experience.

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):*

As part of the annual support planning process, support coordinators assist recipients and their families with the reevaluation process.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as

required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

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

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
APD has adopted a quality assurance strategy that mirrors the CMS Quality Framework. The Discovery function is a universal responsibility, but the majority of the work is done by the CV utilizing a statistically valid sampling methodology for individual single case analysis and a traditional provider compliance process which engages service providers annually. The Remediation function is handled by APD which receives discovery material from the CV. The CV issues alerts to APD upon discovery of health and safety violations and concerns. APD responds immediately to all alerts. Plans of Remediation are required of cited providers that identifies specifc actions and timeframes to address deficiency.

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
(B-1) The Operating Agency ensures that the level of care determination, including the iBudget Eligibility Worksheet, is completed prior to Waiver enrollment on a continuous and ongoing basis. Systematically, the waiver enrollment process disallows enrollment prior to a completed level of care determination. In the event a level of care determination is not completed, the operating agency will work with the regional office and the recipient to make sure that it is completed prior to waiver enrollment.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Support coordinators inform individuals of freedom of choice of institutional services or waiver services during the initial intake interview. The form specifying freedom of choice is the Medicaid Eligibility Worksheet.

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

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

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Bilingual (Spanish speaking) employees are located in the APD Area Offices and are available through support coordination agencies.

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	Residential Habilitation		
Statutory Service	Respite		
Statutory Service	Support Coordination		
Extended State Plan Service	Adult Dental Services		
Extended State Plan Service	Occupational Therapy		
Extended State Plan Service	Physical Therapy		
Extended State Plan Service	Respiratory Therapy		
Extended State Plan Service	Skilled Nursing		
Extended State Plan Service	Specialized Medical Equipment and Supplies		
Extended State Plan Service	Specialized Mental Health Counseling		
Extended State Plan Service	Speech Therapy		
Extended State Plan Service	Transportation		
Other Service	Behavior Analysis Services		
Other Service	Behavior Assistant Services		
Other Service	Dietitian Services		
Other Service	Environmental Accessibility Adaptations		

Service Type	Service
Other Service	Life Skills Development
Other Service	Personal Emergency Response System
Other Service	Personal Supports
Other Service	Private Duty Nursing
Other Service	Residential Nursing
Other Service	Special Medical Home Care
Other Service	Supported Living Coaching

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope)*:

Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirement of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Residential habilitation services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Facility
Agency	Adult Family Care Home
Agency	Group Home
Agency	Foster Home

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Assisted Living Facility
Provider Qualifications
License *(specify):*
In accordance with Chapter 408 and 429, F.S.
Certificate *(specify):*

Other Standard *(specify):*
Direct Service: at least 1 year experience working in a medical, psychiatric, nursing or child care setting or working with individuals diagnosed with developmental disabilities or 30 semester hours, 45 quarter hours, or 720 classroom room hours of college or vocational school and must be age 18 and older.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Adult Family Care Home
Provider Qualifications

License *(specify)*:
In accordance with Chapters 408 and 429, F.S.
Certificate *(specify)*:

Other Standard *(specify)*:
Direct Service: – at least 1 year experience working in a medical, psychiatric, nursing or child care setting or working with individuals diagnosed with developmental disabilities or 30 semester hours, 45 quarter hours, or 720 classroom room hours of college or vocational school and must be age 18 and older.

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Group Home
Provider Qualifications
License *(specify)*:
In accordance with Chapter 393, F.S.
Certificate *(specify)*:

Other Standard *(specify)*:
Direct Service: – at least 1 year experience working in a medical, psychiatric, nursing or child care setting or working with individuals diagnosed with developmental disabilities or 30 semester hours, 45 quarter hours, or 720 classroom room hours of college or vocational school and must be age 18 and older. For exemptions to this requirement, see Rule 65G-2.008, F.A.C.

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Foster Home
Provider Qualifications
License *(specify)*:
In accordance with Chapter 393, F.S.
Certificate *(specify)*:

Other Standard *(specify):*
Direct Service: at least 1 year experience working in a medical, psychiatric, nursing or child care setting or working with individuals diagnosed with developmental disabilities or 30 semester hours, 45 quarter hours, or 720 classroom room hours of college or vocational school and must be age 18 and older. For exemptions to this requirement, see Rule 65G-2.008, F.A.C.

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

C-1/C-3: 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	Sub-Category
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):*
Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirement of the applicable life safety code. Payment for residential habilitation does not include payments

made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual

Provider Type:
Registered Nurse

Provider Qualifications

License *(specify):*
In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual

Provider Type:
Independent Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual

Provider Type:
Licensed Practical Nurse

Provider Qualifications

License *(specify):*
In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Provider Type:

Homemaker/sitter/companion

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Provider Type:
Assisted Living Facility
Provider Qualifications
License *(specify):*
In accordance with Chapter 400, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Nurse Registry
Provider Qualifications
License *(specify):*
In accordance with Chapter 400, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Hospice Agency
Provider Qualifications
License *(specify):*
In accordance with Chapter 400, F.S.
Certificate *(specify):*

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Homemaker/sitter/companion

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License *(specify)*:

In accordance with Chapter 393, F.S.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

C-1/C-3: 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	Sub-Category
Category 1: 01 Case Management	**Sub-Category 1:** 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.

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

of the recipient. When the recipient resides in supported living, assisted living, or licensed residential facility settings, one of the monthly contacts must be face-to-face with the recipient. For recipients who live in the family home, a face-to-face contact is required every 3 months.

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

Transitional Support Coordination: Transitional Support Coordination consists of activities that assist the recipient in transitioning from a nursing facility or an ICF/IDD to the community, or assisting recipients who need a more intensive level of support coordination. Transitional Support Coordination must meet all the same requirements as Full Support Coordination, and the WSC must have, at a minimum, weekly face-to-face contact with the recipient. If an recipient is moving from an institutional placement into the community, the WSC providing enhanced support coordination will work directly with the recipient, institutional staff, and the selected waiver providers prior to the move to ensure a smooth transition to community services, including those funded through the waiver and other services and supports necessary to ensure the health and safety of the recipient. The WSC will coordinate these activities with the facility's discharge planning processer. The WSC must develop an initial support plan for the recipient, taking into account information from the provider's summary of the recipient's development, behavioral, social, health, and nutritional status and a discharge plan designed to assist the recipient in adjusting to their new living environment. The WSC must have, at a minimum, weekly face-to-face contact with the recipient for the first 30 days following discharge from the facility. WSC providing enhanced support coordination is on call 24 hours per day, 7 days per week for the recipient. The WSC must update the recipient's support plan at the end of 30 consecutive calendar days to identify progress made with the transition to community services and possible changes needed in supports and services, and follow-up on unresolved issues.

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
Individual	Independent Support Coordinators
Agency	Support Coordination Agencies

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:

Individual

Provider Type:

Independent Support Coordinators
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Bachelors degree and three years of paid supervised experience in developmental disabilities, special education, mental health, counseling, guidance, social welfare, or health and rehabilitative services. A master's degree in a related field can substitute for one year of the required experience.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:
Agency
Provider Type:
Support Coordination Agencies
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Bachelors degree and two years of paid, supervised 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.

Agency supervisors must have a bachelors degree a three years of paid, supervised experience in developmental disabilities, special education, mental health, counseling, guidance, social work, or health and rehabilitative services. A master's degree in a related field can substitute for one year of the required experience.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

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

HCBS Taxonomy:

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

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

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

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

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.

Dental services for children are provided through Medicaid State Plan services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Adult dental services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Denists
Agency	Dental Agencies

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Independent Denists

Provider Qualifications

License *(specify)*:
In accordance with Chapter 466, F.S.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Dental Agencies

Provider Qualifications

License *(specify)*:
In accordance with Chapter 466, F.S.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

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

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
Occupational therapy services are services prescribed by a physician, ARNP, or physician assistant that produce specific functional outcomes in self-help, adaptive, and sensory motor skill areas, and assist the recipient to control and maneuver within the environment. The services may also include an occupational therapy assessment, which does not require a physician's prescription. In addition, this service may include training direct care staff and caregivers and monitoring those individuals to ensure they are carrying out therapy goals correctly.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Occupational therapy services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is limited to individuals over age 21.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
In accordance with Chapter 400, F.S.
Certificate *(specify):*
In accordance with 42 CFR 484.
Other Standard *(specify):*
Enrolled in the Medicaid Home Health Program.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Provider Type:
Occupational Therapy Assistant
Provider Qualifications
License *(specify):*

Certificate *(specify):*
In accordance with Chapter 468, F.S.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Provider Type:
Occupational Therapist

Provider Qualifications

License *(specify):*

In accordance with Chapter 468, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Occupational Therapy Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In accordance with Chapter 468, F.S.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

In accordance with Chapter 468, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

This waiver service is limited to individuals over age 21.

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	Physical Therapist
Individual	Physical Therapy Assistant
Agency	Physical Therapy Assistant
Agency	Physical Therapist
Agency	Home Health Agency

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Physical Therapist

Provider Qualifications

License *(specify):*
In accordance with Chapter 486, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Physical Therapy Assistant

Provider Qualifications

License *(specify):*
In accordance with Chapter 486, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Physical Therapy Assistant

Provider Qualifications

License *(specify):*

In accordance with Chapter 486, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

In accordance with Chapter 486, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
In accordance with Chapter 400, F.S.
Certificate *(specify):*
In accordance with 42 CFR 484.
Other Standard *(specify):*
Enrolled in the Medicaid Home Health Program.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Respiratory Therapy

HCBS Taxonomy:

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

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

◉ **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

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

Service Definition *(Scope):*
Respiratory therapy is a service prescribed by a physician, ARNP, or physician assistant and relates to impairment of respiratory function and other deficiencies of the cardiopulmonary system. Treatment activities include ventilator support, therapeutic and diagnostic use of medical gases, respiratory rehabilitation, management of life support systems, bronchopulmonary drainage, breathing exercises and chest physiotherapy. The provider determines and monitors the appropriate respiratory regimen and maintains sufficient supplies to implement the regimen. The provider may also provide training to direct care staff to ensure adequate and consistent care is provided. Respiratory therapy services may also include a respiratory assessment.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Respiratory therapy services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is limited to individuals over age 21.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
In accordance with Chapter 400, F.S.
Certificate *(specify):*
In accordance with 42 CFR 484.
Other Standard *(specify):*
Enrolled in the Medical Home Health Program.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Provider Type:
Respiratory Therapist
Provider Qualifications
License *(specify):*
In accordance with Chapter 468, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Provider Type:
Respiratory Therapist
Provider Qualifications
License *(specify):*
In accordance with Chapter 468, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Extended State Plan Service

Service Title:
Skilled Nursing

HCBS Taxonomy:

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

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

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

Service Definition *(Scope)*:
Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

Skilled nursing is a service prescribed by a physician, ARNP, or physician assistant and consists of part-time or intermittent nursing care visits provided by registered or licensed practical nurses for recipients who require a skilled nursing visit.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Skilled nursing services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is limited to individuals over age 21.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Practical Nurse Agency
Agency	Hospice Agency
Agency	Nurse Registry
Individual	Licensed Practical Nurse
Agency	Registered Nurse Agency

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Registered Nurse

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Licensed Practical Nurse Agency

Provider Qualifications

License *(specify):*
In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Hospice Agency

Provider Qualifications

License *(specify):*
In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Nurse Registry
Provider Qualifications
License *(specify):*
In accordance with Chapter 400, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Licensed Practical Nurse
Provider Qualifications
License *(specify):*
In accordance with Chapter 464, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Provider Type:
Registered Nurse Agency
Provider Qualifications
License *(specify):*
In accordance with Chapter 464, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

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

Provider Category:

Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
In accordance with Chapter 400, F.S.
Certificate *(specify):*
In accordance with 42 CFR 484.
Other Standard *(specify):*
Enrolled in the Medicaid Home Health Program.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

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

Provider Category:

Provider Type:
Registered Nurse
Provider Qualifications
License *(specify):*
In accordance with Chapter 464, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Consumable medical supplies and durable medical equipment are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is limited to individuals over age 21.

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

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Retail Stores

Provider Qualifications

License *(specify)*:
In accordance with Chapter 205, F.S.

Certificate *(specify)*:

Other Standard *(specify)*:
If county does not require a permit or license, evidence must be provided and FEID number made available.

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:

Assistive Technology Suppliers and Practitioners

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

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

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Medical supply companies and durable medical equipment suppliers

Provider Qualifications

License *(specify)*:

In accordance with Chapter 205, F.S.

Certificate *(specify)*:

Other Standard *(specify)*:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify)*:

In accordance with Chapter 400, F.S.

Certificate *(specify)*:

Other Standard *(specify)*:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Pharmacy

Provider Qualifications

License *(specify):*

In accordance with Chapter 465, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Specialized Mental Health Counseling

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Specialized mental health counseling for persons with developmental disabilities are services provided to maximize the reduction of a recipient's mental illness and restoration to the best possible functional level. Specialized mental health services focus on the unique treatment of psychiatric disorders and rehabilitation for impairments for persons with developmental disabilities and mental illness. These services include specialized individual, group and family therapy provided to recipients using techniques appropriate to this population.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Specialized mental health counseling services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is limited to individuals over age 21.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Clinical Social Worker
Individual	Marriage and Family Therapist
Agency	Marriage and Family Therapist
Agency	Psychiatrist
Individual	Psychologist
Agency	Clinical Social Worker
Agency	Mental Health Counselor
Individual	Psychiatrist
Individual	Mental Health Counselor
Agency	Psychologist

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Clinical Social Worker
Provider Qualifications
License *(specify):*

In accordance with Chapter 491, F.S.
Certificate *(specify)*:

Other Standard *(specify)*:
Two years experience with individuals who have mental illness and developmental disabilities.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Marriage and Family Therapist
Provider Qualifications
License *(specify)*:
In accordance with Chapter 491, F.S.
Certificate *(specify)*:

Other Standard *(specify)*:
Two years experience with individuals who have mental illness and developmental disabilities.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Marriage and Family Therapist
Provider Qualifications
License *(specify)*:
In accordance with Chapter 491, F.S.
Certificate *(specify)*:

Other Standard *(specify)*:
Two years experience with individuals who have mental illness and developmental disabilities.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Psychiatrist
Provider Qualifications
License *(specify):*
In accordance with Chapters 458 and 459, F.S.
Certificate *(specify):*
In accordance with rule 59G-1.010, F.A.C.
Other Standard *(specify):*
Two years experience with individuals who have mental illness and developmental disabilities.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Psychologist
Provider Qualifications
License *(specify):*
In accordance with Chapter 490, F.S.
Certificate *(specify):*

Other Standard *(specify):*
Two years experience with individuals who have mental illness and developmental disabilities.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Clinical Social Worker
Provider Qualifications
License *(specify):*
In accordance with Chapter 491, F.S.
Certificate *(specify):*

Other Standard *(specify):*
Two years experience with individuals who have mental illness and developmental disabilities.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Mental Health Counselor
Provider Qualifications
License *(specify):*
In accordance with Chapter 491, F.S.
Certificate *(specify):*

Other Standard *(specify):*
Two years experience with individuals who have mental illness and developmental disabilities.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Psychiatrist
Provider Qualifications
License *(specify):*
In accordance with Chapters 458 and 459, F.S.
Certificate *(specify):*
In accordance with rule 59G-1.010, F.A.C.
Other Standard *(specify):*
Two years experience with individuals who have mental illness and developmental disabilities.
Verification of Provider Qualifications
Entity Responsible for Verification:

Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Mental Health Counselor
Provider Qualifications
License *(specify):*
In accordance with Chapter 491, F.S.
Certificate *(specify):*

Other Standard *(specify):*
Two years experience with individuals who have mental illness and developmental disabilities.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Psychologist
Provider Qualifications
License *(specify):*
In accordance with Chapter 490, F.S.
Certificate *(specify):*

Other Standard *(specify):*
Two years experience with individuals who have mental illness and developmental disabilities.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Speech Therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

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

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

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

This waiver service is limited to individuals over age 21.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Audiology Assistant
Agency	Audiologist
Individual	Audiology Assistant

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Audiology Assistant
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
In accordance with Chapter 468, F.S.
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Audiologist
Provider Qualifications
License *(specify)*:
In accordance with Chapter 455, F.S.
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Audiology Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*
In accordance with Chapter 468, F.S.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Speech-Language Pathologist

Provider Qualifications

License *(specify):*
In accordance with Chapter 468, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

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

Provider Category:

Provider Type:
Speech-Language Pathology Assistant
Provider Qualifications
License *(specify):*

Certificate *(specify):*
In accordance with Chapter 468, F.S.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Provider Type:
Speech-Language Pathology Assistant
Provider Qualifications
License *(specify):*
In accordance with Chapter 468, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Provider Type:
Audiologist
Provider Qualifications

License *(specify):*
In accordance with Chapter 455, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
In accordance with Chapter 400, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Speech-Language Pathologist
Provider Qualifications
License *(specify):*
In accordance with Chapter 468, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Transportation

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Services are offered only to gain access to waiver services. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible family, neighbors, friends, or community agencies, which can provide this service without charge, will be utilized.

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

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

This waiver service is limited to individuals over age 21.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Community Transportation Coordinator
Provider Qualifications
License *(specify):*
In accordance with Chapters 316 and 322, F.S.
Certificate *(specify):*

Other Standard *(specify):*
In accordance with Chapter 41-2, F.A.C.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Transportation

Provider Category:
Individual
Provider Type:
Independent (private automobile, wheelchair van, bus, taxi)
Provider Qualifications
License *(specify):*
In accordance with Chapter 322, F.S.
Certificate *(specify):*

Other Standard *(specify):*
Group homes, residential facility or adult day training providers must comply with Chapter 427, F.S.
Verification of Provider Qualifications
Entity Responsible for Verification:

Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Behavior Analysis Services

HCBS Taxonomy:

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

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

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

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

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

Waiver services are limited to individuals over age 21.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:
Individual

Provider Type:
Behavior Analyst

Provider Qualifications

License *(specify):*

Certificate *(specify):*
In accordance with Chapter 393, F.S.

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:
Individual

Provider Type:
Marriage and Family Therapist

Provider Qualifications

License *(specify):*
In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:
Agency

Provider Type:
Psychologist

Provider Qualifications

License *(specify):*
In accordance with Chapter 490, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavior Analysis Services

Provider Category:

Provider Type:

Mental Health Counselor

Provider Qualifications

License *(specify):*

In accordance with Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Provider Type:

Behavior Analyst

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In accordance with Chapter 393, F.S.

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavior Analysis Services

Provider Category:
Individual
Provider Type:
Psychologist
Provider Qualifications
License *(specify)*:
In accordance with Chapter 490, F.S.
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:
Agency
Provider Type:
Clinical Social Worker
Provider Qualifications
License *(specify)*:
In accordance with Chapter 491, F.S.
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:
Agency
Provider Type:
Marriage and Family Therapist
Provider Qualifications
License *(specify)*:

In accordance with Chapter 491, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:
Individual
Provider Type:
Clinical Social Worker
Provider Qualifications
License *(specify):*
In accordance with Chapter 491, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:
Individual
Provider Type:
Mental Health Counselor
Provider Qualifications
License *(specify):*
In accordance with Chapter 491, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Assistant Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

Waiver services are limited to individuals over age 21.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Behavior Assistant
Individual	Behavior Assistant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Assistant Services

Provider Category:
Agency

Provider Type:
Behavior Assistant

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Providers of this service must be age 18 and older, have a high school diploma or a GED and have at least:

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Assistant Services

Provider Category:
Individual
Provider Type:
Behavior Assistant
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers of this service must be age 18 and older, have a high school diploma or a GED and have at least:

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

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

3) Training in an APD approved emergency procedure curriculum where providers will be working with recipients with significant behavioral challenges.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Dietitian Services

HCBS Taxonomy:

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

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

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

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

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

Service Definition *(Scope):*
Dietitian services are those services prescribed by a physician, ARNP, or physician assistant that maintain or improve the overall physical health of a recipient. The services include assessing the nutritional status and needs of a recipient; recommending an appropriate dietary regimen, nutrition support and nutrient intake; and providing counseling and education to the recipient, family, direct service staff and food service staff. The services may also include the development and oversight of nutritional care systems that promote a person's optimal health.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Dietician 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.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Dietitian/Nutritionist
Agency	Dietitian/Nutritionist Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietitian Services

Provider Category:
Individual
Provider Type:
Dietitian/Nutritionist
Provider Qualifications
License *(specify):*
In accordance with Chapter 468, F.S.
Certificate *(specify):*

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietitian Services

Provider Category:

Agency

Provider Type:

Dietitian/Nutritionist Agency

Provider Qualifications

License *(specify)*:

In accordance with Chapter 468, F.S.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

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

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

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

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

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

Service Definition *(Scope):*
Physical adaptations to the home, required by the individual's plan of care, which ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electronic and plumbing systems which are necessary to accommodate the medical equipment and supplies, which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home, which are of general utility, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Environmental Accessibility Adaptations services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Contractor/Electrician
Agency	Architects
Individual	Engineer
Individual	Carpenters/other Independent Vendors
Individual	Plumber
Agency	Engineers
Individual	Architect
Agency	Plumbers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:

Contractor/Electrician
Provider Qualifications
License *(specify):*
In accordance with Chapter 489, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Architects
Provider Qualifications
License *(specify):*
In accordance with Chapter 481, F.S.
Certificate *(specify):*

Other Standard *(specify):*
One year experience in Rehabilitation Engineering or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:
Engineer
Provider Qualifications
License *(specify):*
In accordance with Chapter 471, F.S.
Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Carpenters/other Independent Vendors

Provider Qualifications

License *(specify):*

In accordance with Chapter 205, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Plumber

Provider Qualifications

License *(specify):*

In accordance with Chapter 553, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Engineers
Provider Qualifications
License *(specify):*
In accordance with Chapter 471, F.S.
Certificate *(specify):*

Other Standard *(specify):*
One year experience in Rehabilitation Engineering or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:
Architect
Provider Qualifications
License *(specify):*
In accordance with Chapter 481, F.S.
Certificate *(specify):*

Other Standard *(specify):*
One year experience in Rehabilitation Engineering or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency

Provider Type:
Plumbers
Provider Qualifications
License *(specify):*
In accordance with Chapter 553, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Life Skills Development

HCBS Taxonomy:

Category	Sub-Category
Category 1: 08 Home-Based Services	**Sub-Category 1:** 08040 companion
Category 2: 03 Supported Employment	**Sub-Category 2:** 03021 ongoing supported employment, individual
Category 3: 04 Day Services	**Sub-Category 3:** 04020 day habilitation
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Life Skills Development Services consist of assistance and training to increase the recipient's participation and inclusion in community life and activities. These services stress training in areas of self-help, job skills, adaptive and social skills, and services that are age and culturally appropriate. These services seek to assist the recipient to participate in the day-to-day activities of the community and provide practical skill development in the setting in which the skill is needed. Includes non-medical care, supervision and socialization activities provided to an adult on a one-to-one or in groups not to exceed three recipients. Services that assist the recipient to volunteer, work, learn, and play in their community are also included. An integral part of this service is job skills development and ongoing supports that enable recipients, for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need supports to perform in a regular work setting. Employment services include activities needed to sustain paid work by recipients, including supervision and training. When employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by recipients receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

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

Life Skills Development is provided on a one-on-one basis or in groups not to exceed three recipients under Level I rates. Level II and III rates allow for provision at difference ratios and are for services that are provided outside of a facility and in an adult day training center, respectively; for these levels, there are specific ratios that are defined with specific rates.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Development

Provider Category:

Agency

Provider Type:

Agency Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Level II: completion of required pre-service training.

Other Standard *(specify):*

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

Life Skills II: Providers of supported employment services must meet one or more of the following

requirements:
• Have a bachelor's degree from an accredited college or university with a major in education, rehabilitative science, business or a related degree.
• Have an associate’s degree or two years of college from an accredited college or university and have two years of documented direct experience with recipients with developmental disabilities.
• Have one year of college from an accredited college or university and three years of documented direct experience in working with recipients with developmental disabilities.
• Four years of direct professional experience in working with recipients with developmental disabilities may substitute for college on a year for year basis.
The provider must hold a valid high school diploma or GED diploma.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Development

Provider Category:

Agency

Provider Type:

Adult Day Training Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

Life Skills II: Providers of supported employment services must meet one or more of the following

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Development

Provider Category:
Individual

Provider Type:
Independent Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Level II: completion of required pre-service training.

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

Life Skills II: Providers of supported employment services must meet one or more of the following requirements:
• Have a bachelor's degree from an accredited college or university with a major in education, rehabilitative science, business or a related degree.
• Have an associate's degree or two years of college from an accredited college or university and have two years of documented direct experience with recipients with developmental disabilities.
• Have one year of college from an accredited college or university and three years of documented direct

experience in working with recipients with developmental disabilities.
• Four years of direct professional experience in working with recipients with developmental disabilities may substitute for college on a year for year basis.
The provider must hold a valid high school diploma or GED diploma.

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Development

Provider Category:
Agency

Provider Type:
Home Health Agency

Provider Qualifications

License *(specify):*
In accordance with Chapter 400, F.S.

Certificate *(specify):*

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

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

Level III The provider must meet the following minimum qualifications for staff and staffing ratio:

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Personal Emergency Response System

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope)*:

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Contract agencies for the Community Care for Disabled Adults Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Authorized by Chapter 410, F.S.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Provider Type:
Contract agencies for Community Care for the Elderly Program
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Authorized by Chapter 430, F.S.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Provider Type:
Electrical or alarm system contractors
Provider Qualifications
License *(specify):*

Certificate *(specify):*
In accordance with Chapter 489, F.S.
Other Standard *(specify):*
Must provide a bond, letter of credit, or other collateral.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Provider Type:
Hospitals
Provider Qualifications
License *(specify):*

Certificate *(specify):*

In accordance with Chapter 395, F.S.
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Independent vendor (discount or home improvement stores)
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
In accordance with Chapter 205, F.S.
Other Standard *(specify)*:
Freestanding equipment may also be purchased from independent vendors, such as discount or home improvement stores, but these vendors may not provide monitoring.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Personal Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**

08 Home-Based Services | 08020 home health aide

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

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

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

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

Service Definition *(Scope):*
Personal Supports services for adults age 21 and older or age 18-20 if the individual lives in their own home, provides assistance and/or training to the recipient in activities of daily living to include the areas of eating, bathing, dressing, personal hygiene, and preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include housekeeping chores such as bed making, dusting and vacuuming and assistance to do laundry, shopping, and cooking which are incidental to the care furnished, or which are essential to the health and welfare of the recipient. Services include non-medical care, supervision and socialization activities provided to an adult on an one-to-one basis or in groups not to exceed three recipients.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Personal supports services is provided on a one-on-one, one-to-two or one to three individual basis. If services are provided with two or more individuals present, the amount of time billed must be prorated based on the number of recipients receiving the service (up to three people in the same time period. If services are provided with two or more individuals present, the amount of time billed must be prorated based on the number of recipients receiving the service (up to three recipients).
Personal supports services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Vendor
Agency	Registered Nurse Agency
Individual	Licensed Practical Nurse
Agency	Hospice Agency
Agency	Licensed Practical Nurse Agency
Individual	Registered Nurse
Agency	Nurse Registry
Agency	Group Home
Agency	Assisted Living Facility
Agency	Foster Home
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:
Individual

Provider Type:
Independent Vendor

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:
Agency

Provider Type:
Registered Nurse Agency

Provider Qualifications

License *(specify)*:
In accordance with Chapter 464, F.S.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:
Individual
Provider Type:
Licensed Practical Nurse
Provider Qualifications
License *(specify):*
In accordance with Chapter 464, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:
Agency
Provider Type:
Hospice Agency
Provider Qualifications
License *(specify):*
In accordance with Chapter 400, F.S.
Certificate *(specify):*

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

Solo providers must have a high school diploma or a GED and at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing or child care setting or working with recipients who have a developmental disability In lieu of the required work experience, providers and employees may have or have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Provider Type:
Licensed Practical Nurse Agency
Provider Qualifications
License *(specify):*
In accordance with Chapter 464, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Provider Type:
Registered Nurse
Provider Qualifications
License *(specify):*
In accordance with Chapter 464, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Provider Type:
Nurse Registry
Provider Qualifications
License *(specify)*:
In accordance with Chapter 464, F.S.
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Provider Type:
Group Home
Provider Qualifications
License *(specify)*:
In accordance with Chapter 393, F.S.
Certificate *(specify)*:

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

Solo providers must have a high school diploma or a GED and at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing or child care setting or working with recipients who have a developmental disability In lieu of the required work experience, providers and employees may have or have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Provider Type:
Assisted Living Facility
Provider Qualifications
License *(specify):*
In accordance with Chapter 400, F.S.
Certificate *(specify):*

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

Solo providers must have a high school diploma or a GED and at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing or child care setting or working with recipients who have a developmental disability In lieu of the required work experience, providers and employees may have or have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

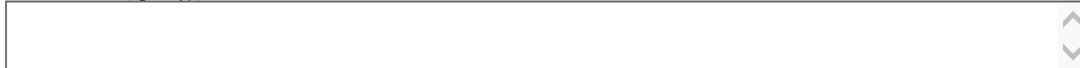
Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Provider Type:
Foster Home
Provider Qualifications
License *(specify):*
In accordance with Chapter 393, F.S.
Certificate *(specify):*



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

Solo providers must have a high school diploma or a GED and at least one year of hands-on verifiable experience working in a medical, psychiatric, nursing or child care setting or working with recipients who have a developmental disability In lieu of the required work experience, providers and employees may have or have 30 semester hours, 45 quarter-hours, or 720 classroom hours of college or vocational school.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
In accordance with Chapter 400, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Private Duty Nursing

HCBS Taxonomy:

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

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

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

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

Private duty nursing services are prescribed by a physician, ARNP, or physician assistant and consist of individual, continuous nursing care provided by registered or licensed practical nurses.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Private duty nursing services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

This waiver service is limited to individuals over age 21.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:
Individual
Provider Type:
Registered Nurse
Provider Qualifications
License *(specify)*:
In accordance with Chapter 464, F.S.
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:
Agency
Provider Type:
Nurse Registry
Provider Qualifications
License *(specify):*
In accordance with Chapter 400, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:
Individual
Provider Type:
Licensed Practical Nurse
Provider Qualifications
License *(specify):*
In accordance with Chapter 464, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Provider Type:

Registered Nurse Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Provider Type:

Licensed Practical Nurse Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

In accordance with 42 CFR 484.

Other Standard *(specify):*

Enrolled in the Medical Home Health Program.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Residential Nursing

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Nurse
Agency	Group Home
Individual	Licensed Practical Nurse
Agency	Licensed Practical Nurse Agency
Agency	Assisted Living Facility
Agency	Registered Nurse Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:
Individual

Provider Type:
Registered Nurse

Provider Qualifications

License *(specify):*
In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency and Medicaid Agency.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:
Agency

Provider Type:
Group Home

Provider Qualifications

License *(specify)*:

In accordance with Chapter 393, F.S.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify)*:

In accordance with Chapter 464, F.S.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:

Agency

Provider Type:

Licensed Practical Nurse Agency

Provider Qualifications

License *(specify)*:

In accordance with Chapter 464, F.S.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

In accordance with Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:

Agency

Provider Type:

Registered Nurse Agency

Provider Qualifications

License *(specify):*

In accordance with Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Special Medical Home Care

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Practical Nurse Agency
Individual	Licensed Practical Nurse
Agency	Registered Nurse Agency
Individual	Registered Nurse
Agency	Certified Nurses Aide
Agency	Group Home

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Licensed Practical Nurse Agency
Provider Qualifications
License *(specify)*:
In accordance with Chapter 464, F.S.
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Licensed Practical Nurse
Provider Qualifications
License *(specify)*:
In accordance with Chapter 464, F.S.
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Registered Nurse Agency
Provider Qualifications
License *(specify):*
In accordance with Chapter 464, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Registered Nurse
Provider Qualifications
License *(specify):*
In accordance with Chapter 464, F.S.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Special Medical Home Care

Provider Category:

Provider Type:

Certified Nurses Aide

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

In accordance with Chapter 464, F.S.

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Provider Type:

Group Home

Provider Qualifications

License *(specify)*:

In accordance with Chapter 393, F.S.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: 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:

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

Service Title:
Supported Living Coaching

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
Supported living coaching services provide training and assistance, in a variety of activities, to support recipients who live in their own homes or apartments. These services may include assistance with locating appropriate housing; the acquisition, retention or improvement of skills related to activities of daily living such as personal hygiene and grooming; household chores; meal preparation; shopping; personal finances and the social and adaptive skills necessary to enable recipients to reside on their own.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Supported Living Coaching services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Vendors
Agency	Agency Vendors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living Coaching

Provider Category:

Individual

Provider Type:
Independent Vendors
Provider Qualifications
License *(specify):*

Certificate *(specify):*

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living Coaching

Provider Category:
Agency
Provider Type:
Agency Vendors
Provider Qualifications
License *(specify):*

Certificate *(specify):*

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency and Medicaid Agency.
Frequency of Verification:
Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency.

Appendix C: Participant Services

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

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (●) **No. The State does not conduct abuse registry screening.**
- ( ) **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

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

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ( ) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- (●) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Assisted Living Facilities	
Foster Care Homes	
Group Home	
Residential Habilitation Centers	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Required information is contained in response to Appendix C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living Facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Life Skills Development	☐
Occupational Therapy	☑
Physical Therapy	☑
Skilled Nursing	☑
Residential Habilitation	☑
Speech Therapy	☑
Special Medical Home Care	☑
Specialized Mental Health Counseling	☑
Support Coordination	☑
Personal Supports	☑
Adult Dental Services	☐
Environmental Accessibility Adaptations	☐
Specialized Medical Equipment and Supplies	☑
Transportation	☐
Personal Emergency Response System	☐
Dietitian Services	☑
Respiratory Therapy	☑
Behavior Assistant Services	☑
Supported Living Coaching	☑
Behavior Analysis Services	☑
Residential Nursing	☑
Respite	☑
Private Duty Nursing	☐

Facility Capacity Limit:

All standard areas are addressed in Assisted Living licensing standards. Chapter 429, F.S. Capacity is determined by the size of the facility.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑

Standard	Topic Addressed
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Foster Care Homes

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Life Skills Development	☐
Occupational Therapy	☑
Physical Therapy	☑
Skilled Nursing	☑
Residential Habilitation	☑
Speech Therapy	☑
Special Medical Home Care	☑
Specialized Mental Health Counseling	☑
Support Coordination	☑
Personal Supports	☑
Adult Dental Services	☐
Environmental Accessibility Adaptations	☐
Specialized Medical Equipment and Supplies	☑
Transportation	☐
Personal Emergency Response System	☑
Dietitian Services	☑
Respiratory Therapy	☑
Behavior Assistant Services	☑
Supported Living Coaching	☑
Behavior Analysis Services	☑
Residential Nursing	☑
Respite	☑

Waiver Service	Provided in Facility
Private Duty Nursing	☐

Facility Capacity Limit:

APD determines the number of clients a facility may accommodate and licenses based on the maximum capacity of the facility. Maximum = no more than 3 recipients. Section 393.18, F.S.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Group Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Life Skills Development	☐
Occupational Therapy	☑
Physical Therapy	☑
Skilled Nursing	☑
Residential Habilitation	☑
Speech Therapy	☑
Special Medical Home Care	☑
Specialized Mental Health Counseling	☑
Support Coordination	☑

Waiver Service	Provided in Facility
Personal Supports	☑
Adult Dental Services	☐
Environmental Accessibility Adaptations	☐
Specialized Medical Equipment and Supplies	☑
Transportation	☐
Personal Emergency Response System	☐
Dietitian Services	☑
Respiratory Therapy	☑
Behavior Assistant Services	☑
Supported Living Coaching	☑
Behavior Analysis Services	☑
Residential Nursing	☑
Respite	☑
Private Duty Nursing	☐

Facility Capacity Limit:

APD determines number of clients a facility accommodates and licenses based on capacity of the facility. Minimum = at least 4 recipients and maximum = no more than 15 recipients. Section 393.18, F.S.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Habilitation Centers

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Life Skills Development	☐
Occupational Therapy	☑
Physical Therapy	☑
Skilled Nursing	☑
Residential Habilitation	☑
Speech Therapy	☑
Special Medical Home Care	☑
Specialized Mental Health Counseling	☑
Support Coordination	☑
Personal Supports	☑
Adult Dental Services	☐
Environmental Accessibility Adaptations	☐
Specialized Medical Equipment and Supplies	☑
Transportation	☐
Personal Emergency Response System	☐
Dietitian Services	☑
Respiratory Therapy	☑
Behavior Assistant Services	☑
Supported Living Coaching	☑
Behavior Analysis Services	☑
Residential Nursing	☑
Respite	☑
Private Duty Nursing	☐

Facility Capacity Limit:

APD determines the number of clients a facility may accommodate and licenses based on maximum capacity. Minimum = at least 9 and maximum is determined by facility size. Section 393.18, F.S.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	

Standard	Topic Addressed
	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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:

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

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. **Methods for Discovery: Qualified Providers**

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

i. **Sub-Assurances:**

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(C-1) Percentage of Florida Department of Health (DOH) licensed providers initially determined to meet minimum licensure and/or certification requirements as detailed in F.A.C. N: Number of DOH licensed providers initially determined to meet minimum licensure and/or certification requirements as detailed in F.A.C. D: Number of DOH licensed provider applicants enrolled in the iBudget Waiver.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

		Sampling Approach*(check each that applies):*

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	
☐ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ 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:
(C-2) Percentage of DOH licensed providers continually determined to meet minimum licensure and/or certification requirements as detailed in F.A.C. N: Number of DOH licensed providers continually determined to meet minimum licensure and/or certification requirements as detailed in F.A.C. D: Number of DOH licensed providers due for renewal.

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:
(C-3) Percentage of non-licensed and non-certified (enrolled) providers initially determined to meet state enrollment requirements as detailed in F.A.C. N: Number of non-licensed/non-certified providers who initially meet state enrollment requirements. D: Total number of new non-licensed/non-certified providers.

Data Source (Select one):
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:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(C-4) % of providers whose staff received training in an agency approved curriculum for behavioral emergency procedures consistent with the requirements of the Reactive Strategies rule. N: # of providers whose staff received training in an agency approved curriculum for behavioral emergency procedures consistent with the requirements of the Reactive Strategies rule. D: Total # of providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Contracted Vendor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Contracted Vendor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(C-5) Percentage of providers with service specific staff training requirements met. N: Total number of providers with service specific staff training requirements met. D: Total number of providers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Contracted Vendor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Contracted Vendor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Florida has adopted a quality assurance strategy that mirrors the CMS Quality Framework. The Discovery function is a universal responsibility, but the bulk of the work is done by the CV, utilizing a statistically valid sampling methodology for individual single case bore analysis and a traditional provider compliance process which engages service providers annually. The Remediation function is handled by APD, which receives discovery material from the CV in near real time. The CV issues immediate alerts upon discovery of health and safety violations or concerns to APD. APD responds with immediacy to alerts; they primarily respond to less urgent matters using a universal Remediation Plan, which is a detailed action plan specifying the corrective action required of the provider and the timeframes for completion. APD utilizes the quality team approach to review a variety of data including that supplied in trend form from the CV and other data sources such as incident and abuse reports. The function of this group is to analyze the data and identify and prioritize appropriate improvements to make ongoing systemic changes.

APD also uses the National Core Indicators to gather additional information concerning recipients'' ability to choose services and providers. This allows for longitudinal trend analysis.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
(C-1) On a continuous and ongoing basis, the Operating Agency validates provider applications have been submitted with documented proof of meeting the licensure and/or certification requirements stipulated in F.A.C. for services (dental, nursing, and therapies) the applicant wishes to render through the iBudget Waiver. The provider enrollment process does not allow an application to be processed unless all required documents are present. If an applicant fails to provide proof of having a current licensure and/or certification, the application is denied or closed.

(C-2) On a continuous and ongoing basis, the Operating Agency validates providers have submitted documented proof of meeting the licensure and/or certification requirements stipulated in F.A.C. for services (dental, nursing, and therapies) the providers wish to continue rendering through the iBudget Waiver at the time of HCBS Waiver Agreement renewal. The provider renewal process does not allow an application to be processed unless all required documents are present. If an applicant fails to provide proof of all required documents, the provider is not renewed.

(C-3) On a continuous and ongoing basis, the Operating Agency validates the provider applicant has submitted documented proof of meeting the provider requirements stipulated in the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook for services the applicant wishes to render through the iBudget Waiver. The provider enrollment process does not allow an application to be processed unless all required documents are present. If an applicant fails to provide proof of meeting the minimum requirements (i.e., education, background screening, training, experience), the application is denied or closed.

(C-4) On a continuous and ongoing basis, providers are required to train staff with an agency approved curriculum for behavioral emergency procedures consistent with the Reactive Strategies rule. For all deficiencies cited on a Provider Discovery Review, providers are required to prepare, submit for approval, and then execute approved Remediation

Plans. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency; and recipient issues and their resolutions are recorded in the providers' files.

(C-5) On a continuous and ongoing basis, providers are required to ensure service specific staff training requirements are met. For all deficiencies cited on a Provider Discovery Review, providers are required to prepare, submit for approval, and then execute approved Remediation Plans. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

ii. **Remediation Data Aggregation**
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

○ **No**
◉ **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
These discovery activities are a component of the current CV. Alerts on issues for remediation are being generated by the CV and sent to APD. APD responds as appropriate given the nature of the issue. APD is in the process of competitively procuring its centralized database for collecting remediation data; all remediation activities will be entered, tracked, and trended to ensure that all issues requiring remediation are brought into compliance within state required time frames. Until that time, APD will be required to track remediation activities using standardized Excel templates and submit data on remediation to the State Medicaid Agency for remediation data aggregation purposes.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the

course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☑ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

This waiver provides each recipient a prospective individual budget amount. Additional funding will be provided for recipients whose needs are so extraordinary that the use of this approach is inappropriate or who experience one-time needs or changes in needs that cannot be accommodated within the individual budget. The algorithm and methodology will determine the budget for all of a recipient's waiver services. The recipient may not exceed this budget amount for paid waiver services.

The algorithm was developed by a Ph.D.-level statistician with stakeholder input using multiple regression techniques to equitably distribute available funds based on historical funding patterns. The algorithm considers individual recipient characteristics, which are statistically proven to correlate with costs, and generates a budget amount for each person prior to the support planning process. The data used in the algorithm is reliable and valid, and its sources include the client database and the agency-approved needs assessment instrument. Factors considered by the algorithm include age, living setting, and results from the APD's needs assessment instrument. The weight of these factors in the algorithm is based on the nature of their relationship with the historical costs for individuals enrolled in the Developmental Disabilities Individual Budgeting Waiver; those with the greatest relationship to costs have the most weight in the algorithm.

The methodology for determining an individual budget is open for public inspection in several ways. Prior to finalizing the methodology for determining an individual budget, APD convened a formal workgroup comprised of representatives from key stakeholder groups, including self-advocates, families with loved ones receiving waiver services, those on the waitlist, waiver support coordinators, independent waiver support coordinators, and other members from the public. In addition, the specific criteria for determining the individual budget amount is provided in Florida Administrative Code. All state rules are published online and subject to public input during the rule promulgation process.

The APD determines each recipient's budget amount using the funding formula and algorithm. Some recipients have extraordinary needs that do not fit a formula. Also, all recipients are subject to unplanned, temporary service needs and changes in their personal circumstances that require reexamination of their budget. A change may be temporary or permanent. It may require a one-time expenditure or a permanent budget adjustment. Accordingly, this waiver makes provision for these needs through reserving a portion of the APD's overall budget to meet them. The APD may approve an increase to the amount determined by the funding formula prior to notifying the recipient of their budget amount, or recipients may apply to access these additional funds.

If service needs increase beyond the maximum annual dollar amount assigned to a recipient or if there is a documented change in circumstance, the recipient will be evaluated using the APD approved assessment and other processes for a potential increase in the budget amount.

Recipients will receive an evaluation using the APD approved assessment. The results of the assessment, along with other information required by the algorithm, will be used to determine the recipient's budget amount. All recipients will receive written notification of the maximum annual dollar amount assigned to that recipient. Recipients will also receive written notice with instructions should they wish to request a fair hearing regarding the determination.

☐ **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.

See Attachment #2, HCB Settings Waiver Transition Plan, for a description regarding how the state will achieve compliance with the HCB settings requirements of the final rule for both residential and non-residential settings.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Waiver Support Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies)*:
   - ☐ **Registered nurse, licensed to practice in the State**
   - ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
   - ☐ **Licensed physician (M.D. or D.O)**
   - ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
   - ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
     Specify qualifications:
   - ☐ **Social Worker**
     Specify qualifications:
   - ☐ **Other**
     Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*
   - ◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The support coordinator conducts activities that assist the recipient in determining his or her own future. At least one time annually during the support planning meeting, the support coordinator assists the recipient, family or guardian, or primary caregiver, to:

•-Identify the recipient's desired outcomes, personal goals and needs, and the supports necessary to achieve or meet them.
•-Complete the support plan and cost plan, including signatures of those present during the meeting, and recipient/guardian signature.
•-Complete the Waiver Eligibility Worksheet, which documents the individual's categorical and functional eligibility for the waiver and documents their choice between the waiver and an institutional placement.

Before the initial support plan meeting, the support coordinator is required to have a face-to-face visit with the recipient and his or her family or guardian to discuss all areas of the waiver, including who will participate in the decision-making process for supports and services. The support coordinator provides a written summary of the waiver program and services prior to the initial face-to-face visit. The support coordinator also shares with the recipient and his or her family other resources useful in identifying and selecting services and supports, such as the internet Web site of the CV and other listings of community supports. A person-centered plannng process is utilized in helping the consumer to identify and develop their support plan.

The support plan is valid for one year. Prior to the expiration of the plan, the support coordinator discusses with the recipient the purpose of the planning process and provides a summary of the past year's plan and services. The recipient is asked to identify changes to the goals or services received and a discussion of changes of providers if needed. The meeting is planned based on the recipient's preferences for the dates and times of the meeting. In addition, the support coordinator discusses who the recipient would like to invite to the meeting, including providers, family members, and friends. The support coordinator notifies invitees of the recipient's choice of the time, place, and date of the meeting.

It is the responsibility of the support coordinator to, at least annually, and more frequently if indicated, provide recipients attending an adult day training program information about competitive employment opportunities available in their community. Further, the support coordinator provides appropriate referral of the recipient to other sources of employment support such as vocational rehabilitation. The purpose of this requirement is to ensure that the recipient can make an informed, meaningful decision about the type of day activity or employment opportunity of his or her choice.

On a regular and ongoing basis, the support coordinator will provide necessary technical assistance and oversight of the recipient's individual budget to assure there is adequate funding remaining in the budget to meet needs for the cost plan year and to assist the recipient in making adjustments to frequency, intensity, and duration of services.

The support coordinator must be available to meet the recipient's needs and to perform the responsibilities for support coordination services. The support coordinator must have an on-call system approved by the APD so that recipients can reach their support coordinators when needed. For those individuals who receive limited support coordination, the on-call system will be defined by the recipient and their family. Any time a back-up support coordinator is used during the provider's absence, the back-up support coordinator must be a certified and enrolled support coordinator. The name and contact information for the back-up support coordinator must be clearly communicated to the individual receiving services and to the APD office. Telephone access to the provider or back up support coordinator must be toll-free.

There are three components of support coordination: Full Support Coordination, Limited Support Coordination, and Transitional Support Coordination.

Full Support Coordination: Full Support Coordination provides significant support to a recipient to ensure the recipient's

health, safety, and well-being. The WSC can share tasks with the recipient and the recipient's family, or other support persons as they desire, but ultimately the WSC must be responsible for performing all tasks required to locate, select, and coordinate services and supports, whether paid with waiver funds or through other resources. Full Support Coordination includes a 24/7 on-call system; providing basic information to recipients about the waiver and iBudget system; completing annual support plan and cost plan and updates; assisting with locating, interviewing, selecting, and coordinating providers; determining if the services being provided meet the recipient's expectations; and attending medical appointments, recipient education plan meetings, social security meetings, and similar appointments at the recipient's request. Full Support Coordination requires at least two contacts monthly with the recipient or on the behalf of the recipient. When the recipient resides in supported living, assisted living, or licensed residential facility settings, one of the monthly contacts must be face-to-face with the recipient. For recipients who live in the family home, a face-to-face contact is required every three months.

Limited Support Coordination: Limited support coordination services are intended to be less intense than full support coordination. Limited support coordination services are billed at a reduced rate and have reduced contact requirements. Limited support coordinators are not on-call 24 hours per day, 7 days per week. Limited support coordination occurs during times and dates prearranged by the recipient and the WSC. In the event that the recipient experiences emergencies that require a more intensive level of support coordination, a change to full support coordination is initiated. Limited Support Coordination includes providing basic information about the iBudget Waiver system; completing the annual support and cost plan and updates; providing information and referrals on locating, selecting, and coordinating providers; and providing guidance in evaluating the quality of services. Limited Support Coordination requires at least one contact monthly with the recipient or on the behalf of the recipient. For individuals in the family home, the WSC must conduct two face-to-face visits annually. For individuals in independent living, the face-to-face visit must be every three months. Limited Support Coordination is only available to individuals in the family home or independent living situations.

Limited Support Coordination is an optional type of Support Coordination for individuals or legal guardians who are able to coordinate a greater portion of their services independently. Limited Support Coordination is not intended for individuals who require an intense level of Support Coordination, such as those transitioning from institutional settings to the waiver or individuals newly enrolled on the waiver who are initially learning about waiver service options. Limited Support Coordination occurs during times and dates prearranged by the participant and support coordinator and assists participants with person-centered planning activities, which include identifying, developing, coordinating, and assisting the participant in accessing services. If a participant experiences a situation that requires more Support Coordination or wishes to increase their level of Support Coordination services, they may change to Full Support Coordination. Limited Support Coordination services are billed at a reduced rate and have reduced contact requirements.

Transitional Support Coordination: Transitional Support Coordination consists of activities that assist the recipient in transitioning from a nursing facility or an ICF/IDD to the community, or assisting recipients who need a more intensive level of support coordination. Transitional Support Coordination must meet all the same requirements as Full Support Coordination, and the WSC must have, at a minimum, weekly face-to-face contact with the recipient. If a recipient is moving from an institutional placement into the community, the WSC providing enhanced support coordination will work directly with the recipient, institutional staff, and the selected waiver providers prior to the move to ensure a smooth transition to community services, including those funded through the waiver and other services and supports necessary to ensure the health and safety of the recipient. The WSC will coordinate these activities with the facility's discharge planning processer. The WSC must develop an initial support plan for the recipient, taking into account information from the provider's summary of the recipient's development, behavioral, social, health, and nutritional status and a discharge plan designed to assist the recipient in adjusting to their new living environment. The WSC must have, at a minimum, weekly face-to-face contact with the recipient for the first 30 days following discharge from the facility. A WSC providing enhanced support coordination is on call 24 hours per day, 7 days per week for the recipient. The WSC must update the recipient's support plan at the end of 30 consecutive calendar days to identify progress made with the transition to community services and possible changes needed in supports and services, and follow-up on unresolved issues.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Prior to the support plan development, the Questionaire for Situational Information (QSI) assessment instrument is completed by APD staff that are trained and certified in its administration. The assessment includes items in the areas of functional, behavioral, and physical status. The assessment instrument is updated as needed and is re-administered every three years. The support plan development process includes a wide range of information from the recipient, family, other loved ones, and service providers. The QSI identifies needs in the areas of functional, behavioral, and physical (health). This needs assessment provides information to the waiver support coordinator regarding the health care needs of the recipient. Additionally, the waiver support coordinator gathers information from the recipient and from providers, including physicians, to ensure the health needs of the recipient are addressed.

For new enrollees to the waiver, once the recipient's individual budget has been established, the recipient and the support coordinator begin the support planning process approximately thirty (30) days before the beginning of the support plan year. The cost plan is developed on a fiscal year basis. The support plan will be developed every 12 months using the current individual budget. The support coordinator reviews the assessment instrument for valuable information about the person's need for support and may also review assessments from other sources such as the school system, Vocational Rehabilitation, or a certified behavior analyst to assure that the plan will address any emerging needs not previously addressed. The support coordinator also reviews annual reports of progress, needs and preferences, and activities from all providers who served the recipient in the previous year. Once these documents have been reviewed, the recipient is consulted about his or her preferences regarding who will participate in the support planning meeting and when and where it will be held.

The support plan process is intended to be person-centered in that it is directed and controlled by the recipient. Prior to the meeting, the support coordinator will, through conversations with the recipient, determine who the recipient wants to invite to the meeting, and determine a date, time, and location. During the meeting, the support coordinator records the information gathered in the recipient's own words for development of the plan. The recipient, with input from those invited to participate, discusses the recipient's needs, personally-determined goals and preferences, and potential services that are desired to help meet needs and achieve goals. The recipient will know the amount of funding available to meet his or her needs based on his or her previously-established individual budget. Prior to or during the support plan meeting, the support coordinator will assist the recipient and his or her family in identifying family, neighborhood, and community supports funded by private, city, and county resources prior to seeking services available through federal and state resources. The support coordinator will also assist the recipient in accessing Medicaid State Plan services prior to seeking services funded by the waiver. When non-waiver services must be purchased by either APD or the recipient or his or her family, the support coordinator will work cooperatively with APD to locate service providers who meet the needs of the recipient in the most cost-effective manner possible. So that the recipient has the information necessary to make decisions about services needed, the support coordinator will thoroughly discuss the service families that contain the specific services he has selected for the coming year. The party or entity responsible for each goal and need are identified and documented for inclusion on the support plan form. The support plan and the cost plan will identify the services to be provided and the responsibility for the tasks associated with each goal implementation. The support coordinator, through regular contacts with the recipient and services providers, monitors the implementation and progress toward achieving the recipient's individually determined goals.

This waiver allows recipients the opportunity to choose among services within the limits of their individual budgets. To facilitate this, similar services will be grouped in service families. Recipients will often have authority to shift funds between services within a service family and between service families, enabling them to respond to their changing needs. Prior service review processes will be tailored to maximize recipient flexibility while assuring health and safety.

Once the support plan has been completed, a cost plan will be prepared by the support coordinator. The cost plan identifies the specific service families and services selected and their intensity, frequency, and duration and the unit rate for that service. For an initial cost plan developed upon the recipient's transition to this waiver, there will be a service review by the APD or a qualified entity under contract to the APD. The purpose of the review is to verify that the services requested using waiver funding are not available from any other source. APD will also review to ensure the cost plan complies with the prospective individual budget limit and other polices regarding budgeting for a recipient. For subsequent cost plan years, this review may not be required for recipients who have not had a change in their service families, have not had a change in their circumstances that may necessitate an increase in their individual budget, who comply with budgeting policies, or who do not meet other criteria which indicate a higher risk to health or safety. Should specific services be denied or reduced, the individual will be provided with information about the opportunity to request a fair hearing, in accordance with applicable state and federal law.

Once the services on the cost plan have been approved, the waiver support coordinator will ensure the recipient has a copy of the cost plan and will issue a service authorization to the selected approved providers. If there is a need to change services, the recipient will work with the waiver support coordinator to review the service authorization. The service authorization is the document that authorizes the provider to bill Medicaid for services rendered.

Throughout the year, a recipient's service and support needs may change, necessitating an update in his or her cost plan. While it may not be necessary to update the support plan, a comprehensive description of these changes and sufficient information concerning the change in service needs should be thoroughly documented in the support coordinator's progress

notes. An amendment to the plan may be submitted during the year if there is a documented significant change in the recipient's condition or circumstance that impacts on health, safety, or welfare, or when a change in the plan is required to avoid institutionalization.

Recipients and their families will be supported in exercising greater choice by being offered training though waiver support coordinators, paid waiver services, and other means. Recipients and families will also be provided relevant information, such as about what waiver and community supports are available. An on-line budget tool will help recipients in selecting waiver service and managing their individual budgets.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the scheduled support plan meeting and throughout the year, the support coordinator must remain aware of possible risks to the health, safety, and welfare of the recipient. The support coordinator will counsel recipients on the selection of supports and services that best mitigate risks to the recipient. The support coordinator will engage in continuous monitoring, including use of the individual budget and through face-to-face meetings held by the support coordinator with the recipient that will identify possible risk factors to address and thereby reduce or eliminate those factors from the recipient's daily life. The service plan, developed with the participation of the recipient and his or her family and guardian, in accordance with their preferences, identifies critical services that affect the recipient's health, safety, and welfare with backup supports identified, including paid or unpaid supports. With every contact with or on behalf of the recipient, the provision of those identified critical services should be specifically reviewed and addressed if necessary. When a recipient seeks to make choices that place him or herself at unacceptable risk, the support coordinator will work with the area office to implement strategies to address the situation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

A list of qualified providers is available at each AHCA and APD office and is also available on the Internet. Support coordinators provide this information to recipients and train families to interview potential providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Florida Medicaid Agency reviews the frequency, amount, and duration of recipient support plans through the use of a Federally Designated Contracted Vendor. The Operating Agency (APD) is required through an interagency agreement with the State Medicaid Agency (AHCA) to approve client plans of care to ensure the services on the plan are those without which the client would require the services of an intermediate care facility for the developmentally disabled. Support plans are submitted to area APD offices and are updated at least annually, or when there is a change in recipient circumstance. The Operating Agency does not use a sample size, but rather reviews 100% of the plans of care.

The interagency agreement between the AHCA and the APD states that Florida Medicaid has the authority to monitor and approve all APD waiver related policies and operating procedures, including the service plan format and instructions. Waiver policies are discussed and reviewed at periodic meetings between the State Medicaid Agency and the Operating Agency, and via topic-specific workgroups if extensive changes to the format, procedures, or instructions are needed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Florida State Medicaid Agency monitors the service providers and outcomes of recipients through the use of a Federally Designated CV. The CV is responsible for conducting person-centered reviews, provider performance reviews, special studies, report development, report delivery, and education and training of recipients, family members, caregivers, provider organizations, and staff members of APD and AHCA.

Recipients are interviewed as part of a Person Centered Review using the National Core Indicator (NCI) survey tool, an Individual Interview Instrument, a Health/Behavioral Assessment, Medical Peer Review, and service specific record reviews. Quality Assurance Reviewers of the CV are required to contact the APD Area Office to report of any observations that need immediate attention and contact the Abuse Registry hotline to report any alert of abuse, neglect, or exploitation.

Annually, service providers are reviewed using a Provider Performance Discovery Review tool. Administrative records and service records are reviewed for compliance with the Developmental Disabilities Coverage and Limitations Handbook.

The CV is contractually required to provide monthly, quarterly, and annual reports on provider reviews and aggregate outcomes. Individual and Provider reports are available on a secured web site for review by designated AHCA and APD staff. The findings of the CV are also discussed at monthly status meetings.

Florida waiver support coordinators conduct face-to-face visits with each participant to discuss progress toward their goals and satisfaction with current supports received. Face-to-face visits are scheduled every three months for recipients living in their family home, monthly for recipients living in a licensed facility or their own home, and every six months for those receiving limited support coordination.

The WSC is required to receive and approve provider implementation plans and review provider’s documentation of service delivery and information to ensure the services are provided at the frequency, intensity, and duration specified in the support (service) plan and authorized in the cost plan. WSCs also correspond routinely with waiver recipients or their legal representative to ensure services are provided to their satisfaction and in accordance with the service plan.

Florida waiver support coordinators are directed by policy and regulation to secure services sufficient to meet the needs of the recipient. The Operating Agency conducts periodic formal surveys to ensure adequate providers of services in different parts of the state, and uses local office staff to help recruit and train providers where indicated. Additionally the Operating Agency

uses informal data gathered through monthly provider forums to assess adequacy of various provider types to ensure service availability.

Participants' services are assured of meeting their needs by the support coordinator through written records of services delivery, and verbal communication with participants and vendors. Participants may select new providers if the services do not meet their needs.

Provider back up plans are developed by the support coordinator with the recipient input and reviewed and validated by the Operating Agency to be safe for the participant and to ensure effective delivery of services.

The health and safety of the participants is assured through standards contained in administrative rule, the constant observation and monitoring of the support coordinators, and the periodic monitoring of the waiver standards by the Operating Agency and the CV.

Participants are supported in their choice of provider selection by the design of support coordination in this waiver being an exclusive service, which prevents self-referrals and promotes freedom of choice. The participant is supported in the selection and changing of services providers informally on a monthly basis, with a required formal opportunity to continue the selection of waiver services at least annually at the re-certification of the eligibility worksheet.

Florida Medicaid offers a variety of options in health services delivery to include the selection of traditional fee-for-services models and various managed care options including HMOs and PPO arrangements. Additionally, services are required to be pursued by other payers or natural supports in the community whenever these supports are offered to meet the needs of the participant. The Florida Medicaid DD Waiver Handbook and state law support this important component of choice.

Designated APD staff is tasked with the responsibility of ensuring that all follow-up actions are completed in a prompt manner. Incidents that involve violations on the part of waiver providers are tracked via the APD's Remediation Tracking System. The APD is also contracting with a vendor to design an electronic database that will further enhance the State's ability to track and report on follow-up actions.

To ensure the ongoing provision of quality services to APD clients, it is required that all identified deficiencies, regardless of the discovery source, shall be sufficiently addressed in a timely manner. Critical deficiencies related to health, safety, and welfare must have a Plan of Remediation (POR) completed within seven calendar days or less. For all other deficiencies, the completion for the POR deadline is no greater than 90 calendar days from the APD letter/email notification date.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(D-3) Percentage of recipients whose service plans address the recipients' personal goals. N: Number of recipients whose support plans address the recipient's personal goals. D: All service plans reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/-5
☑ **Other** Specify: Contracted Vendor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Contracted Vendor	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
(D-1) Percentage of recipients whose service plans include supports and services consistent with assessed needs. N: Number of recipients whose support plans include supports and services consistent with assessed needs. D: All service plans reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/-5
☑ **Other** Specify: Contracted Vendor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Contracted Vendor	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
(D-2) Percentage of recipients whose service plans reflect supports and services necessary to address assessed risks. N: Number of recipients whose support plans reflect supports and services necessary to address assessed risks. D: All service plans reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5
☑ **Other** Specify: Contracted Vendor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Contracted Vendor	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

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 participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(D-5) Percentage of recipients whose needs have changed and service plans were reviewed and updated, as warranted, to address those changed needs. N: Number of recipients whose needs have changed whose support plans were reviewed and updated, as warranted, to address those changed needs. D: The number of recipients whose needs have changed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/-5
☑ **Other** Specify: Contracted Vendor	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Contracted Vendor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(D-4) Percentage of recipients whose service plans are updated within 12 months of the last service plan. N: Number of recipients whose support plans are updated within 12 months of their last service plan. D: All service plans reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/-5
☑ **Other** Specify: Contracted Vendor	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Contracted Vendor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(D-6) Percentage of recipients who receive the services by type, scope, amount, duration, and frequency identified in their plans. N: Number of recipients who receive the services by type, scope, amount, duration, and frequency identified in their cost plans. D: All cost plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Reviews, Support Coordinator Reviews

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/-5
☑ **Other** Specify: Contracted Vendor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Contracted Vendor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(D-8) Percentage of recipients afforded choice of services and service providers. N: Number of recipients afforded choice of services and service providers. D: All service plans reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/-5
☑ **Other** Specify: Contracted Vendor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Contracted Vendor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(D-7) Percentage of recipients afforded a choice between waiver services and institutional care. N: Number of recipients afforded a choice between waiver services and institutional care. D: All service plans reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +-5
☑ **Other** Specify: Contracted Vendor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Contracted Vendor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Florida has adopted a quality assurance strategy that mirrors the CMS Quality Framework. The Discovery function is a universal responsibility, but the bulk of the work is done by the CV, utilizing a statistically valid sampling methodology for individual single case bore analysis and a traditional provider compliance process which engages service providers annually. The Remediation function is handled by APD, which receives discovery material from the CV in near real time. The CV issues immediate alerts upon discovery of health and safety violations or concerns to APD. APD responds with immediacy to alerts; they primarily respond to less urgent matters using a universal

Remediation Plan, which is a detailed action plan specifying the corrective action required of the provider and the timeframes for completion. APD utilizes the quality team approach to review a variety of data including that supplied in trend form from the CV and other data sources such as incident and abuse reports. The function of this group is to analyze the data and identify and prioritize appropriate improvements to make ongoing systemic changes.

APD also uses the National Core Indicators to gather additional information concerning recipients'' ability to choose services and providers. This allows for longitudinal trend analysis.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

(D-1) On a continuous and ongoing basis, providers are required to ensure service plans include supports and services consistent with assessed needs. For all deficiencies cited on a Provider Discovery Review, providers are required to prepare, submit for approval, and then execute approved Remediation Plans. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

(D-2) On a continuous and ongoing basis, providers are required to ensure service plans reflect supports and services necessary to address assessed risks. For all deficiencies cited on a Provider Discovery Review, providers are required to prepare, submit for approval, and then execute approved Remediation Plans. This will be reviewed quarterly by the Contracted Vendor. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

(D-3) On a continuous and ongoing basis, providers are required to ensure service plans address the recipients' personal goals. For all deficiencies cited on a Provider Discovery Review, providers are required to prepare, submit for approval, and then execute approved Remediation Plans. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

(D-4) On a continuous and ongoing basis, providers are required to ensure recipients' service plans are updated within 12 months of their last service plan. For all deficiencies cited on a Provider Discovery Review, providers are required to prepare, submit for approval, and then execute approved Remediation Plans. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

(D-5) On a continuous and ongoing basis, providers are required to ensure service plans are reviewed and updated, as warranted, for recipients whose needs have changed. For all deficiencies cited on a Provider Discovery Review, providers are required to prepare, submit for approval, and then execute approved Remediation Plans. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

(D-6) On a continuous and ongoing basis, providers are required to ensure recipients receive the services by type, scope, amount, duration, and frequency identified in their service plans. For all deficiencies cited on a Provider Discovery Review, providers are required to prepare, submit for approval, and then execute approved Remediation Plans. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

(D-7) The provider (Waiver Support Coordinator) is responsible to meet with the recipient on an annual basis to complete and sign an eligibility worksheet where the recipient specifies choice of either receiving waiver services or institutional care. Providers who fail to provide choice counseling are required to prepare, submit for approval, and then execute approved corrective action plans. The implementation and outcomes of the correction action plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

(D-8) On a continuous and ongoing basis, providers are required to ensure recipients are afforded choice of services and service providers. For all deficiencies cited on a Provider Discovery Review, providers are required to prepare, submit for approval, and then execute approved Remediation Plans. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

○ **No**
◉ **Yes**
Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
These discovery activities are a component of the current CV. Alerts on issues for remediation are being generated by the CV and sent to APD. APD responds as appropriate given the nature of the issue. APD is in the process of competitively procuring its centralized database for collecting remediation data; all remediation activities will be entered, tracked, and trended to ensure that all issues requiring remediation are brought into compliance within state required time frames. Until that time, APD will be required to track remediation activities using standardized Excel templates and submit data on remediation to the State Medicaid Agency for remediation data aggregation purposes.

Appendix 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.

The individual is informed of his/her right to a Fair Hearing when action has been taken regarding his/her Medicaid waiver services. A Fair Hearing may be requested at any time the individual feels that he/she has not been given the choice of home and community-based services as an alternative to institutional care; has been denied the service or provider of their choice; has had his/her services denied, suspended, reduced, or terminated; or feels that other rules, regulations, or laws have not been followed in the determination of his/her eligibility or the delivery of his/her services. The individual receives a notice from the operating agency or contracted entity every time an eligibility determination is made. This notice includes information regarding how the individual can request a redetermination regarding the decision and/or a Fair Hearing.

Any individual, or his/her parent, guardian, guardian advocate, if a minor, or authorized representative may request a Fair

Hearing. No specific form is required. Fair Hearings for Medicaid programs administered by the operating agency are conducted by the Department of Children and Family Services pursuant to Sections 393.125 and 409.285, Florida Statutes, and follow procedures consistent with federal law and rules applicable to Medicaid cases. Procedural steps for requesting a Medicaid Fair Hearing will be clearly specified in the waiver's Coverage and Limitations handbook made available to providers and will be shared with participants of the waiver.

Written notice of all service decisions are provided to the individual through the Prior Authorization entity and support coordinator, both orally and in writing. These notices provide clear instructions on how to request a Fair Hearing. Support coordinators are trained on how to assist individuals in requesting a Fair Hearing. Agency employees involved in providing services to individuals are also trained on how to assist individuals in requesting a Fair Hearing.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

   ◉ **No. This Appendix does not apply**
   ○ **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

   ◉ **No. This Appendix does not apply**
   ○ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The following are considered critical incidents under the APD's Operating Procedure for Incident Reporting and Risk Prevention for recipients living in the community and are required to be reported to the APD Regional/Field Office by the recipient, representative, support coordinator, or service provider within one hour of becoming aware of the incident. An APD Incident Reporting Form must be submitted to the APD Regional/Field Area Office no later than the next business day.

The APD Regional/Field Office will immediately inform the APD Central Office in Tallahassee of the critical incident. The incident reporter must also provide immediate notification to the recipient's support coordinator, and to the child's or incompetent adult's parent or guardian.

Critical Incidents include:
1. Unexpected Client Death
2. Life Threatening Injury
3. Sexual Misconduct
4. Missing Child or Adult Who Has Been Adjudicated Incompetent
5. Media attention
6. Client Arrest for Violent Crime
7. Verified Abuse, Neglect or Exploitation Investigations

The following are considered reportable incidents under rule 65G-2, F.A.C. and the APD's Operating Procedure for Incident Reporting and Risk Prevention for clients living in the community and are required to be reported to the APD Regional/Field Office by the recipient, representative, support coordinator, or service provider within one business day of becoming aware of the incident by submitting a complete Incident Reporting form.

Reportable Incidents include:
1. Client Deaths
2. Altercations
3. Client Injury
3. Client Arrest
4. Missing Competent Adult
5. Suicide Attempted
6. Baker Act
7. Hospitalization for illness or injury
8. Client Arrest from Non-Violent Crime

This does not replace the abuse, neglect, and exploitation reporting required by state law and rule. Allegations of abuse, neglect, or exploitation must always be reported immediately to the Florida Abuse Hotline.

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.

Providers and support coordinators are required to provide this information, explain the information, and verify during face-to-face visits with recipients, families, and guardians. Contact numbers and names should be made available. Rights and reporting processes should be posted and must be explained in a way that is understandable.

This information should be updated regularly and discussed during monthly visits and annual updates. Recipients and families should be encouraged to ask questions.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

It is the responsibility of the APD to train providers to report incidents to the APD in accordance with the operating procedure and licensing rule 65G-2, F.A.C.

Critical incidents are required to be reported to APD Regional/Field Offices by the recipient, representative, support coordinator, or service provider within one hour of becoming aware of the incident. The initial report must be followed by an APD Incident Reporting Form no later than the next business day. The APD Regional/Field Office will immediately notify APD Central Office of the critical incident or event.

Service providers will have primary responsibility for reporting critical incidents occurring at their facility. There may be instances where parallel investigations are conducted by the APD Area Office and/or the APD Central Office in Tallahassee.

The APD Field Office will notify the service provider if further follow up is required or referral to an outside agency is recommended.

Upon completion and review of the investigation, APD or the support coordinator, will notify the participant and all relevant parties regarding the results.

Follow up investigation of each incident commences immediately to ensure clients involved in an incident are healthy and safe. The length of the internal investigation varies from case to case. Investigations of incidents which are conducted by the APD may take up to 90 days to complete. Investigations conducted are for internal use only and may result in disciplinary actions upon providers, changes in providers, etc. The Florida Department of Children and Families (DCF) and local law enforcement officials are the authorized agencies in Florida to investigate allegations of abuse, neglect, and exploitation involving children or vulnerable adults. Florida law authorizes only the DCF and law enforcement agencies to conduct investigations into allegations of abuse, neglect, or exploitation involving children or adults with developmental disabilities. The APD provides information and assistance as requested and necessary to those entities during the investigatory process. The APD also takes action following the closure of such investigations, which may include disciplinary actions against providers, assisting recipients in choosing alternative waiver providers, and the provision of additional services and supports as required to ensure health and safety needs are met. Protective services investigations are typically completed within 90 days of initiation.

Section 39.409, F.S., and Chapter 415, F.S., designate DCF as the primary investigative agency.

The specific process (by incident severity level) is as follows:

a) A Class I (Low Risk) incident would be minor in nature and not create a serious consequence or investigation by DCF or local law enforcement. This type of incident must be documented in the participant's case record by the case management agency, staffed by the case manager and the case management supervisor, and any corrective action taken documented in the participant's case record.

b) A Class II (Intermediate Risk) incident is considered serious in nature and requires a report to the local Medicaid area office and a report of abuse, neglect or exploitation to the DCF, if applicable, within 24 hours of knowledge of the incident, or a report to local law enforcement, if applicable, within 24 hours. The case management agency provides oral notice of the event, followed by a written management agency will provide weekly updates on the progress of the investigations and any actions required or taken on the participant's behalf until the participants risk level is back to normal and the investigation has been completed.

c) A Class III (High Risk) is considered grave in nature and must be reported immediately to the DCF for investigation by local law enforcement.

Depending upon the result of an investigation conducted by DCF, law enforcement, or APD, the APD may impose a variety of disciplinary actions against providers. There are no established timeframes for informing a provider or relevant parties of the investigation results. The APD's investigations are primarily for internal use. As a result of an investigation a Plan of Remediation, Administrative action, or corrective action will be taken by the agency. The provider will be notified immediately of Agency action. The following individuals/entities may be notified of the results of the investigation as necessary:

a) The alleged victim and legal representative
b) Law Enforcement
c) Emergency Medical Services
d) Courts
e) State Attorney's Office

f) Long Term Care Ombudsman
g) Medicaid Fraud Control Unit
h) APD/AHCA
i) Department of Health's Division of Medical Quality Assurancej)
j) County medical Examiner

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The APD has responsibility for monitoring and oversight of response to critical incidents or events. This occurs at APD Central Office, in coordination with the APD Regional/Field Offices. Critical incidents are reviewed by agency senior management in regularly scheduled weekly briefings. All are followed-up on as appropriate in response to the nature of the incident.

Aggregate data, as determined by APD Central Office, on incidents that have been reported to the Area Office will be compiled by each Office.

APD Central Office will direct an analysis of the compiled data. This analysis will include, at a minimum, trends in type, location, provider, service and date of incidents. The purpose of the analysis is to identify systemic issues in order to mitigate the recurrence of incidents. This analysis will be considered part of the APD's quality management activities.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Chapter 393, Florida Statutes, requires emergency procedures to be used only for imminent danger. The APD has promulgated Rule 65G-8, F.A.C., "Reactive Strategies" to establish Agency-approved emergency procedure curricula for staff training to assure competent implementation of these procedures when preventative or less restrictive procedures have failed. Providers must maintain a reactive strategy policy and procedure, conduct assessments to determine history of trauma and pre-existing medical conditions that may preclude specific techniques or procedures, and specify who can authorize the use of these procedures. This rule also identifies limits for use of reactive strategies, prohibits selected procedures, and requires documentation and reporting of these procedures when used.

Rule 65G-4, F.A.C., "Behavioral Practice and Procedure," includes the monitoring and oversight of these procedures by the Local Review Committee, as well as a requirement to develop a behavior program when criteria for frequent use of seclusion and restraints are met.

Types of permitted restraint or containment include:
a. Manual restraint
b. Mechanical restraint
c. Chemical restraint
d. Behavioral protective devices
e. Medical protective devices

f. Time-out (< 20 minutes)
g. Time-out (> 20 minutes), reported as Seclusion (door cannot be locked).

Alternative methods to avoid the use of restraint and seclusion are a required component within the emergency procedure curricula reviewed and approved by the Agency. Provider agencies that use emergency procedures are required to ensure staff are trained in one of these curricula. These curricula are required to include common preventative or diffusionary approaches such as:
a. Prompting and redirection
b. Varied verbal and nonverbal methods of defusing behavior problems, such as
1. Environmental modifications;
2. Body posture and movement;
3. Facial expression;
4. Empathic listening;
5. Increasing space between the individual and staff;
6. Things to say and how to say them/tone of voice;
7. Taking a walk.
c. Preventative measures, such as
1. Behavioral programs, including a required component for training and reinforcing replacement or alternative behavior;
2. Environmental modifications;
3. Rich, meaningful and diversionary activities;
4. Reinforcement procedures for demonstrating appropriate behavior;
5. Skill training, such as: social skills, problem solving, relaxation training, anger management training;
6. Medication for diagnosed mental health conditions;
7. Medical and dental exams to rule out any underlying physical conditions;
8. Other traditional therapies.

All emergency procedures (including seclusion and restraint) must be documented and reported monthly to the local APD Field Office. Submitted reports are reviewed by the Area Behavior Analyst and/or their designee. Reporting is reviewed monthly at the Local Review Committee and feedback is provided to individual providers. Excessive frequency and duration of use as well as cases with injury will result in provider-specific feedback for correction or additional review of the person's behavioral data and behavior program. Individuals who have received an emergency procedure at a frequency of more than two times in any thirty-day period, or six times in any twelve-month period, will result in a request for behavioral services and typically a behavioral assessment and behavior program development.

In an emergency, when continuous and ongoing behavior poses a threat to self, others or property, and all other interventions to diffuse the problem behavior have failed, then with the proper number of direct care staff, they may implement reactive strategies that they have been trained and certified to implement. At the onset of seclusion or restraint implementation, staff will notify the appropriate authorizing agent of the conditions leading up to the use of the emergency procedure. The authorizing agent is then responsible for assuring that the procedure is in compliance with policy and rule or terminate the procedure. These procedures are monitored continuously during their application. When the emergency has ended the procedures are to be terminated. As soon as possible after the procedures have been terminated, staff must document the use of the reactive strategy.

All personnel that use reactive strategies must be trained in an emergency procedure protocol. The emergency procedure training curriculum includes the following:
- non-physical crisis (preventative) intervention techniques;
- history of applied use to persons with developmental disabilities;
- criteria for use of reactive strategies, and methods for reducing physical interventions
- instruction in reactive strategy precautions and potential hazards; and
- it also includes a “release” criterion (e.g., a stated period of calm behavior) that is of short duration and that is client-driven or initiated.

The state employs the following practices to ensure the health and safety of individuals. Annually, the person's medical condition must be assessed to determine whether or not he or she might be placed at risk of physical injury during restraint or seclusion, or otherwise precludes the use of one or more emergency procedures. An emergency procedure must provide for the least possible restriction consistent with its purpose. The requirements of rule require reactive strategies to be implemented in a manner that permits the greatest possible amount of comfort and protection from injury to the individual. Staff must continuously observe the client during restraint procedures, monitor respiration rate, and determine when release criteria have been met. Before initiating a seclusion or restraint procedure, staff must inspect the environment and the individual in order to ensure that any foreign objects that might present a hazard to the individual's safety are removed. Any room in which the

individual is held must have sufficient lighting and ventilation to permit the individual to be seen, to maintain a comfortable temperature, and must have enough space to permit him or her to lie down comfortably. The door to any room in which an individual is secluded without an attending staff person must not be locked; however, the door can be held shut by a staff person using a spring bolt, magnetic hold, or other mechanism that permits the individual in seclusion to leave the room if the caregiver leaves the vicinity.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Chapter 393, Florida Statutes, requires emergency procedures to be used only for imminent danger and the APD has promulgated Rule 65G-8, F.A.C., “Reactive Strategies,” and amended Rule 65G-4, F.A.C., “Behavioral Practice and Procedure,” to establish limitations and requirements when these procedures are used on waiver enrolled recipients.

These rules call for use of restraints or seclusion as a last resort, with efforts implemented to use preventative or less restrictive interventions first. All use of restraints and seclusion must be logged by providers, with reports submitted to APD monthly. In addition, behavioral services are monitored by the behavior analyst assigned to provide services either as an independent provider or as part of a residential program. This level of monitoring, as well as monitoring of incident reports provides additional opportunities to assure that reactive strategies are documented and used appropriately.

All waiver providers serving individuals with significant inappropriate behavior that may require use of physical management techniques are required to train their staff in an APD approved curriculum for emergency procedures. Minimum standards for curriculum content are outlined in Rule 65G-8, F.A.C., “Reactive Strategies.” The providers are obligated to notify the APD of the curriculum they have elected to use and maintain records of certification of all staff for review by APD.

Reports of Reactive Strategy use will be reviewed at least monthly during the regular meeting of the APD Local Review Committee (LRC) to assure that individuals meeting limiting criteria for emergency procedure use have a behavior analysis support plan developed and reviewed to monitor the effectiveness of programs when they are in place. Behavior programs for individuals receiving use of reactive strategies will be reviewed at a frequency determined by the LRC chairperson, or at least annually.

Data related to reactive strategies is monitored for trends and patterns at three levels:

Clinician Level: For those individuals with behavior programs, the behavior analyst providing services is watching the reactive strategy data in conjunction with data for targeted behavior that are the focus of the behavior program. This data is used to evaluate the effectiveness of the program written, along with fidelity data to show how well staff are implementing the plan. These data help to guide the need for revisions to the plan or additional training and monitoring of staff.

Local Field Office Level: The second level of review is conducted by the Area Behavior Analyst who sees data from all providers reporting use of reactive strategies locally. Providers appearing to use higher frequency and duration of procedures are given feedback by the Area Behavior Analyst to make corrections, or closer scrutiny of individualized behavior programs for their residents may be undertaken at the Local Review Committee conducted by the Area Behavior Analyst. This allows peers to offer suggestions for improvements to behavior programs.

State Office Level: The third level of review occurs at the State Office level where all Field Office reports are submitted monthly. Data is reviewed and trended to determine the average frequency, average duration, and numbers of procedures used on average across the state and within each area served by a Field Office. These trends are generated for each local area to allow feedback to be provided to the Area Behavior Analysts for follow-up with providers and/or the individuals they serve.

On a monthly basis, the APD aggregates and analyzes data regarding follow-up on use of reactive strategies with injuries or durations greater than 60 minutes. Reports are submitted to the Medicaid agency on a quarterly basis and reviewed jointly with the State Medicaid Agency and the APD. On a continuous and ongoing basis, the contracted QIO vendor reviews and reports residential provider compliance with required reactive strategy training to APD and the Medicaid agency. The APD submits an annual report on the health and welfare of iBudget participants to the Medicaid agency. This report includes information regarding reactive strategies (seclusion and restraint). Ad hoc reports regarding reactive strategies are generated by APD and provided to the Medicaid agency upon request.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Chapter 393.13, Florida Statutes, outlines the rights of clients receiving treatment from the APD and its providers, within the least restrictive conditions necessary to achieve the purpose of treatment. Treatment programs involving use of noxious or painful stimuli are prohibited. As set forth in ch. 393 the rights of clients include, unrestricted right to communication, the possession and use of one's own clothing and personal effects, prompt and appropriate medical treatment, space for storage of possessions, opportunities for physical exercise, humane discipline, medical examination prior to behavioral treatment, be free from unnecessary use of restraint and seclusion, have a central record, and have the ability to vote. Unless there is reason to believe that unrestricted exercise of these provisions may be harmful to the client or others, then the individual's support plan must identify those circumstances and a plan of treatment must be developed to provide temporary limitation and active remediation that will lead to full restoration.

Initially, the Support Coordinator takes lead on identifying service needs and discussing proposed treatment options with the consumer, their legal guardian and the person's circle of supports. The support plan identifies services, level of supervision or supports, as well as formalized services found in a behavior analysis support plan, in a safety plan or a combination of the two. When behavioral interventions are appropriate, standards of practice outlined in Rule Chapter 65G-4,F.A.C. Behavioral Service Practice and Procedure call for the "least restrictive most effective intervention."

The procedures to be used in the behavior plan are determined on a case-by-case basis depending on the results of a comprehensive functional assessment to identify the behaviors to be addressed, as well as the causes or functions of the behavior and to rule out other appropriate alternative treatments, including medical, physical or occupational interventions. Also evaluated are the risks presented to self, others and property. It is often the case that there are multiple known treatments found in the behavioral literature for a particular problem behavior. However, individual circumstances and the environment within which the treatment will be implemented will dictate the choice of procedures in an intervention package. In all cases a reinforcement component is required, at least to reinforce appropriate alternative replacement behavior for the targeted inappropriate or undesirable behavior.

Behavior plans addressing behaviors dangerous to self and others or those containing restrictive procedures must be submitted to the Local Review Committee (LRC), a peer review committee. The behavior plan is reviewed to ensure protection of client's rights, clinical integrity and compliance with the requirements of Rule Chapter 65G-4, F.A.C. In addition, the LRC renders a decision to approve the program or not, and establishes the frequency of periodic review of the program. Reviews are intended to evaluate the continued appropriateness of the procedures and their effectiveness. Behavior programs are updated and reviewed as needed, and reviewed at least annually by the LRC. When the data does not show the anticipated change or progress, then the behavior analyst needs to determine whether there is a problem with the procedures written or a problem with implementation. If there is a problem within the program, then modification will be made and resubmitted to the LRC.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The APD is primarily responsible for monitoring and providing oversight for the use of restrictive procedures implemented with the recipients it serves, as outlined in Chapter 393, Florida Statutes, and specified in Rule 65G-4, F.A.C. (Behavioral) Service Delivery Practice and Procedure.

Chapter 393.13, F.S., calls for the adoption of a system for the oversight of the plans or behavioral programs. The system was intended to establish guidelines and procedures governing the design, approval, implementation, and monitoring of all behavior programs involving clients. This establishing language authorized the development of rule chapter 65G-4,F.A.C. Behavioral Service Practice and Procedure. This rule identifies the qualifications and credentials required for individuals who provide behavioral services. Furthermore, it identifies a senior clinician to oversee, maintain and give direction to standards of behavioral practice statewide. Under this rule Area Behavior Analysts are established and out-posted throughout the state to reinforce standards of practice through the Local Review Committees (LRC) that provide peer review for new and ongoing behavior programs developed and implemented by behavioral service providers. The LRC reviews and approves behavior programs to assure that they comply with Ch. 393, F.S., Rule 65G-4 and 65G-8,F.A.C. Reactive Strategies, F.A.C., and is consistent with contemporary behavior analysis practices. Behavior programs are reviewed regularly based on a schedule of review determined by the LRC, as often as monthly depending on the severity of behaviors or restrictiveness of procedures, but at least on an annual basis.

In addition, the QIO conducts monitoring of behavioral services to assure that they are implemented consistent with the requirements under the Medicaid Waiver and the requirements for behavioral programing specified in Rule 65G-4, F.A.C., "(Behavioral) Service Delivery Practice and Procedure." During a QIO review, if a "rights" violation or concern is identified an "Alert" notice is provided to the Agency. "Alerts" related to behavioral services require follow-up and documentation of remediation by the Area Behavior Analyst.

Monthly, the licensing staff within each local Field Office, across the state, monitor all residential providers. During these visits they view the home and the individuals residing there and the direct care staff. While conversing with the residents or staff, reviewing consumer records, log books for cross-shift communication or behavioral data collection sheets, evidence may emerge that leads to the discovery of inappropriate use of "restrictive interventions" that abridge the rights of individuals.

If any of these events rise to the level of an "incident" or a call to the abuse hot line, the use or misuse of "restrictive interventions" may be identified. Those events that result in investigations of abuse, neglect or exploitation, incident reporting or use of reactive strategies are reported in the Evidentiary (372) Reports submitted annually, with monthly assurance indicators reviewed and reported to the state Medicaid agency on a quarterly basis.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Chapter 393, Florida Statutes, requires restrictive procedures to be used only for imminent danger. The APD has promulgated Rule 65G-8, F.A.C., "Reactive Strategies" to establish Agency-approved emergency procedure curricula, for staff training to assure competent implementation of these procedures when preventative or less restrictive procedures have failed. Providers must maintain a reactive strategy policy and procedure, conduct assessments annually to determine history of trauma and pre-existing medical conditions that may preclude use of specific techniques or procedures, and specify who can authorize the use of these procedures. This rule also

identifies limits for use of reactive strategies, prohibits selected procedures, and requires documentation and reporting of these procedures when used.

Under this rule, “seclusion” is defined as, enforced confinement to a room or area, and is not a “time out”. However, if a time-out procedure exceeds 20 minutes in duration it must be reported as “seclusion”. Any room or space that is used for seclusion must have sufficient lighting and ventilation in accordance with normal standards of comfort, and allow for sufficient dimensions for the person to stand or to lie down comfortably. The door to the room may be held by staff, or by means of a mechanical device requiring constant staff pressure, but cannot be locked. Staff must monitor the individual in seclusion continuously.

All reactive strategies require an “authorizing agent” to approve the use of the procedure. A procedure is limited to one hour. If additional time in the procedure is necessary, then reauthorization is required. As soon as the procedure is terminated staff must document its use. A monthly summary of all reactive strategies must be submitted to the local APD Field Office, with all provider reports compiled and submitted to the State Office for review.

Rule 65G-8, F.A.C., Reactive Strategies and rule 65G-4, F.A.C., Behavioral Practice and Procedure, requires the monitoring and oversight of these procedures by the assigned behavioral services provider, the Area Behavior Analyst, the Local Review Committee, and the Agency Senior Behavior Analyst. If an individual receives a reactive strategy as an emergency procedure more than two times in a 30 day period or more than six times in any twelve-month period then the provider or facility must request behavior analysis services for the individual. In most cases this leads to completion of a behavioral assessment and development of a behavior plan in the interest of devising less restrictive procedures to intervene leading to the development of more adaptive alternative behaviors and reduction of the challenging behaviors for which reactive strategies have been necessary.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Chapter 393, Florida Statutes, requires restrictive procedures to be used only for imminent danger and APD has promulgated Rule 65G-8, F.A.C., “Reactive Strategies,” and amended Rule 65G-4, F.A.C., “Behavioral Practice and Procedure,” to establish limitations and requirements when these procedures are used with waiver enrolled recipients.

These rules call for use of restraints or seclusion as a last resort, with efforts implemented to use preventative or less restrictive interventions first. All use of restraints and seclusion must be logged by providers, with reports submitted to APD monthly. In addition, behavioral services are monitored by the behavior analyst assigned to provide services either as an independent provider or as part of a residential program. This level of monitoring, as well as monitoring of incident reports provides additional opportunities to assure that reactive strategies are documented and used appropriately.

By rule, all waiver providers serving individuals with significant inappropriate behavior that may require use of physical management techniques are required to train their staff in an APD approved curriculum for emergency procedures. Minimum standards for curriculum content are outlined in Rule 65G-8, F.A.C., “Reactive Strategies.” The providers are obligated to notify the APD of the curriculum they have elected to use and maintain records of certification of all staff for review by APD.

Reports of Reactive Strategy use will be reviewed at least monthly during the regular meeting of the APD Local Review Committee (LRC) to assure that individuals meeting limiting criteria for emergency procedure use have a behavior analysis support plan developed and reviewed to monitor the effectiveness of programs when they are in place. Behavior programs for individuals receiving use of reactive strategies will be reviewed at a frequency determined by the LRC chairperson, or at least annually.

Data related to reactive strategies, including seclusion, is monitored for trends and patterns at three levels:

Clinician Level: For those individuals with behavior programs, the behavior analyst providing services is watching the reactive strategy data in conjunction with data for targeted behavior that are the focus of the behavior program. This data is used to evaluate the effectiveness of the program written, along with fidelity data to show how well staff are implementing the plan. These data help to guide the need for revisions to the plan or additional training and monitoring of staff.

Local Field Office Level: The second level of review is conducted by the Area Behavior Analyst who sees data from all providers reporting use of reactive strategies locally. Providers appearing to use higher frequency and duration of procedures are given feedback by the Area Behavior Analyst to make corrections, or closer scrutiny of

individualized behavior programs for their residents may be undertaken at the Local Review Committee conducted by the Area Behavior Analyst. This allows peers to offer suggestions for improvements to behavior programs.

State Office Level: The third level of review occurs at the State Office level where all Field Office reports are submitted monthly. Data is reviewed and trended to determine the average frequency, average duration, and numbers of procedures used on average across the state and within each area served by a Field Office. These trends are generated for each local area to allow feedback to be provided to the Area Behavior Analysts for follow-up with providers and/or the individuals they serve.

Rule 65G-4, F.A.C., "(Behavioral) Service Delivery Practice and Procedure," includes the monitoring and oversight of these procedures by the Local Review Committee, as well as the requirement to develop a behavior program when criteria for frequent use of "reactive strategies" has been met.

Seclusion within a locked room is not permitted. However, time-out, used either as a planned intervention within a behavior program or used on an emergency basis, whether used within a separate room or not, exceeding 20 minutes in duration is reported as "seclusion."

Alternative methods to avoid the use of "seclusion" are a required component within the emergency procedure curricula reviewed and approved by the Agency required under Rule 65G-8, F.A.C., "Reactive Strategies." Provider agencies that use emergency procedures are required to ensure staff are trained in one of these approved curricula. The curricula are required to include common preventative or diversionary approaches such as:
a. Prompting and redirection
b. Varied verbal and nonverbal methods of defusing behavior problems, such as
1. Environmental modifications;
2. Body posture and movement;
3. Facial expression;
4. Empathic listening;
5. Increasing space between the individual and staff;
6. Things to say and how to say them/tone of voice;
7. Taking a walk.
c. Preventative measures, such as
1. Behavioral programs, including a required component for training and reinforcing replacement or alternative behavior;
2. Environmental modifications;
3. Rich, meaningful and diversionary activities;
4. Reinforcement procedures for demonstrating appropriate behavior;
5. Skill training, such as: social skills, problem solving, relaxation training, anger management training;
6. Medication for diagnosed mental health conditions;
7. Medical and dental exams to rule out any underlying physical conditions;
8. Other traditional therapies.

The State utilizes multiple levels of detection for the unauthorized use or misuse of seclusion. Monthly, the licensing staff within each local Field Office across the state monitor all residential providers. During these visits they view the home and the individuals residing there and the direct care staff. While conversing with the residents or staff, reviewing consumer records, log books for cross-shift communication or behavioral data collection sheets, evidence may emerge that leads to the discovery of either appropriate or inappropriate practices. Each of these methods enable reviewers to determine whether these events were addressed appropriately or not.

Similarly, if an event rises to the level of an "incident" or a call to the abuse hotline, the unauthorized use or misuse of seclusion may be identified. In addition, providers are required under Rule 65G-8, F.A.C., "Reactive Strategies" to report all applications of seclusion and restraint. The report indicates whether seclusion was used or not, the duration and whether any injuries occurred. If reported, and reported accurately, this allows the review, analysis and follow-up by the Regional Behavior Analyst, as well as the Agency Senior Behavior Analyst at the State Office level.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The service providers have rules, policies, and procedures to follow to ensure the safe administration or supervision of medication administration.

The participant's support coordinator is also involved in reviewing the participant's medical records and Medication Administration Record (MAR) if the individual resides in an APD group home. Those residing in a supported living residence, could have a supported living coach who assists, or provides oversight for medication administration.

Field Office staff with the APD monitor group homes on a monthly basis. APD staff, service providers, and support coordinators all work with the APD Medical Case Managers to address areas of concern regarding medication regimens on an ongoing basis.

Medical Case Managers will review medications, physician orders, and MARs, as requested by licensing staff, service providers, and support coordinators. The contracted vendor also monitors provider compliance (if applicable) with medication administration on an ongoing basis, and issues alerts or reports to both the provider and APD for remediation of identified issues.

APD Medical Case Managers provide training to APD Field Office staff on Chapter 393.506, Florida Statutes, and Rule 65G-7, F.A.C., Medication Administration. Any medication error discovered in APD licensed homes results in a "notice of non-compliance" and a corrective action plan. This encourages providers to self-report medication errors, and suggest what remediation they will put in place to prevent future occurrences. All medication errors are reviewed by APD Medical Case Managers, with follow-up if necessary. If the Medical Case Manager determines that the error justifies corrective action (additional training, new policy/procedure for the provider, etc.), APD notifies the provider of the corrective action and includes a specific timeframe for completion. APD State Office nursing staff reviews medication error spreadsheets with each Regional/Field office a minimum of twice yearly. All providers who are responsible for medication administration are required to both record and report all medication errors to the APD Regional/Field Office.

In addition, unlicensed direct care staff are trained to compare the prescription to both the medication label and the entry in the MAR with each administration of medication, and to report discrepancies to their supervisors immediately.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The APD Medical Case Managers review and follow-up on issues cited by licensing, providers, APD Field Office staff, support coordinators, and the contracted vendor on an ongoing basis.

Medication errors are reported to the APD on the Medication Error Report Form. The APD Medical Case Managers will review and follow up as necessary. If the APD Medical Case Manager determines that a medication error justifies corrective action, including additional training, the APD will notify the provider and include a specific and reasonable timeframe for completion.

The APD Field Office staff, Medical Case Managers, and contracted vendor monitor and review MARs, recipient Authorization for Medication Administration and Informed Consent, and the direct service provider's Validation Certificate and Medication Administration Training Certificate.

Florida Medicaid has also contracted with a federally qualified contracted vendor to monitor the performance of waiver providers in the administration of medications to waiver participants. This monitoring is conducted during provider discovery reviews and person centered reviews on a continuous basis. The contracted vendor conducts

monitoring statewide on a statistically valid sample of providers and individual recipients.

Any medication error discovered in an APD licensed home that was not self-reported, results in a "notice of non-compliance" and a corrective action plan. This encourages group home providers to self-report medication errors, and suggest what remediation they will do to prevent future occurrences. All providers who are responsible for medication administration (anywhere that medication administration occurs, including ADT, supported living, and any other environments where services are provided) are required to both record and report medication errors to the APD Regional/Field Office. All medication errors are reviewed by APD Medical Case Managers, with follow-up if necessary.

If the Medical Case Manager determines that the error justifies corrective action (additional training, new policy/procedure for the provider, etc.), the APD notifies the provider of the corrective action and includes a specific timeframe for completion. The APD State Office reviews medication error spreadsheets with each Regional/Field Office at least twice yearly.

The contracted vendor also monitors provider compliance (if applicable) with medication administration on an ongoing basis, and reports any problems identified to APD for remediation. The state monitoring program gathers information continuously through the Provider Performance Discovery Reviews (PDRs) and Person Centered Reviews (PCRs). Information can readily be categorized into two sets, those requiring immediate follow up and longer term quality improvement activities.

1) Any incident which potentially affects the health, safety, and welfare or the individual rights of a participant is addressed through an Alert. This process provides information to the Operating Agency (APD) immediately on discovery, and notification of the state abuse hotline as indicated by the nature of the issue at hand. The State Medicaid Agency is notified as well to provide continuous follow up on the issue. Alerts are addressed with the participant and/or waiver provider immediately, but not to exceed three business days.

2) Deficiencies not rising to the level of an alert are addressed in the reporting processes of the contracted vendor. The report data is provided to the Operating Agency, the State Medicaid Agency, and the provider. The Operating Agency then follows the remediation activities of the waiver provider to ensure improvement activity. The vendor is monitored to demonstrate improved compliance at intervals of 30 days until all corrective actions are completed.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Chapter 393.506, Florida Statutes and Rule 65G-7, F.A.C., Medication Administration govern the administration of medications or the supervision of medication administration for unlicensed staff. This outlines:

a. Who can administer or supervise;
b. Training required;
c. Validation of skills;
d. Informed consent;
e. Medication administration procedures;
f. Medication errors;
g. Storage requirements;
h. Documentation and record keeping; and
i. Off-site medication administration.

Direct service providers who administer medication must first take a Medication Administration Training course that has been approved by the APD and which is taught by a Registered Nurse. They must pass this course with a score of 80% or greater on the final exam. Before administering medications, they must be ‘validated’ to administer medications by a RN, ARNP, MD, or PA, in an actual client setting, with an actual client, and using medication that is ordered for that client. No simulation is allowed. Each route of medication administration must be validated separately. The routes direct service providers are allowed to administer are: oral, enteral, topical, otic, inhaled, ophthalmic, rectal, and transdermal. There is no requirement that each direct service provider be validated on all routes, but no direct service provider may administer medication via a route on which they have not received validation. All validations must be renewed annually. If validation of the primary route (usually oral or enteral) is allowed to lapse, the direct service provider must re-take the Medication Administration Training course, and then attempt validation.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

APD Medical Case Managers/Regional/Field Offices.

(b) Specify the types of medication errors that providers are required to *record:*

-Medications given to the wrong person
-Wrong dose of medication given
-Newly prescribed order not initiated within 24 hours
-Medication refill not ordered timely
-Controlled Medication Sheet not accurate
-MAR not accurately documented
-Wrong medication given
-Medication not given
-Medication not given at the right time
-Refused medication

(c) Specify the types of medication errors that providers must *report* to the State:

-Medications given to the wrong person
-Wrong dose of medication given
-Newly prescribed order not initiated within 24 hours
-Medication refill not ordered timely
-Controlled Medication Sheet not accurate
-MAR not accurately documented
-Wrong medication given
-Medication not given
-Medication not given at the right time
-Refused medication

Medication errors that occur in other service environments are also reported.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Field Office staff with the APD monitor group homes on a monthly basis. The APD Field Office staff work with the APD Medical Case Managers to address issues of concern.

Medication errors are reported to APD on the Medication Error Report Form. The APD Medical Case Managers review and follow up as necessary. If the APD Medical Case Manager determines that a medication error justifies corrective action, including additional training, the APD will notify the provider and include a specific and reasonable timeframe for completion.

The APD Medical Case Managers provide training to the APD Field Office staff on Chapter 393.506, Florida Statutes, and Rule 65G-7, F.A.C., Medication Administration. Any medication error discovered in an APD licensed homes results in a "notice of non-compliance" and a corrective action plan. This encourages providers to self-report medication errors, and suggest what remediation they will put in place to prevent future occurrences. All medication errors are reviewed by the APD Medical Case Managers, with follow-up if necessary. If the Medical Case Manager determines that the error justifies corrective action (additional training, new policy/procedure for the provider, etc.), the APD notifies the provider of the corrective action and includes a specific timeframe for completion. The APD State Office reviews Medication Error Spreadsheets with each Regional/Field office at least twice yearly. All providers who are responsible for medication administration are required to both record and report all medication errors to the APD Regional/Field Office.

The contracted vendor also monitors provider compliance (if applicable) with medication administration on an ongoing basis, and reports any problems identified to APD for follow-up and possible remediation. Regional/Field Office Medical Case Managers record all reported medication errors on an Excel Spreadsheet that is reviewed with to APD State Office, Clinical Support RN staff at least twice yearly. State Office RN staff review the medication error spreadsheets with each Regional/Field Offices, asks for clarification if needed, and aggregates the errors to look for trends. If trends are noted on either a local, regional or statewide level, State Office works with Regional/Field Office staff to develop solutions and improvement strategies. Medication errors are discussed during each monthly Medical Case Management conference call.

The contracted vendor acquires medication administration data through the PDR and PCR process, which is routinely aggregated to inform the state of trends and to support ongoing improvement activity. Data is provided quarterly in addition to ad-hoc requests in response to specific areas of interest. This data is presented in reports to the Quality council, and to the agencies to address ongoing improvement activities.

The APD State Office aggregates medication errors on a monthly basis for reporting to the AHCA.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(G-1) Percentage of critical incidents reported to APD within required time frames. N: Number of critical incidents reported to APD within required time frames. D: Number of critical incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(G-2) Percentage of critical incidents finalized, including strategies to mitigate/prevent future incidents, within the required time frame. N: Number of critical incidents finalized, including strategies to mitigate/prevent future incidents, within the required time frame. D: All critical incidents, by type of incident.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

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:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(G-3) Percentage of reactive strategies reported by providers with adverse outcomes or excessive duration where appropriate follow-up was completed as required. N: Number of reactive strategies with adverse outcomes or excessive duration reported by provider where appropriate follow-up was completed as required. D: Number of reactive strategies with adverse outcomes or excessive duration.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reactive Strategies Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(G-4) Percentage of recipients whose identified health and/or safety needs are addressed. N: Number of recipients whose identified health and/or safety needs are addressed. D: Total number of recipients reviewed with health and/or safety needs.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%+/5
☑ **Other** Specify: Contracted Vendor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Contracted Vendor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
In addition to issues of abuse, neglect, and exploitation reported through the State's official reporting process or identified by the CV, concerns and complaints from consumers, families, providers, and other stakeholders about any issue of health or safety may be submitted to the APD at any time. The APD will follow-up immediately. They will also enter all issues into the central database for tracking and trending.

For the performance measure related to individuals assisted by providers to know about their rights the CV monitors providers to determine if individuals were assisted to know about their rights. During the Support Coordination Provider Discovery Review, the CV reviews the record and conducts an interview the provider to capture this information. The provider must provide examples of how individuals have been fully assisted to exercise their rights and make informed choices. The provider also must present examples of how the provider has observed the rights and responsibilities of individuals. The CV interviewer, interactively with the provider, reviews documentation supporting the discussion.

As part of the Person Centered Review, the CV also interviews the waiver recipient to determine if the person is educated and assisted by supports and services to learn about rights and to fully exercise rights, but especially those that matter most to the person. This includes dignity, respect, and privacy. The individual is asked probing questions

such as:
1) Who talks to you about your rights?
2) What right is most important to you?
3) Is there anything you want to do that you are not allowed to do?
4) Do you feel respected? What does privacy mean to you?
5) Where do you go when you would like to be by yourself (while at home and work)?
6) Has there ever been a time when someone has shared your personal information without your permission?
7) If you feel someone is violating your rights, what do you do?

The CV provides data to APD for reporting and follow-up purposes.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

(G-1) Remediation occurs most frequently at the individual recipient level, and follow-up action is taken on a case-by-case basis at the Operating Agency Regional Office level. Aggregated data at the Operating Agency State Office level will be analyzed to identify systemic problems. Prior to action by the Operating Agency, some issues are dealt with by the provider in response to discovery. The Regional Operating Agency Office where the critical incident occurred would be next to respond and conduct follow-up with the provider to confirm resolution to performance gaps identified. Problems are addressed depending on the risk and the complexity of the situation. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

(G-2) Providers are required to prepare, submit for approval, and then execute approved corrective plans for failure to provide follow up on critical incident reports, which includes strategies to mitigate/prevent future incidents of a repeated or similar occurrence. The implementation and outcomes of corrective plans (strategies to mitigate/prevent future incidents) are tracked by the Operating Agency and reported to the State Medicaid Agency.

(G-3) Remediation occurs at the individual recipient level, and action is taken on a case-by-case basis at the Operating Agency Regional Office level. Monthly reports from providers are submitted to the local Regional Office and reviewed by the Area Behavior Analyst (ABA). Those cases where there is an adverse outcome (client death or injury) or the application of a reactive strategy that exceeds 60 minutes requires follow-up with the provider by the ABA. These cases, as well as the aggregated data will be used to determine whether an additional Local Review Committee review and behavior program changes are needed. The Operating Agency also reviews and analyzes the aggregated data to identify individual recipient concerns as well as systemic problems that require notification and follow-up by a specific ABA, or all ABAs throughout the State.

(G-4) On a continuous and ongoing basis, providers are required to ensure recipients' identified health and/or safety needs are addressed. For all deficiencies cited in a Provider Discovery Review (that includes Person Centered Review information), providers are required to prepare, submit for approval, and then execute approved remediation pans. The implementation and outcomes of remediation plans are tracked by the Operating Agency and reported to the State Medicaid Agency, and the providers' resolutions are verified by the Operating Agency to close the remediation plans.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- ○ **No**
- ◉ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Basic processes have been put in place for discovery and remediation. An operating procedure for incident reporting has been revised to include medication error reporting and reports of deaths. The procedure provides instructions for providers and the APD regional staff to report and perform follow-up in a consistent manner. Training was provided to regional staff and Waiver Support Cooridnators. The APD collects the information and aggregrates discovery and remediation data.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the 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;
- 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 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Operating Agency has established an internal quality assurance and improvement team. This team has established a broad plan to trend data and prioritize needed system changes. A CV has been contracted as a key partner in the discovery component to gather and trend major data elements, such as those reflecting provider quality, and recipient choice and service plan development. The Operating Agency will itself gather and trend other data elements not available to the CV in order to develop and maintain a comprehensive view.

The Operating Agency will work with a Quality Council to prioritize system improvements based on an analysis of discovery and remediation information. The Operating Agency will design and oversee the implementation of these systems improvements.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Based on the CMS framework, QIO responsibilities are shared across a number of levels.

Contracted Vendor
*Discovery
*Data collection
  Person Centered Reviews (PCR)
  Provider Performance Discovery Reviews (PDR)
*Alert Reporting
*Reports and distribution
*Review of provider performance outcomes, trends & patterns
*Recommendations

APD
*Remediation
*Data collection

*Review of data/reports to determine compliance with waiver assurances
*Review of regional/field performance outcomes, trends & patterns
*Approval of remediation plans (Quality Improvement Plan/Plans of Remediation) (QIP/POR)
*Monitors progress & follow up on QIP's/PORs
*Implementation of policies and procedures identified; modified, new or terminated
*Coordination & monitoring of Quality Management System
*Reviews statewide performance outcomes, trends, and patterns
*Initiates policy, procedures and practices to implement system design changes to enhance quality
*Evaluates data sources required to measure system performance
*With input from other stakeholders, determines, prioritizes, and coordinates the implementation of quality improvement system changes

AHCA
*Review of provider billing
*Recoupment of funds from inappropriate billings
*Contract management
*Oversight

Recipient/Family
*Measuring Satisfaction
*Budget Management

Providers
*Development and implementation of person centered supports/plans
*Accountability
*Case management
*Licensed/Trained/Certified

There will be an integration of functions within the Quality Management System that will encompass an overall organizational capacity along with collaboration to ultimately improve services and supports, and provide for waiver assurance oversight.

Data collection will be input from a number of sources, ultimately into a statewide database. Database sources are to include at minimum APD and CV entries. The statewide database would be part of an electronic information management system that will include, but is not limited to:
*Individual Client Electronic Records
*Incident Reporting System
  -Death reports
  -Medication errors
  -Critical/Reportable Incidents
  -Reactive strategies.
  -Abuse, Neglect and Exploitation

A Quality Council (QC) has been established to collaborate with stakeholders, organizations, and agencies to ensure that Floridians with developmental disabilities are receiving the highest quality of services by providers and to allow individuals to utilize their abilities to the fullest extent.

The QC will be asked to:
•Provide feedback on quality assurance activities for recipients of developmental disabilities receiving services from the Home and Community-Based Services Waivers;
•Provide feedback to enhance quality of services and appropriate health, safety and quality of life for people based on data generated by Discovery reviews;
•Provide feedback to the Contracted Vendor on their implementation of quality assurance reviews of Home and Community-Based Services Waivers providers;
•Provide feedback on quality improvement of service delivery at the:
  - provider level,
  - area level,
  - state level; and
•Compare Florida's performance measures to national data.

The APD, in conjunction with the Quality Council, will review longitudinal trend data for the measures related to the system design changes to determine whether system design changes have had the intended effects. Providers, area offices, and recipients and their family members will continue to submit required data and responses as inputs for data

collection. The QIO will also continue to collect data and provide reports on trends. Additional data may be collected from these parties to enable the state to assess the implementation and outcome of the system changes.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The evaluation of the Quality Improvement Strategy is an ongoing process. This process will have two main goals: determining whether the Quality Improvement Strategy is being implemented according to the waiver and whether it is in fact improving quality outcomes.

To address the first goal, at least annually, the APD will review the functioning of the QIS to assess compliance with its stated processes, such as whether the various parties involved are performing their responsibilities as outlined in the waiver. This process will also include input from the QIO, APD Regional/Field Offices, and APD stakeholders to identify any improvements that can be made to accurately carry out the strategy contained herein. The Operating Agency will also solicit feedback on how roles, responsibilities, and processes might be modified to enhance the effectiveness of the Quality Improvement Strategy.

Additionally, a high-level analysis of data regarding the outcomes of all of the system design changes made to enhance the system's effectiveness will be conducted and reviewed annually by the headquarters office and the Quality Council. This will help the state determine whether its efforts to prioritize and implement system improvements are in fact effective. For example, positive trends in a majority of indicators related to system improvements will demonstrate that the process for prioritizing and implementing system design changes is broadly effective.

As the Quality Improvement Strategy requires enhancement, the operating agency will work with stakeholders to identify and implement appropriate modifications.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The integrity of payments is ensured through AHCA's claim system for the Medicaid program, the Florida Medicaid Management Information System (FMMIS), which interfaces with the APD Allocation, Budget and Contract (ABC) and iBudget systems. The Developmental Disabilities Individual Budgeting Waiver providers bill through FMMIS, which interfaces with ABC, allowing only services approved by the APD Regional/Field Office to be paid. Financial Audits are conducted by the APD, the AHCA, and the Auditor General's Office.

Florida Medicaid contracts for CV services to conduct provider discovery reviews. These reviews are conducted on a statistically valid sample size with a 95% confidence interval and includes verification of the evidence to support provider billings is in the record of the participant prior to invoicing Medicaid. The CV also conducts Person Centered Reviews, which result in a direct on-site review of every service provider for the participant. This review encompasses the review of all billing and supporting documentation for all services provided to the individual for the last year. These processes are more fully described in Appendix G-3-b-ii; State Oversight and Follow-up.

The Operating Agency also conducts audits based on complaints or performance concerns, which include a review of the documentation supporting billings. These reviews are conducted by the APD's Inspector General, with significant findings referred to the State Auditor General or to Florida's Attorney General Medicaid Fraud Control Unit.

The State Medicaid Agency conducts periodic and routine reviews through the Program Integrity and the AHCA Inspector General's office. The CV findings are reviewed for follow up and recoupment through the Medicaid Fraud Prevention and Compliance Unit. The Florida Medicaid Management Information System interfaces with the APD iBudget and Allocation, Budget and Control system to ensure that only services authorized in the cost plan are paid. The state is also conducting advanced data analysis of billing patterns to detect improper and fraudulent billing.

All claims for waiver services are submitted through the state Medicaid fiscal agent provider payment system, FMMIS. The FMMIS includes edits to compare waiver enrollment data with dates of service to ensure individuals are eligible on the date of service. The iBudget waiver services are authorized on a quarterly basis and reviewed by the CV monthly to identify the billing provider, unduplicated recipient counts, amounts billed and actual reimbursement amounts. The state staff monitors waiver providers for fiscal accountability through post payment audits of paid claims.

The APD creates an electronic file which is transferred to the state fiscal agent and includes all approved service authorizations contained in the APD database. Each approved service authorization contains the recipient ID, provider ID, procedure code/modifiers, date range, approved amount and the unit rate. Thus, no claims are paid unless the services were previously authorized and the billing matches the prior authorization record on file.

The CV conducts audits as part of the overall monitoring of the iBudget waiver program. The CV routinely verifies that providers comply with the state's required billing practices. The CV quarterly reports contain data that reflects the review and compliance of providers billing practices. Providers non-compliant with billing requirements are reported to the AHCA and the APD.
The APD regional office staff conducts further review to determine whether recoupment action is required and the repayment amount for the provider. As part of the remediation process, the APD Regional Administrator, or designee will meet with the cited provider to explain the parameters of repayment to the state. The discussion typically includes the provider's corrective action plan, detailing how the provider will eliminate the billing deficiency. As with all remediation, the APD Regional Office monitors the provider's progress to ensure it completes the action plan set forth. In some instances the issue is referred to the state's Medicaid Program Integrity (MPI) unit for further investigation and possible sanctions. When fraud is suspected the matter is referred to the State Attorney General's Medicaid Fraud Control Unit.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability Assurance:**
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(I-1) Percentage of providers billing for services in accordance with the recipient's service authorization. N: Number of providers billing for services in accordance with the recipient's service authorization. D: Number of providers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Contracted Vendor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Contracted Vendor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(I-3) Percentage of claims paid at the correct rate, as published in the fee schedule submitted in the waiver application. N: Number of claims paid in accordance with the

rate in the fee schedule and all other policy requirements. D: Number of total claims paid.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Contracted Vendor	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Contracted Vendor	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify:

Performance Measure:

(I-2) Percentage of providers billing for waiver services at the correct rate. N: Number of providers billing for waiver services at the correct rate. D: Number of providers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Contracted Vendor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Contracted Vendor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
(I-1, I-2, I-3) The provider bills through the FMMIS system which has edits in place to disallow payment of claims unless they have been prior approved by APD and reported on the gatekeeper matrix file.

ii. **Remediation Data Aggregation**
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** 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).

Provider rates are determined based on funding appropriated by the Florida Legislature and previous expenditure history for those services. The methodology for rate determination is the same for all services and consumers, and providers have the opportunity to provide input on rates via the administrative rule-making process. The AHCA has rule-making authority including promulgation of the Coverage and Limitations Handbook and rate rules.

Rates are promulgated into rule. During the rule promulgation process, the Medicaid agency publishes a notice in the Florida Administrative Register (FAR) alerting the public of scheduled workshops and hearings where input may be provided. Written comments may also be submitted in lieu of oral comments at the public meeting.

Rates are posted on the Internet by AHCA and APD and available to waiver participants at the following websites: http://ahca.myflorida.com/medicaid/review/Promulgated/rate_tables/59G-13-081_iBudget_Rate_Table_Adoption.pdf (AHCA)
http://apd.myflorida.com/docs/Rate%20Changes%20Effective%2007012016.pdf (APD)
http://apd.myflorida.com/providers/rates-billing/docs/procedure-code-table.pdf (APD)

When changes occur, the public is generally notified through a healthcare alert. The public can enroll to receive healthcare alerts at the following website:
http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderAlerts/tabId/43/Default.aspx.

Waiver participants have the option to sign up for notices in the FAR, alerting the public of any new rules at the following website: https://www.flrules.org/Default.asp

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The FMMIS system has recipient eligibility and provider information. The recipient information is updated as part of the eligibility determination process. A provider file is established upon enrollment of a provider. Payments will be reflected on the provider's file. Edits in FMMIS are designed to ensure that payments for DD Waiver services are made only for authorized services to eligible recipients rendered by enrolled providers.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

(●) **No. State or local government agencies do not certify expenditures for waiver services.**

( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51 (b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The process begins with the support plan or cost plan approval at the APD Regional/Field Office. Support Coordinators are responsible for verifying Medicaid eligibility through FMMIS or the Department of Children and Families, which determines eligibility in Florida. No services can be planned or delivered without that validation. Upon verification of eligibility, the support plan process begins and services are planned and delivered accordingly. The provider bills through the FMMIS system, which has edits in place to disallow payment of claims unless they have been prior approved by the APD Regional/Field Office.

Support Coordinators validate service delivery during monthly visits to ensure the recipient received necessary supports and services. This is also validated during the CV reviews examining claims billed and services delivered.

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.**
- [x] **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.** *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- ( ) **This waiver is a part of a concurrent �1115/�1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The �1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

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**
- [x] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

  Appropriation is made to the APD. Funds are electronically transferred to the AHCA for the payment of providers. The AHCA makes the request for the federal match from CMS.

- [ ] **Other State Level Source(s) of Funds.**

  Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
○ **Applicable**
Check each that applies:
☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
○ **The following source(s) are used**
Check each that applies:
☐ **Health care-related taxes or fees**
☐ **Provider-related donations**
☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The amount of room and board payment that participants will make is determined by the Florida Department of Children and Families Adult Services Program. The determination is based upon the participant's income from third party benefits and

other income. If income is not sufficient to meet the room and board charges of the facility, the participant's circumstances can be reviewed to determine whether they will be eligible for an Optional State Supplement (OSS). The OSS payments are applied toward the cost of room and board.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. **Co-Payment Requirements.**

iv. **Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

◉ **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

○ **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	32010.34	8839.85	40850.19	140041.83	5385.62	145427.45	104577.26
2	33408.91	9228.80	42637.71	146203.67	5622.59	151826.26	109188.55
3	34883.70	9634.87	44518.57	152636.63	5869.98	158506.61	113988.04
4	36423.69	10058.80	46482.49	159352.64	6128.26	165480.90	118998.41
5	38020.45	10501.39	48521.84	166364.16	6397.90	172762.06	124240.22

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable) Level of Care: ICF/IID
Year 1	34742	34742
Year 2	36242	36242
Year 3	37742	37742
Year 4	39242	39242
Year 5	40742	40742

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay on the waiver was 339 days, which was based on based on historical length of stay data for waiver recipients. Most recipients on the Developmental Disabilities Individual Budgeting Waiver remain enrolled until they move out of state or pass away. The average length of stay is based on the 2016-17 CMS 372 Report for the Developmental Disabilities Individual Budgeting Waiver.

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 for these estimates is as follows:

The Factor D estimates are based on expenditures from the entire iBudget waiver population during waiver year 2016-17.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D’ estimates are derived from the actual Medicaid cost for State Plan services for waiver recipients. Medicaid/Medicare dual eligible individuals receive prescription drugs through Medicare Part D and enrollment in Medicare approved prescription drug plans. Edits in the FMMIS system prevent Medicaid payment of prescription drug costs for Medicaid/Medicare dual eligible recipients.

A calculation of 4.4% was used to project inflationary costs. The cost inflation factor was calculated by averaging the increase in costs from Federal Fiscal Year 2016 to Federal Fiscal Year 2018 of the National Medicaid Benefit Expenditures per Enrollee Estimates, as published in the 2016 Actuarial Report on the Financial Outlook for Medicaid published by the CMS Office of the Actuary.

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 Intermediate Care Facilities for individuals with Developmental Disabilities during 2016-17 using claims from the Florida Medicaid Management Information system that were submitted and adjudicated as of September 2018.

A calculation of 4.4% was used to project inflationary costs. The cost inflation factor was calculated by averaging the increase in costs from Federal Fiscal Year 2016 to Federal Fiscal Year 2018 of the National Medicaid Benefit

Expenditures per Enrollee Estimates, as published in the 2016 Actuarial Report on the Financial Outlook for Medicaid published by the CMS Office of the Actuary.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' estimates are derived from the actual Medicaid cost for state plan services for ICF/IDD residents. Medicaid/Medicare dual eligible individuals receive prescription drugs through Medicare Part D and enrollment in Medicare approved prescription drug plans. Edits in the FMMIS system prevent Medicaid payment of prescription drug costs for Medicaid/Medicare dual eligible recipients.

A calculation of 4.4% was used to project inflationary costs. The cost inflation factor was calculated by averaging the increase in costs from Federal Fiscal Year 2016 to Federal Fiscal Year 2018 of the National Medicaid Benefit Expenditures per Enrollee Estimates, as published in the 2016 Actuarial Report on the Financial Outlook for Medicaid published by the CMS Office of the Actuary.

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	
Residential Habilitation	
Respite	
Support Coordination	
Adult Dental Services	
Occupational Therapy	
Physical Therapy	
Respiratory Therapy	
Skilled Nursing	
Specialized Medical Equipment and Supplies	
Specialized Mental Health Counseling	
Speech Therapy	
Transportation	
Behavior Analysis Services	
Behavior Assistant Services	
Dietitian Services	
Environmental Accessibility Adaptations	
Life Skills Development	
Personal Emergency Response System	
Personal Supports	
Private Duty Nursing	
Residential Nursing	
Special Medical Home Care	
Supported Living Coaching	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. **Estimate of Factor D.**

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:							**466737977.08**
Month	☐	Month	9562	10.80	3674.83	**379498224.17**	
Day	☐	Day	2608	106.90	297.63	**82977815.38**	
Live-In	☐	Day	124	308.20	111.52	**4261937.54**	
Respite Total:							**18755173.84**
Quarter Hour	☐	Quarter Hour	2600	2092.30	3.29	**17897534.20**	
Day	☐	Day	212	33.00	122.59	**857639.64**	
Support Coordination Total:							**54454382.41**
Limited	☐	Month	3906	9.60	74.34	**2787571.58**	
Transitional	☐	Month	90	2.80	352.47	**88822.44**	
Full	☐	Month	31257	11.10	148.66	**51577988.38**	
Adult Dental Services Total:							**6193411.60**
Adult Dental Services	☐	Occurrence	8201	4.20	179.81	**6193411.60**	
Occupational Therapy Total:							**2837787.08**
Assessment	☐	Occurrence	42	1.00	48.50	**2037.00**	
Service	☐	Quarter Hour	697	254.60	15.98	**2835750.08**	
Physical Therapy Total:							**5168640.91**
Service	☐	Quarter Hour	1298	248.90	15.98	**5162693.76**	
Assessment	☐	Occurence	121	1.00	49.15	**5947.15**	
Respiratory Therapy Total:							**498244.54**
Service	☐	Quarter Hour	51	609.60	16.02	**498055.39**	
Assessment	☐	Occurrence	3	1.30	48.50	**189.15**	
Skilled Nursing Total:							**459787.44**
RN	☐	Occurence	6	288.40	30.60	**52950.24**	
LPN	☐					**406837.20**	
GRAND TOTAL:							**1112103161.54**
Total: Services included in capitation:							
Total: Services not included in capitation:							1112103161.54
Total Estimated Unduplicated Participants:							**34742**
Factor D (Divide total by number of participants):							**32010.34**
Services included in capitation:							
Services not included in capitation:							32010.34
Average Length of Stay on the Waiver:							339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Occurence	24	629.00	26.95		
Specialized Medical Equipment and Supplies Total:							**15349562.15**
Consumable Medical Supplies	☐	Item	8762	5.30	13.34	**619490.92**	
Durable Medical Equipment	☐	Item	383	31015.90	1.24	**14730071.23**	
Specialized Mental Health Counseling Total:							**2877055.20**
Specialized Mental Health Counseling	☐	Quarter Hour	348	21.60	382.75	**2877055.20**	
Speech Therapy Total:							**2278298.79**
Service	☐	Quarter Hour	717	198.30	15.99	**2273475.79**	
Assessment	☐	Occurence	100	1.00	48.23	**4823.00**	
Transportation Total:							**44092487.77**
Trip	☐	Occurrence	12012	332.70	10.19	**40723238.56**	
Month	☐	Occurrence	1910	10.50	146.71	**2942269.05**	
Mile	☐	Occurrence	180	2080.80	1.14	**426980.16**	
Behavior Analysis Services Total:							**20812803.27**
Doctorate Degree	☐	Quarter Hour	3137	207.70	19.07	**12425151.94**	
Assessment	☐	Occurrence	662	1.00	276.51	**183049.62**	
Bachelor Degree	☐	Quarter Hour	1544	237.20	10.67	**3907746.66**	
Masters Degree	☐	Quarter Hour	1222	209.80	16.76	**4296855.06**	
Behavior Assistant Services Total:							**4431586.23**
Behavior Assistant Services	☐	Quarter Hour	388	2560.90	4.46	**4431586.23**	
Dietitian Services Total:							**125275.36**
Dietitian Services	☐	Quarter Hour	112	84.10	13.30	**125275.36**	
Environmental Accessibility Adaptations Total:							**1123448.76**
Environmental Accessibility Adaptations	☐	Occurrence	259	7.20	602.45	**1123448.76**	
Life Skills Development Total:							**134123813.89**
Level I						**37231904.21**	

GRAND TOTAL:	**1112103161.54**
Total: Services included in capitation:	
Total: Services not included in capitation:	1112103161.54
Total Estimated Unduplicated Participants:	**34742**
Factor D (Divide total by number of participants):	**32010.34**
Services included in capitation:	
Services not included in capitation:	32010.34
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	☐	Quarter Hour	5282	2700.70	2.61		
Level II	☐	Quarter Hour	2013	356.90	8.31	5970233.91	
Level III	☐	Hour	14514	1040.60	6.02	90921675.77	
Personal Emergency Response System Total:							**60678.28**
Service	☐	Month	181	9.20	34.60	57615.92	
Installation	☐	Occurrence	14	1.00	218.74	3062.36	
Personal Supports Total:							**265181902.31**
Personal Supports	☐	Day	2573	198.30	105.13	53640048.87	
Quarter Hour	☐	Quarter Hour	13015	4428.80	3.67	211541853.44	
Private Duty Nursing Total:							**29865421.81**
LPN	☐	Quarter Hour	305	14713.40	6.32	28361549.84	
RN	☐	Quarter Hour	23	9006.30	7.26	1503871.97	
Residential Nursing Total:							**7778872.85**
LPN	☐	Quarter Hour	130	9094.50	6.20	7330167.00	
RN	☐	Quarter Hour	51	1210.20	7.27	448705.85	
Special Medical Home Care Total:							**958774.32**
Special Medical Home Care	☐	Day	23	56.00	744.39	958774.32	
Supported Living Coaching Total:							**27937775.65**
Supported Living Coaching	☐	Quarter Hour	4751	785.10	7.49	27937775.65	
GRAND TOTAL:							**1112103161.54**
Total: Services included in capitation:							
Total: Services not included in capitation:							1112103161.54
Total Estimated Unduplicated Participants:							**34742**
Factor D (Divide total by number of participants):							**32010.34**
Services included in capitation:							
Services not included in capitation:							32010.34
Average Length of Stay on the Waiver:							339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:							**508323524.62**
Month	☐	Month	9975	10.80	3836.52	**413308299.60**	
Day	☐	Day	2720	106.90	310.73	**90350340.64**	
Live-In	☐	Day	130	308.20	116.43	**4664884.38**	
Respite Total:							**20396267.51**
Quarter Hour	☐	Quarter Hour	2712	2092.30	3.43	**19462909.37**	
Day	☐	Day	221	33.00	127.98	**933358.14**	
Support Coordination Total:							**59305686.58**
Limited	☐	Month	4075	9.60	77.61	**3036103.20**	
Transitional	☐	Month	94	2.80	367.98	**96852.34**	
Full	☐	Month	32607	11.10	155.20	**56172731.04**	
Adult Dental Services Total:							**6744967.32**
Adult Dental Services	☐	Occurrence	8555	4.20	187.72	**6744967.32**	
Occupational Therapy Total:							**3093845.70**
Assessment	☐	Occurrence	44	1.00	50.63	**2227.72**	
Service	☐	Quarter Hour	728	254.60	16.68	**3091617.98**	
Physical Therapy Total:							**5627801.87**
Service	☐	Quarter Hour	1354	248.90	16.68	**5621336.81**	
Assessment	☐	Occurrence	126	1.00	51.31	**6465.06**	
Respiratory Therapy Total:							**540400.59**
Service	☐	Quarter Hour	53	609.60	16.72	**540203.14**	
Assessment	☐	Occurrence	3	1.30	50.63	**197.46**	
Skilled Nursing Total:							**497787.78**
RN	☐	Occurrence	6	288.40	31.95	**55286.28**	
LPN	☐	Occurrence	25	629.00	28.14	**442501.50**	

GRAND TOTAL:	**1210805881.07**
Total: Services included in capitation:	
Total: Services not included in capitation:	1210805881.07
Total Estimated Unduplicated Participants:	**36242**
Factor D (Divide total by number of participants):	**33408.91**
Services included in capitation:	
Services not included in capitation:	33408.91
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:							**16639064.78**
Consumable Medical Supplies	☐	Item	9141	5.30	13.93	**674870.89**	
Durable Medical Equipment	☐	Item	399	31015.90	1.29	**15964193.89**	
Specialized Mental Health Counseling Total:							**3133105.27**
Specialized Mental Health Counseling	☐	Quarter Hour	363	21.60	399.59	**3133105.27**	
Speech Therapy Total:							**2480837.40**
Service	☐	Quarter Hour	748	198.30	16.69	**2475601.00**	
Assessment	☐	Occurence	104	1.00	50.35	**5236.40**	
Transportation Total:							**48027190.20**
Trip	☐	Occurrence	12531	332.70	10.64	**44358837.77**	
Month	☐	Occurrence	1993	10.50	153.17	**3205312.00**	
Mile	☐	Occurence	187	2080.80	1.19	**463040.42**	
Behavior Analysis Services Total:							**22667995.49**
Doctorate Degree	☐	Quarter Hour	3272	207.70	19.91	**13530724.50**	
Assessment	☐	Occurence	690	1.00	288.68	**199189.20**	
Bachelor Degree	☐	Quarter Hour	1611	237.20	11.14	**4256919.29**	
Masters Degree	☐	Quarter Hour	1275	209.80	17.50	**4681162.50**	
Behavior Assistant Services Total:							**4833186.57**
Behavior Assistant Services	☐	Quarter Hour	405	2560.90	4.66	**4833186.57**	
Dietitian Services Total:							**136673.43**
Dietitian Services	☐	Quarter Hour	117	84.10	13.89	**136673.43**	
Environmental Accessibility Adaptations Total:							**1227226.75**
Environmental Accessibility Adaptations	☐	Occurrence	271	7.20	628.96	**1227226.75**	
Life Skills Development Total:							**145927454.73**
Level I	☐	Quarter Hour	5510	2700.70	2.72	**40475931.04**	

GRAND TOTAL:	**1210805881.07**
Total: Services included in capitation:	
Total: Services not included in capitation:	1210805881.07
Total Estimated Unduplicated Participants:	**36242**
Factor D (Divide total by number of participants):	**33408.91**
Services included in capitation:	
Services not included in capitation:	33408.91
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level II	☐	Quarter Hour	2100	356.90	8.68	6505573.20	
Level III	☐	Hour	15141	1040.60	6.28	98945950.49	
Personal Emergency Response System Total:							66230.86
Service	☐	Month	189	9.20	36.12	62805.46	
Installation	☐	Occurrence	15	1.00	228.36	3425.40	
Personal Supports Total:							288715556.48
Personal Supports	☐	Day	2684	198.30	109.76	58418355.07	
Quarter Hour	☐	Quarter Hour	13577	4428.80	3.83	230297201.41	
Private Duty Nursing Total:							32518910.02
LPN	☐	Quarter Hour	318	14713.40	6.60	30880483.92	
RN	☐	Quarter Hour	24	9006.30	7.58	1638426.10	
Residential Nursing Total:							8430418.18
LPN	☐	Quarter Hour	135	9094.50	6.47	7943591.02	
RN	☐	Quarter Hour	53	1210.20	7.59	486827.15	
Special Medical Home Care Total:							1044476.16
Special Medical Home Care	☐	Day	24	56.00	777.14	1044476.16	
Supported Living Coaching Total:							30427272.79
Supported Living Coaching	☐	Quarter Hour	4956	785.10	7.82	30427272.79	

GRAND TOTAL:	1210805881.07
Total: Services included in capitation:	
Total: Services not included in capitation:	1210805881.07
Total Estimated Unduplicated Participants:	36242
Factor D (Divide total by number of participants):	33408.91
Services included in capitation:	
Services not included in capitation:	33408.91
Average Length of Stay on the Waiver:	339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:							**552617442.00**
Month	☐	Month	10387	10.80	4005.33	**449316317.27**	
Day	☐	Day	2833	106.90	324.40	**98243793.88**	
Live-In	☐	Day	135	308.20	121.55	**5057330.85**	
Respite Total:							**22167085.52**
Quarter Hour	☐	Quarter Hour	2824	2092.30	3.58	**21152985.62**	
Day	☐	Day	230	33.00	133.61	**1014099.90**	
Support Coordination Total:							**64476574.25**
Limited	☐	Month	4243	9.60	81.02	**3300171.46**	
Transitional	☐	Month	98	2.80	384.17	**105416.25**	
Full	☐	Month	33956	11.10	162.03	**61070986.55**	
Adult Dental Services Total:							**7333140.44**
Adult Dental Services	☐	Occurrence	8909	4.20	195.98	**7333140.44**	
Occupational Therapy Total:							**3362331.75**
Assessment	☐	Occurrence	46	1.00	52.86	**2431.56**	
Service	☐	Quarter Hour	758	254.60	17.41	**3359900.19**	
Physical Therapy Total:							**6117039.76**
Service	☐	Quarter Hour	1410	248.90	17.41	**6110022.09**	
Assessment	☐	Occurrence	131	1.00	53.57	**7017.67**	
Respiratory Therapy Total:							**585673.75**
Service	☐	Quarter Hour	55	609.60	17.46	**585398.88**	
Assessment	☐	Occurrence	4	1.30	52.86	**274.87**	
Skilled Nursing Total:							**538206.66**
RN	☐	Occurrence	6	288.40	33.36	**57726.14**	
LPN	☐	Occurrence	26	629.00	29.38	**480480.52**	

GRAND TOTAL:	**1316580627.83**
Total: Services included in capitation:	
Total: Services not included in capitation:	1316580627.83
Total Estimated Unduplicated Participants:	**37742**
Factor D (Divide total by number of participants):	**34883.70**
Services included in capitation:	
Services not included in capitation:	34883.70
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:							**18152082.62**
Consumable Medical Supplies	☐	Item	9519	5.30	14.54	**733553.18**	
Durable Medical Equipment	☐	Item	416	31015.90	1.35	**17418529.44**	
Specialized Mental Health Counseling Total:							**3406109.62**
Specialized Mental Health Counseling	☐	Quarter Hour	378	21.60	417.17	**3406109.62**	
Speech Therapy Total:							**2696644.25**
Service	☐	Quarter Hour	779	198.30	17.42	**2690966.69**	
Assessment	☐	Occurrence	108	1.00	52.57	**5677.56**	
Transportation Total:							**52220156.12**
Trip	☐	Occurence	13049	332.70	11.11	**48232979.55**	
Month	☐	Occurence	2075	10.50	159.91	**3484039.12**	
Mile	☐	Occurrence	195	2080.80	1.24	**503137.44**	
Behavior Analysis Services Total:							**24643844.25**
Doctorate Degree	☐	Quarter Hour	3407	207.70	20.79	**14711708.78**	
Assessment	☐	Occurence	719	1.00	301.38	**216692.22**	
Bachelor Degree	☐	Quarter Hour	1678	237.20	11.63	**4628991.21**	
Masters Degree	☐	Quarter Hour	1327	209.80	18.27	**5086452.04**	
Behavior Assistant Services Total:							**5263008.03**
Behavior Assistant Services	☐	Quarter Hour	422	2560.90	4.87	**5263008.03**	
Dietitian Services Total:							**148772.90**
Dietitian Services	☐	Quarter Hour	122	84.10	14.50	**148772.90**	
Environmental Accessibility Adaptations Total:							**1333221.55**
Environmental Accessibility Adaptations	☐	Occurrence	282	7.20	656.63	**1333221.55**	
Life Skills Development Total:							**158719752.31**
Level I	☐	Quarter Hour	5738	2700.70	2.84	**44010391.14**	

GRAND TOTAL:	**1316580627.83**
Total: Services included in capitation:	
Total: Services not included in capitation:	1316580627.83
Total Estimated Unduplicated Participants:	**37742**
Factor D (Divide total by number of participants):	**34883.70**
Services included in capitation:	
Services not included in capitation:	34883.70
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level II		Quarter Hour	2187	356.90	9.06	7071695.12	
Level III		Hour	15768	1040.60	6.56	107637666.05	
Personal Emergency Response System Total:							71813.23
Service		Month	196	9.20	37.71	67998.67	
Installation		Occurrence	16	1.00	238.41	3814.56	
Personal Supports Total:							314009271.61
Personal Supports		Day	2796	198.30	114.59	63534058.81	
Quarter Hour		Quarter Hour	14139	4428.80	4.00	250475212.80	
Private Duty Nursing Total:							35336228.73
LPN		Quarter Hour	331	14713.40	6.89	33555232.91	
RN		Quarter Hour	25	9006.30	7.91	1780995.82	
Residential Nursing Total:							9182853.49
LPN		Quarter Hour	141	9094.50	6.75	8655690.38	
RN		Quarter Hour	55	1210.20	7.92	527163.12	
Special Medical Home Care Total:							1135862.00
Special Medical Home Care		Day	25	56.00	811.33	1135862.00	
Supported Living Coaching Total:							33063512.98
Supported Living Coaching		Quarter Hour	5161	785.10	8.16	33063512.98	
GRAND TOTAL:							1316580627.83
Total: Services included in capitation:							
Total: Services not included in capitation:							1316580627.83
Total Estimated Unduplicated Participants:							37742
Factor D (Divide total by number of participants):							34883.70
Services included in capitation:							
Services not included in capitation:							34883.70
Average Length of Stay on the Waiver:							339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:							**599832898.34**
Month	☐	Month	10800	10.80	4181.56	**487737158.40**	
Day	☐	Day	2945	106.90	338.67	**106620258.74**	
Live-In	☐	Day	140	308.20	126.90	**5475481.20**	
Respite Total:							**24082775.90**
Quarter Hour	☐	Quarter Hour	2937	2092.30	3.74	**22982618.27**	
Day	☐	Day	239	33.00	139.49	**1100157.63**	
Support Coordination Total:							**69989054.27**
Limited	☐	Month	4412	9.60	84.58	**3582402.82**	
Transitional	☐	Month	101	2.80	401.07	**113422.60**	
Full	☐	Month	35306	11.10	169.16	**66293228.86**	
Adult Dental Services Total:							**7960740.48**
Adult Dental Services	☐	Occurrence	9264	4.20	204.60	**7960740.48**	
Occupational Therapy Total:							**3650007.98**
Assessment	☐	Occurrence	48	1.00	55.19	**2649.12**	
Service	☐	Quarter Hour	788	254.60	18.18	**3647358.86**	
Physical Therapy Total:							**6641315.34**
Service	☐	Quarter Hour	1466	248.90	18.18	**6633652.93**	
Assessment	☐	Occurrence	137	1.00	55.93	**7662.41**	
Respiratory Therapy Total:							**644841.45**
Service	☐	Quarter Hour	58	609.60	18.23	**644554.46**	
Assessment	☐	Occurrence	4	1.30	55.19	**286.99**	
Skilled Nursing Total:							**600429.87**
RN	☐	Occurrence	6	288.40	34.83	**60269.83**	
LPN	☐	Occurrence	28	629.00	30.67	**540160.04**	

GRAND TOTAL:	**1429338329.35**
Total: Services included in capitation:	
Total: Services not included in capitation:	1429338329.35
Total Estimated Unduplicated Participants:	**39242**
Factor D (Divide total by number of participants):	**36423.69**
Services included in capitation:	
Services not included in capitation:	36423.69
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:							**19688658.25**
Consumable Medical Supplies	☐	Item	9897	5.30	15.18	**796253.24**	
Durable Medical Equipment	☐	Item	432	31015.90	1.41	**18892405.01**	
Specialized Mental Health Counseling Total:							**3697127.06**
Specialized Mental Health Counseling	☐	Quarter Hour	393	21.60	435.53	**3697127.06**	
Speech Therapy Total:							**2927933.81**
Service	☐	Quarter Hour	810	198.30	18.19	**2921732.37**	
Assessment	☐	Occurrence	113	1.00	54.88	**6201.44**	
Transportation Total:							**56691072.91**
Trip	☐	Occurrence	13568	332.70	11.60	**52363253.76**	
Month	☐	Occurrence	2158	10.50	166.95	**3782920.05**	
Mile	☐	Occurrence	203	2080.80	1.29	**544899.10**	
Behavior Analysis Services Total:							**26750109.23**
Doctorate Degree	☐	Quarter Hour	3543	207.70	21.70	**15968619.87**	
Assessment	☐	Occurrence	748	1.00	314.64	**235350.72**	
Bachelor Degree	☐	Quarter Hour	1745	237.20	12.14	**5024915.96**	
Masters Degree	☐	Quarter Hour	1380	209.80	19.07	**5521222.68**	
Behavior Assistant Services Total:							**5698104.94**
Behavior Assistant Services	☐	Quarter Hour	438	2560.90	5.08	**5698104.94**	
Dietitian Services Total:							**160432.52**
Dietitian Services	☐	Quarter Hour	126	84.10	15.14	**160432.52**	
Environmental Accessibility Adaptations Total:							**1446172.99**
Environmental Accessibility Adaptations	☐	Occurrence	293	7.20	685.52	**1446172.99**	
Life Skills Development Total:							**172228515.97**
Level I	☐	Quarter Hour	5966	2700.70	2.96	**47692633.55**	

GRAND TOTAL:	**1429338329.35**
Total: Services included in capitation:	
Total: Services not included in capitation:	1429338329.35
Total Estimated Unduplicated Participants:	**39242**
Factor D (Divide total by number of participants):	**36423.69**
Services included in capitation:	
Services not included in capitation:	36423.69
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level II		Quarter Hour	2274	356.90	9.46	7677647.08	
Level III		Hour	16394	1040.60	6.85	116858235.34	
Personal Emergency Response System Total:							77872.02
Service		Month	204	9.20	39.37	73889.62	
Installation		Occurrence	16	1.00	248.90	3982.40	
Personal Supports Total:							341112239.69
Personal Supports		Day	2907	198.30	119.63	68961682.50	
Quarter Hour		Quarter Hour	14701	4428.80	4.18	272150557.18	
Private Duty Nursing Total:							38325728.01
LPN		Quarter Hour	344	14713.40	7.19	36391535.02	
RN		Quarter Hour	26	9006.30	8.26	1934192.99	
Residential Nursing Total:							10005569.61
LPN		Quarter Hour	147	9094.50	7.05	9425085.08	
RN		Quarter Hour	58	1210.20	8.27	580484.53	
Special Medical Home Care Total:							1233275.68
Special Medical Home Care		Day	26	56.00	847.03	1233275.68	
Supported Living Coaching Total:							35893453.03
Supported Living Coaching		Quarter Hour	5366	785.10	8.52	35893453.03	
GRAND TOTAL:							1429338329.35
Total: Services included in capitation:							
Total: Services not included in capitation:							1429338329.35
Total Estimated Unduplicated Participants:							39242
Factor D (Divide total by number of participants):							36423.69
Services included in capitation:							
Services not included in capitation:							36423.69
Average Length of Stay on the Waiver:							339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:							**650213183.99**
Month	☐	Month	11213	10.80	4365.55	**528669851.22**	
Day	☐	Day	3058	106.90	353.57	**115582103.71**	
Live-In	☐	Day	146	308.20	132.48	**5961229.06**	
Respite Total:							**26071584.45**
Quarter Hour	☐	Quarter Hour	3049	2092.30	3.90	**24879748.53**	
Day	☐	Day	248	33.00	145.63	**1191835.92**	
Support Coordination Total:							**75859656.06**
Limited	☐	Month	4581	9.60	88.30	**3883222.08**	
Transitional	☐	Month	105	2.80	418.72	**123103.68**	
Full	☐	Month	36655	11.10	176.60	**71853330.30**	
Adult Dental Services Total:							**8628500.16**
Adult Dental Services	☐	Occurrence	9618	4.20	213.60	**8628500.16**	
Occupational Therapy Total:							**3955651.32**
Assessment	☐	Occurrence	49	1.00	57.62	**2823.38**	
Service	☐	Quarter Hour	818	254.60	18.98	**3952827.94**	
Physical Therapy Total:							**7203129.19**
Service	☐	Quarter Hour	1523	248.90	18.98	**7194837.81**	
Assessment	☐	Occurrence	142	1.00	58.39	**8291.38**	
Respiratory Therapy Total:							**696340.90**
Service	☐	Quarter Hour	60	609.60	19.03	**696041.28**	
Assessment	☐	Occurrence	4	1.30	57.62	**299.62**	
Skilled Nursing Total:							**657480.39**
RN	☐	Occurrence	7	288.40	36.36	**73403.57**	
LPN	☐	Occurrence	29	629.00	32.02	**584076.82**	

GRAND TOTAL:	**1549029037.56**
Total: Services included in capitation:	
Total: Services not included in capitation:	1549029037.56
Total Estimated Unduplicated Participants:	**40742**
Factor D (Divide total by number of participants):	**38020.45**
Services included in capitation:	
Services not included in capitation:	38020.45
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:							**21334659.86**
Consumable Medical Supplies	☐	Item	10276	5.30	15.85	**863235.38**	
Durable Medical Equipment	☐	Item	449	31015.90	1.47	**20471424.48**	
Specialized Mental Health Counseling Total:							**4007092.03**
Specialized Mental Health Counseling	☐	Quarter Hour	408	21.60	454.69	**4007092.03**	
Speech Therapy Total:							**3173670.93**
Service	☐	Quarter Hour	841	198.30	18.99	**3166968.00**	
Assessment	☐	Occurrence	117	1.00	57.29	**6702.93**	
Transportation Total:							**61444703.62**
Trip	☐	Occurrence	14086	332.70	12.11	**56752451.74**	
Month	☐	Occurrence	2240	10.50	174.30	**4099536.00**	
Mile	☐	Occurrence	211	2080.80	1.35	**592715.88**	
Behavior Analysis Services Total:							**28986153.93**
Doctorate Degree	☐	Quarter Hour	3678	207.70	22.65	**17302801.59**	
Assessment	☐	Occurrence	776	1.00	328.48	**254900.48**	
Bachelor Degree	☐	Quarter Hour	1811	237.20	12.67	**5442641.76**	
Masters Degree	☐	Quarter Hour	1433	209.80	19.91	**5985810.09**	
Behavior Assistant Services Total:							**6175610.35**
Behavior Assistant Services	☐	Quarter Hour	455	2560.90	5.30	**6175610.35**	
Dietitian Services Total:							**174180.35**
Dietitian Services	☐	Quarter Hour	131	84.10	15.81	**174180.35**	
Environmental Accessibility Adaptations Total:							**1566480.38**
Environmental Accessibility Adaptations	☐	Occurrence	304	7.20	715.68	**1566480.38**	
Life Skills Development Total:							**186656407.80**
Level I	☐	Quarter Hour	6194	2700.70	3.09	**51689939.62**	

GRAND TOTAL:	**1549029037.56**
Total: Services included in capitation:	
Total: Services not included in capitation:	1549029037.56
Total Estimated Unduplicated Participants:	**40742**
Factor D (Divide total by number of participants):	**38020.45**
Services included in capitation:	
Services not included in capitation:	38020.45
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level II	☐	Quarter Hour	2361	356.90	9.88	**8325292.09**	
Level III	☐	Hour	17021	1040.60	7.15	**126641176.09**	
Personal Emergency Response System Total:							**84578.89**
Service	☐	Month	212	9.20	41.10	**80161.44**	
Installation	☐	Occurrence	17	1.00	259.85	**4417.45**	
Personal Supports Total:							**369464779.75**
Personal Supports	☐	Day	3018	198.30	124.89	**74742843.37**	
Quarter Hour	☐	Quarter Hour	15263	4428.80	4.36	**294721936.38**	
Private Duty Nursing Total:							**41654279.23**
LPN	☐	Quarter Hour	358	14713.40	7.51	**39558152.97**	
RN	☐	Quarter Hour	27	9006.30	8.62	**2096126.26**	
Residential Nursing Total:							**10800840.60**
LPN	☐	Quarter Hour	152	9094.50	7.36	**10174199.04**	
RN	☐	Quarter Hour	60	1210.20	8.63	**626641.56**	
Special Medical Home Care Total:							**1337061.60**
Special Medical Home Care	☐	Day	27	56.00	884.30	**1337061.60**	
Supported Living Coaching Total:							**38883011.77**
Supported Living Coaching	☐	Quarter Hour	5571	785.10	8.89	**38883011.77**	

GRAND TOTAL:	**1549029037.56**
Total: Services included in capitation:	
Total: Services not included in capitation:	1549029037.56
Total Estimated Unduplicated Participants:	**40742**
Factor D (Divide total by number of participants):	**38020.45**
Services included in capitation:	
Services not included in capitation:	38020.45
Average Length of Stay on the Waiver:	339