

59G-13.080 Home and Community-Based Services Waivers.

(1) Purpose. Under authority of Section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting. To meet federal requirements, Medicaid must demonstrate each waiver's cost-effectiveness.

(2) Definitions. General Medicaid definitions applicable to this program are located in Rule 59G-1.010, F.A.C. Additional descriptions of services available under this program are provided in subsection (3) of this rule. The following definitions apply:

(a) "Agency" means the Agency for Health Care Administration, the Florida state agency responsible for the administration of Medicaid waivers for home and community-based (HCB) services.

(b) "Department" means the Florida Department of Elderly Affairs (DOEA).

(3) Home and Community-Based (HCB) Waiver Services are those Medicaid services approved by the Centers for Medicare and Medicaid under the authority of Section 1915(c) of the Social Security Act. The definitions of the following services are provided in the respective HCB services waiver, as are specific provider qualifications. Since several similar services with different names may be provided in more than one waiver, this section lists them as a cluster. A general description of each service cluster is provided. Individuals eligible for the respective HCB services waiver programs may need and receive the following services:

(a) Adaptive and Assistive Equipment, and Adaptive Equipment, include selected self-help items that are necessary for recipient safety and that assist recipients to increase their functional ability to perform activities of daily living.

(b) Adult Day Health Care and Day Health Care are services provided in an ambulatory care setting. They are directed toward meeting the supervisory, social, and health restoration and maintenance needs of adult recipients who, due to their functional impairments, are not capable of living independently.

(c) Caregiver Training and Support are services that encourage the provision of care for the recipient in the home or home-like settings from caregivers such as relatives, friends, and neighbors. Activities include workshops or in-home training conducted by professionals to increase the caregivers' knowledge of caregiving skills and understanding of the aging or disease process and to provide emotional support through caregivers' support groups.

(d) Case Aide services are adjunctive to case management and provided by paraprofessionals under the direction of case managers. These services include: assistance with implementing plans of care, assistance with obtaining access to appointments for care plan and other services, supervision of provider activities, and assisting with linkages of providers with recipients via additional telephone contacts and visits. They will not develop care plans or conduct assessments or reassessments.

(e) Case Management, Waiver Case Management, and Support Coordination are services that assist Medicaid eligible individuals in gaining access to needed medical, social, educational and other services, regardless of funding source.

(f) Chore Services and Housekeeping/Chore Services are provided to maintain the home in a clean, sanitary and safe environment. Chore services will be provided only in cases where neither the recipient, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency, or third party payor is capable of or responsible for their provision.

(g) Companion Services include those activities necessary to assist the recipient in performing household or personal tasks and providing social stimulation to relieve the negative effects of loneliness and isolation.

(h) Consumable Medical Supplies are expendable, disposable, and non-durable items used for the treatment of specific injuries or diseases, or for persons who have chronic medical or disabling conditions. These supplies exceed those routinely furnished by the provider in conjunction with skilled care and home health aide visits.

(i) Counseling, Mental Health Services, Education and Support, and Behavioral Analysis are services provided for the diagnosis or treatment of mental, psychoneurotic, or personality disorders, or providing assistance to recipients in identifying feasible goals, providing emotional support and guidance, providing advice about community resources, or exploring possible alternative behavior patterns.

(j) Day Training service programs support the participation of recipients in daily, valued routines of the community, which for adults may include work-like settings but exclude services directed at teaching specific job skills or meeting employment objectives of non-supported, competitive, paid or unpaid employment in the general work force. Day training programs for children are limited to children who, because of age, are not eligible for services through the local education agencies. Early developmental intervention

activities are provided to maximize the development of the child. This service stresses self-help, adaptive, and social skills which are age-appropriate for the individual.

(k) Emergency Alert Response, Medical Alert and Response Service, and Personal Emergency Response Systems are methods of monitoring persons, through electronic or other means, in their own home to assure their safety by identifying their need for assistance or medical intervention and dispatching qualified personnel to the home.

(l) Environmental Modifications, Minor Physical Adaptations to the Home/Home Modifications, and Home Modifications are structural changes to the home which are necessary to enhance a recipient's safety and well-being or to help the recipient to function with greater independence in the home. These adaptations/improvements must be of direct medical or remedial benefit to the client.

(m) Financial Education and Protection Services consist of formal instruction in budget management, sensible purchasing habits, and financial management skills to make optimum use of limited financial resources and to avoid exploitation.

(n) Home Delivered Meals and Special Home Delivered Meals are designed to provide meals to persons who have difficulty shopping for or preparing food without assistance.

(o) Home Health Aide Services include therapeutic, supportive, and compensatory health and personal care tasks and activities for recipients in their homes provided by an aide employed by a licensed home health agency working under the supervision of a registered professional nurse or another appropriate health professional.

(p) Homemaker, and Homemaker and Personal Care Services provide assistance with daily living activities and household tasks related to supporting clients in a home setting. Services include assistance with bathing, dressing, eating, maintenance of personal belongings, and performance of light housekeeping, and meal planning and preparation.

(q) Non-Residential Support Services are activities provided in an individual, community-integrated, non-residential setting. These activities are age-appropriate and geared to enhance acceptable behaviors, increase the individual's ability to control the environment, and emphasize those qualities that are integrative and normative. For adults, these services may be provided in work-like settings in the community.

(r) Occupational Therapy is the use of prescribed activities designed for a specific remedial purpose to restore, improve, or maintain impaired functions for the purpose of increasing or maintaining independent functioning.

(s) Personal Care Services provide assistance with, or supervision of, activities of daily living. Personal care services offer an alternative to home health aide services when a client's condition no longer requires the attention of a nurse or aide acting under regular supervision.

(t) Physical Therapy, is treatment by physical agents or methods to restore, improve, or maintain impaired bodily functions by massage, exercise, and the use of physical, chemical, and other properties of motion, heat, electromagnetic radiation, light, electricity, or sound, as defined in Chapter 486, F.S., incorporated by reference. In some waiver programs, it may include an assessment.

(u) Private Duty Nursing Services are individual and continuous care provided by licensed nurses in the recipient's home.

(v) Residential Habilitation is 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 recipient to reside in a non-institutional setting.

(w) Respite Care is the provision of supervisory, supportive, and short-term emergency care necessary to maintain the health and safety of a recipient when the primary caregiver is not available to provide such care or requires relief from the stress and demands associated with daily care.

(x) Risk Reduction services provide care and guidance to caregivers, based on a plan of specific exercises for the recipient to increase physical capacity, strength, dexterity, and endurance to perform activities of daily living. This service also includes assessment and guidance for the recipient and caregiver to learn to prepare and eat nutritious meals and promote better health through improved nutrition. This service may include instructions on shopping for appropriate food, preparation, and monitoring of same. This service also provides guidance for budgeting and paying bills, which may include establishing checking accounts and direct deposits to lessen the risk of financial exploitation and abuse of the recipient.

(y) Skilled Nursing and Skilled Care are skilled nursing services provided to assure the client's safety and to achieve the objectives of the physician authorized treatment plan. This care may also include the services of a licensed respiratory therapist. These skilled services may be provided in the client's home.

(z) Special Drug and Nutritional Assessments assure that basic health care needs are being accurately prescribed. Drug assessments include a review of prescriptions to assure that multiple medications are being administered correctly. Nutritional

assessments include a review of the recipient's nutritional needs, development of special diets, and nutrition education of the recipient or caregivers.

(aa) Special Medical Home Care is nursing care and supervision required by medically fragile persons residing in small licensed group homes. The service includes 24-hour-a-day nursing service.

(bb) Specialized Personal Care Services to Foster Care Children is special care given in foster, group, and shelter care homes to children with AIDS. Additional care is given to these children primarily in the areas of monitoring, supervision, disinfection and stimulation. Payment for this service is exclusive of that paid by the Department for room and board.

(cc) Speech Therapy is the provision of services necessary for the diagnosis and treatment of speech and language disorders that have resulted in a communication disability.

(dd) Substance Abuse Treatment includes counseling and therapeutic services by licensed providers directed to assist substance abusers in understanding and resolving or ameliorating contributory behavioral patterns or life conditions and to provide support and assistance to those recipients during this process.

(ee) Supported Living Coaching services are provided to recipients living in their own home or apartment and support them in maintaining an autonomous household in the community.

(ff) Transportation is travel to and from service providers or community resources identified in the service plan. This service is available under the HCB services waiver to enable recipients to gain access to planned services when transportation to those services is not otherwise Medicaid compensable.

(4) Covered Services – General. Services provided under the HCB services waivers include those described in paragraphs (3)(a) through (ff). The availability of these services to waiver program participants is subject to approval by the Medicaid office and is subject to the availability of the services under the specific waiver program for which a recipient has been determined eligible.

(5) Service Limitations – General. The following general limitations and restrictions apply to all home and community-based services waiver programs:

(a) Covered services are available to eligible waiver program participants only if the services are part of a waiver plan of care ("care plan", "individual support plan", or "family support plan"). Care plan requirements are outlined in subsections (6) and (8) of this rule.

(b) The agency or its designee shall approve plans of care based on budgetary restrictions, the recipient's necessity for the services, and appropriateness of the service in relation to the recipient, prior to their implementation for any waiver recipient.

(c) Additional service limitations applicable to specific waiver programs are specified in subsections (10) through (14) of this rule.

(6) Program Requirements – General.

(a) The Medicaid program will deny an applicant's enrollment request if the proposed enrollment could cause the program to exceed the maximum enrollment level authorized by the Health Care Financing Administration in the applicable HCB services waiver.

(b) A person can not receive Medicaid waiver services until he is determined eligible, waiver funding is available, and is enrolled in the appropriate waiver program.

(c) The Agency or its designee will conduct home visits of waiver program applicants or participants. Assessments of the applicant's or participant's home situation will be made to determine if it is acceptable in providing for his general health or safety. If the applicant's or participant's home situation does not provide for the applicant's or participant's general health or safety, the Agency shall restrict the applicant or participant from participation in the waiver program.

(d) The Department or its designee will perform an evaluation of the level of care needed by an applicant for services when there is a reasonable indication that the applicant might need institutionalization in the near future, if the covered HCB services were not available.

(e) The Department or its designee will perform reevaluations of level of care at least annually, or as changes in the recipient's condition or community care setting may warrant.

(f) The plan of care will identify the type of services to be provided, the amount, frequency, and duration of each service, and the type provider to furnish each service.

(g) Reimbursement claims for the provision of Medicaid services not listed in the plan of care of HCB services waiver program participants are subject to denial or recoupment.

(h) In providing applicants or participants freedom of choice, the Agency or its designee must:

1. Inform all prospective waiver program participants of the feasible alternatives available under the respective waiver program and afford recipients a freedom of choice to participate in the community program in lieu of institutional placement;

2. Afford recipients the opportunity to choose from those enrolled providers capable of providing the covered services identified in the recipient's plan of care; and,

3. Afford all enrolled recipients the right to disenroll at any time.

(i) The Agency or its designee, will disenroll waiver program participants who:

1. Do not follow a recommended plan of care, as evidenced by: not keeping two consecutive appointments, or demonstrating multiple failures to avail themselves of offered services.

2. Demonstrate behavior that is disruptive, unruly, abusive, or uncooperative to the extent that their participation in the program seriously impairs the provider's ability to furnish services to the participant or other participants. Prior to disenrolling participants for the above reasons, the Agency or its designee must provide the participant at least one verbal and at least one written warning that the consequence of their actions, or inactions will be disenrollment from the program.

(7) Provider Qualifications and Provider Enrollment. To enroll and participate in the waiver programs, providers must comply with the provisions of Chapter 59G-5, F.A.C. Additional provider requirements are specified in subsections (10) through (14) of this rule.

(8) Case Management Requirements. Case managers advocate for recipients during the eligibility determination process and assist applicants in complying with requests for information, interviews, or activities required for a determination of Medicaid eligibility. Case managers will conduct a comprehensive needs assessment and identify areas in the person's life that require supports or services to reduce the risk of having to be placed in an institution. In addition, each case manager will:

(a) Begin the initial needs assessment before services are provided and complete it within 30 days of enrollment in the waiver program;

(b) Make a home visit as part of the needs assessment process;

(c) Prepare a written plan of care for each program participant and maintain the plan in the participant's case record;

(d) Reassess the plan of care at least every six months to review service goals, outcomes, and functional changes that may warrant the modification of the plan and reassessment of the recipient's level of care;

(e) After the needs assessment has been completed, maintain in each client's record case progress notes that document the provision of services;

(f) Make legible entries in the case progress notes in sufficient detail to document the case management service rendered and to allow an audit of the appropriateness of charges;

(g) Date and sign all written case record entries;

(h) Notify the Agency of all disenrollments by waiver program participants within 30 days after the effective date; and,

(i) Maintain records in an accessible location for review by authorized federal and state representatives for monitoring and auditing purposes; ensure that recipient specific information is maintained as "confidential"; ensure that program, administrative, and financial information is maintained for a period of at least five years after termination of participation as a waiver service provider. If an audit has been initiated and audit findings have not been resolved at the end of five years, the records will be retained until resolution of the audit findings.

(9) Home and Community-Based Services Waiver Programs. The following are authorized HCB services waivers: Adult Cystic Fibrosis Waiver; Adult Day Health Waiver; Aged and Disabled Adult Waiver; Alzheimer's Disease Waiver; Assisted Living for the Elderly Waiver; Channeling Waiver; Consumer-Directed Care Waiver; Developmental Disabilities Waiver; Family Supported Living Waiver; Familial Dysautonomia Waiver; Model Waiver; Project AIDS Care Waiver; and Traumatic Brain Injury and Spinal Cord Injury Waiver.

(10) Channeling Waiver.

(a) Program Summary. The Channeling program is directed toward a group of seriously impaired, aged Medicaid eligible individuals. The core functions of outreach, screening, assessment, care planning, and case management focus community services on program participants as an alternative to institutional care.

(b) Covered Services and Provider Qualifications. The Agency contracts with the organized health care delivery system for the provision of these services to enrolled recipients. The standards applicable to the contractor's selection of vendors and providers of covered services are outlined in the contract between the Agency and the contractor. The following services are available:

1. Adult Day Health Care;

2. Caregiver Training and Support;
3. Companion Services;
4. Consumable Medical Supplies;
5. Financial Education and Protection Services;
6. Home Health Aide Services;
7. Personal Care Services;
8. Chore Services;
9. In Home Counseling;
10. Medical Alert and Response Service;
11. Mental Health Services;
12. Minor Physical Adaptations to the Home/Home Modification;
13. Occupational Therapy;
14. Physical Therapy;
15. Respite Care;
16. Skilled Nursing;
17. Special Home Delivered Meals;
18. Special Drug and Nutritional Assessments;
19. Special Medical Equipment;
20. Special Medical Supplies;
21. Speech Therapy; and,
22. Waiver Case Management.

(c) Recipient Eligibility. Recipients eligible for services under this waiver must be Broward or Dade County residents, 65 years of age or older, and eligible under the HCB services waiver optional coverage groups as defined by 42 CFR section 435.217, or otherwise be Medicaid eligible. Recipients must be assessed as meeting level of care criteria for skilled or intermediate nursing home care as defined in Rules 59G-4.290 and 59G-4.180, F.A.C. The contractor may refuse participation in the program to otherwise qualified recipients whose estimated cost of community care exceeds 85 percent of the cost of institutional care in that recipient's county of residence.

(d) Provider enrollment is coordinated by the Channeling provider.

(e) Payment Methodology. Payment is based on a prospective monthly per diem reimbursement rate. Medicaid will make monthly payment to the contractor for satisfactory performance of duties and responsibilities as set forth in the contract. The per diem rate is set annually as a part of the contract renewal process. The rates are developed using historical Channeling Project data for similar services in the same geographic area, adjusted for anticipated service and cost increases.

(11) Model Waiver.

(a) Program Summary. The model waiver allows the provision of specified HCB services to persons with degenerative spinocerebellar disease. These services are provided to eligible persons who would otherwise require the level of care provided in an acute care hospital.

(b) Services Availability. Eligible program participants may receive covered services if approved by the case manager as part of a service plan developed in accordance with the requirements outlined in this section.

(c) Recipient Eligibility. Individuals eligible for HCB services under the model waiver must be:

1. Persons under 21 years of age, disabled with a degenerative spinocerebellar disease as identified in the International Classification of Diseases, 9th Revision (ICD-9), 1995 Edition, effective October 1, 1994, code range beginning with the first three digits of 330 through 337, inclusive; hereby incorporated by reference;

2. Assessed as being at risk of hospitalization by the comprehensive assessment and review for long term care services (CARES) team administered by DOEA; or the Children's Multidisciplinary Assessment Team (CMAT), administered by the Department of Health, Children's Medical Services; and able to live safely at home with the Medicaid HCB services made available to him; and,

3. Cost-effective to the state for each individual program participant, pursuant to the approved federal waiver.

(d) Covered Services and Provider Qualifications. Provider qualifications for services available under this waiver are:

1. Case Management providers must be licensed as a registered nurse in the state of Florida and meet applicable state

requirements, pursuant to Chapter 464, F.S.

2. Respite Care providers must be a Florida licensed and Medicaid participating home health agency and meet applicable state requirements, pursuant to Chapter 400, F.S.

(12) Assistive Care Services and Assisted Living for the Elderly Waiver. All Assistive Care Services and Assisted Living for the Elderly Waiver providers must comply with the provisions of the Florida Medicaid Assistive Care Services and Assisted Living for the Elderly Waiver Coverage and Limitations Handbook, July 2001, which is incorporated by reference and available from the Medicaid fiscal agent's Web Portal at <http://mymedicaid-Florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. Paper Copies are available by calling the Provider Contact Center at 1(800)289-7799 and selecting Option 7.

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