

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 section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the 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 an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

- A. The **State of Florida** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
- B. **Program Title:**
Florida Long-Term Care
- C. **Waiver Number:**FL.0962
- D. **Amendment Number:**FL.0962.R02.03
- E. **Proposed Effective Date:** (mm/dd/yy)

04/01/25

Approved Effective Date: 04/01/25

Approved Effective Date of Waiver being Amended: 04/01/22

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Increase the unduplicated count of participants for waiver years 4 and 5 (Appendix B) and update the estimates of PDO usage accordingly (Appendix E).

Update Cost Neutrality figures for waiver years 4 and 5 (Appendix J).

3. Nature of the Amendment

- A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	
Appendix A - Waiver	

Component of the Approved Waiver	Subsection(s)
Administration and Operation	
Appendix B - Participant Access and Eligibility	B-3-a, B-3-b
Appendix C - Participant Services	
Appendix D - Participant Centered Service Planning and Delivery	
Appendix E - Participant Direction of Services	E-1-n
Appendix F - Participant Rights	
Appendix G - Participant Safeguards	
Appendix H	
Appendix I - Financial Accountability	
Appendix J - Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

Modify target group(s)

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Add participant-direction of services

Other

Specify:

1. Request Information (1 of 3)

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

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

Florida Long-Term Care

C. Type of Request: amendment

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

3 years 5 years

Waiver Number:FL.0962.R02.03

Draft ID: FL.041.02.06

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/22

Approved Effective Date of Waiver being Amended: 04/01/22

PRA Disclosure Statement

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR § 440.10

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

Hospital level of care will be limited to the subcategory of individuals ages 18 years and older with a diagnosis of cystic fibrosis and individuals ages 18 years and older with a diagnosis of acquired immune deficiency syndrome (AIDS).

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

Select applicable level of care

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

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

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

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

1. Request Information (3 of 3)

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

Select one:

Not applicable**Applicable**

Check the applicable authority or authorities:

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

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

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

section 1915(b)(1) (mandated enrollment to managed care)

section 1915(b)(2) (central broker)

section 1915(b)(3) (employ cost savings to furnish additional services)

section 1915(b)(4) (selective contracting/limit number of providers)

A program operated under section 1932(a) of the Act.

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

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

Specify the program:

H. Dual Eligibility 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.*

Section 409.978, Florida Statutes, authorizes the statewide Long-term Care (LTC) managed care program for Florida Medicaid enrollees who are (a) 65 years of age or older, or age 18 or older and eligible for Florida Medicaid by reason of a disability; and (b) determined to require nursing facility level of care. Individuals over the age of 18 years who are diagnosed with cystic fibrosis or acquired immune deficiency syndrome (AIDS) may meet hospital level of care. The Agency for Health Care Administration (AHCA) administers the Long-term Care managed care program in partnership with the Department of Elder Affairs (DOEA).

The specific authorities requested in the 1915(b) and (c) waiver applications allow the State to require eligible Florida Medicaid recipients to receive their nursing facility, and home and community based services (HCBS) through LTC plans selected by the State through a competitive procurement process. The Comprehensive Assessment and Review for Long-Term Care Services (CARES) Unit determines level of care. No HCBS funding funds nursing facility services. Florida Medicaid recipients eligible for the LTC program have a choice of plans and may select any plan available to them in their region. The State is divided into eleven regions, each of which is required to have a specified number of long-term care plans, which were be selected through a competitive procurement.

In renewing the Florida Long-Term Care Managed Care Program, AHCA will monitor plan performance, measure quality of service delivery, identify and remediate any issues, and facilitate working relationships between LTC plans and providers. Through these efforts, the State has created incentives to serve recipients in the least restrictive setting, and eligible recipients should receive improved access to care and quality of care.

Based on language approved in the Appendix K amendment associated with this waiver, due to the COVID pandemic, a quality review report was not completed for the previous waiver cycle. Additionally, 372 reports due during the emergency have not been submitted. Upon expiration of the Appendix K amendment, Florida will gather data and submit the quality review in addition to any outstanding 372 reports as quickly as the required information can be gathered and analyzed. If necessary, the state will submit waiver amendments based on identified deficiencies in the quality review report and/or 372 report(s) within 90 days of receiving the final quality review report and 372 report acceptance decision.

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

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

Yes. This waiver provides participant direction opportunities. Appendix E is required.

No. This waiver does not provide participant direction opportunities. Appendix E is not required.

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

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

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

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

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

4. Waiver(s) Requested

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

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

Not Applicable

No

Yes

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

No

Yes

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

Geographic Limitation. A waiver of statewide 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 statewide is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.

Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization,

psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients 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 section 1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR Part 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. 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 Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

The Agency provides public notice as specified in 42 CFR 441.304(f) to solicit meaningful input from recipients, providers, and all stakeholders on waiver amendments or renewals at least 30 days prior to submission. The Agency posts the waiver renewal or amendment request and a description of the proposed changes to the Agency website for public review and comment. The Agency also publishes a notice of the Agency's intent to renew the waiver or amend the waiver through the Florida Administrative Register and through a provider alert.

Below is a summary of the public comments the Agency has received:

Care Plans and Service Descriptions:

- Concerns about the care planning process being overwhelming for recipients was expressed.
- Care plans being completed electronically, including the signature collection, is confusing for enrollees.

The Agency took no action within the Waiver Renewal Request due to these comments.

Case Management:

- Request to limit the number of individuals a Case Manager may serve at a time.
- Conflict of Interest Concern: Case Managers being employed by the Long-Term Care (LTC) plans.
- Need for increased recipient access to Case Managers to request additional services.

The Agency took no action within the Waiver Renewal Request due to these comments.

Unduplicated Participant Count:

- Support for the increased unduplicated participant counts across the waiver years.

No Agency action was required.

Subscriber Assistance Program

- The statute authorizing the Subscriber Assistance Program was repealed.

Appendix F-3. State Grievance/Complaint System b. Operational Responsibility --The Agency removed reference to the Subscriber Assistance Program.

Evaluation/Assessment

- Request for additional analysis on the intensity of services provided in addition to the frequency data that is already collected.
- Request additional analysis on the impact of workforce shortages.

The Agency took no action within the Waiver Renewal Request due to these comments.

Ombudsman

- Request for a LTC-specific platform for complaints, advocacy, and resolution beyond the Complaint Hub currently in operation.

The Agency took no action within the Waiver Renewal Request due to these comments.

Independent Consumer Support Program (ICSP)

- The ICSP Platform provides assistance, education, and guidance on enrollee rights and navigating the grievance and appeal process; however, there has been no data released detailing metrics and results of the provided guidance, remediation, and resolution of systematic issues.

The Agency took no action within the Waiver Renewal Request due to these comments.

Independent Assessments

- Request for the Independent Assessment to be expanded, and the research questions tailored more to specifically ascertain if people are receiving the Home and Community- Based Services (HCBS) they need. Request that these reviews be conducted annually, and consumer advocates involved in developing the questions and reviewing the results.

The Agency took no action within the Waiver Renewal Request due to these comments.

Fair Hearing Notices

- Request to allow for a digital delivery option to circumvent postal delays.
- Request that the state amend the template Notice of Adverse Benefit Determination to include reference to the availability of free legal assistance and a link to local legal aid providers.

The Agency took no action within the Waiver Renewal Request due to these comments.

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:

Ann

First Name:

Dalton

Title:

Bureau Chief of Medicaid Policy

Agency:

Agency for Health Care Administration

Address:

2727 Mahan Drive, Mail Stop #20

Address 2:

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:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Florida

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

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:

First Name:

Title:

Agency:

Address:

	2727 Mahan Drive		
Address 2:	Mail Stop #8		
City:	Tallahassee		
State:	Florida		
Zip:	32308		
Phone:	(850) 412-4115	Ext:	TTY
Fax:	(850) 414-1721		
E-mail:	Brian.Meyer@ahca.myflorida.com		
Attachments	Brian.Meyer@ahca.myflorida.com		

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:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

Division of Medicaid

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

AHCA contracts with long-term care plans in each region to provide all waiver services through their provider networks.

Managed care plans will be responsible for delivering services congruent with the long-term care needs of enrollees, and supporting these services with an appropriate provider and customer service framework. Specific functions will include:

- Operate member services hotline
- Create and distribute enrollee and provider materials (handbooks, directory, forms, policies and procedures)
- Quality improvement
- Utilization review
- Community outreach
- Provider services including credentialing, enrollment/contracting, and reimbursement
- Provider training materials
- Monitoring and compliance information
- Case management
- Care planning
- Enrollee complaint hotline
- Provider and enrollee dispute resolution

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:

AHCA monitors and assesses the performance of long-term care plans.

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:

The contract with long-term care plans requires plans to submit monthly, quarterly and annual reports on various aspects of program operations through which the State exerts control over program operations and assesses the performance of long-term care plans. The following long-term care (LTC) reports will be required:

- ASR Claim Lags Template
- ASR Financial Report
- Administrative Subcontractors and Affiliates Report
- Adverse and Critical Incident Summary Report
- Annual Fraud and Abuse Activity Report
- Case Management File Audit Report
- Case Manager and Provider Training Report
- Case Manager Caseload Report
- Claims Aging Report
- Critical Incident Report- Individual
- Denial, Reduction, Termination or Suspension of Services Report
- Denied/Suspended/Terminated Provider Report
- Enhanced Care Coordination Report
- Enrollee Complaints, Grievances and Appeals Report
- Enrollee Roster and Facility Residence Report
- Inter-Rater Reliability (IRR) Report
- Marketing Agent Status Report
- Marketing/Public/Educational Events Report
- Member Satisfaction Improvement Report
- Missed Services Report
- Non-Emergency Transportation (NET) Timeliness Report
- Non-Special Needs Plan (Non-SNP) Financial Report
- Participant Direction Option (PDO) Roster Report
- Performance Measure Action Plan
- Performance Measures Report
- Provider Complaint /Appeal Report
- Provider Network and Qualifications Report
- Provider Network File
- Quarterly Fraud and Abuse Activity Report
- Residential Psychiatric Treatment Report
- Suspected/Confirmed Fraud and Abuse Reporting
- Suspected/Confirmed Waste Reporting
- Unable to Provide Case Management Report
- Other Reports – This represents a placeholder for any other information that the state determines at a later date may be necessary

The second most important method to assess compliance with contract requirements is contract compliance monitoring. This monitoring process assesses each contract requirement through desk reviews of a sample number of plan enrollees. At the conclusion of the monitoring process, any deficiencies are noted and plans are required to correct them within specified time frames. Each plan receives a copy of the completed monitoring report.

The third most important method used to assess plan performance is the evaluation of performance improvement plans (PIPs). By contract, plans are required to submit their PIPs for evaluation by AHCA's External Quality Review Organization (EQRO). The EQRO assesses each plan's progress on completing the PIP in accordance with CMS PIP evaluation standards. The PIP evaluation process assesses the plan's performance in developing and performing PIPs and improving program services and enrollee outcomes.

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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the 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:

Percentage of case record reviews conducted by AHCA in accordance with the approved sampling methodology N: Number of case record reviews conducted by AHCA in accordance with the approved sampling methodology D: Number of case records in sample

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95%
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:

Percentage of non-abandoned direct calls processed by the enrollment broker monthly N:

Number of non-abandoned direct calls processed monthly D: Total number of direct calls received monthly

Data Source (Select one):

Other

If 'Other' is selected, specify:

Enrollment broker call 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:

Performance Measure:

Percentage of LTC plans' Performance Improvement Plans validated annually by the External Quality Review Organization (EQRO) N: Number of LTC plans' Performance Improvement Plans validated annually by EQRO D: Total number of LTC plans' Performance Improvement Plans required to be validated by the EQRO by program contract

Data Source (Select one):**Other**

If 'Other' is selected, specify:

PIP Summary Forms

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:

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

Performance Measure:

The percentage of Agency reviewed case files that are 100% compliant with contract requirements. N: Number of files that were 100% compliant with contract requirements. D: Number of files reviewed.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 85%
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.

The Agency contracts with an External Quality Review Organization (EQRO) to validate program performance improvement projects (PIPs) and performance measures.

The Agency contracts with an enrollment broker to handle managed care program enrollments and outreach.

Legislative appropriations are based on the estimated costs of services. Estimates are determined using historical expenditures and enrollment as well as utilization data and service trends. Program expenditures are projected by the Agency generally three times per year and presented to State economists and budgetary staff for adoption at the Social Services Estimating Conference. This process allows the State to effectively align appropriations with programs costs, and to make necessary budgetary adjustments contemporaneously which is done through a Legislative Budget Commission (LBC) amendment the Agency submits.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The Agency monitors whether the case record reviews were completed in accordance with the approved sampling methodology.

The contract with the LTC plans requires them to submit performance improvement projects (PIPs) to the External Quality Review Organization (EQRO) for evaluation. If a deficiency is determined, the plan is required to submit a revised PIP to the Agency.

The Agency contracts with an enrollment broker vendor to manage enrollment activities. The current contract requires the enrollment broker to maintain records on the number and disposition of calls received. Abandoned calls cannot exceed 10% of direct calls on a monthly basis. The vendor's system tracks abandoned calls and generates monthly reports. The Agency reviews the call reports and takes compliance actions against the vendor if abandoned calls exceed 10% of direct calls.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

No

Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age			
				Maximum Age Limit	No Maximum Age Limit		
Aged or Disabled, or Both - General							
		Aged		65			
		Disabled (Physical)		18		64	
		Disabled (Other)					
Aged or Disabled, or Both - Specific Recognized Subgroups							
		Brain Injury		18		64	
		HIV/AIDS		18		64	

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Medically Fragile	18	64	
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

The Medically Fragile subgroup is limited to individuals ages 18 years and older with a diagnosis of cystic fibrosis.

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:

There is no "transition" procedure for the disabled group aged 18 to 64. The age criteria for this population refers to the designation of disabled according to Social Security criteria. This group will continue to participate in the waiver.

Recipients may continue to participate in the waiver as there is no maximum age limit.

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:

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	105111
Year 2	116195
Year 3	120983
Year 4	136901
Year 5	143603

- 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	84000
Year 2	93853
Year 3	101000
Year 4	117000
Year 5	124660

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes	
Adults with Cystic Fibrosis	

Appendix B: Participant Access and Eligibility

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

Purpose (*provide a title or short description to use for lookup*):

Adults with Cystic Fibrosis

Purpose (*describe*):

The reserved capacity is for individuals ages 18 years of age and older with a diagnosis of cystic fibrosis.

Describe how the amount of reserved capacity was determined:

The State utilized the unduplicated count from the Adults with Cystic Fibrosis Waiver to determine the reserved capacity. This number has met the State's need and there are not individuals waiting for services. As such, the State determined that 150 reserved capacity is sufficient for this population.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	150
Year 2	150
Year 3	150
Year 4	150
Year 5	150

Appendix B: Participant Access and Eligibility

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

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

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

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

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

Entrants must meet the following qualifications:

1. Be age 18 or older and determined disabled according to Social Security standards or be age 65 or older;
2. Meet nursing facility level of care criteria;
3. Meet hospital level of care criteria for individuals 18 years of age and older with a diagnosis of cystic fibrosis;
4. Meet nursing facility level of care criteria or hospital level of care criteria for individuals 18 years of age and older with a diagnosis of AIDS;
5. Be Medicaid eligible; and
6. Not be enrolled in another Medicaid HCBS waiver.

Recipients will make an informed choice of receiving home and community-based services in lieu of nursing facility care.

The State's requested number of waiver slots is based on current Long-term Care Waiver enrollment trends.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

Section 1634 State

SSI Criteria State

209(b) State

2. **Miller Trust State.**

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

No

Yes

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

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

Parents and Other Caretaker Relatives (42 CFR § 435.110)

Pregnant Women (42 CFR § 435.116)

Infants and Children under Age 19 (42 CFR § 435.118)

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 section 1902(a)(10)(A)(ii)(XIII) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 1902(e)(3) of the Act)

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

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

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

Specify:

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

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

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under section 1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

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

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

Use spousal post-eligibility rules under section 1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)

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

Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

- b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).**

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:

Recipients in Assisted Living Facilities (ALF)

The recipient's personal needs allowance is calculated according to the following formula: Three meals per day and the semi-private room rate (ALF Basic Room and Board Rate) + 20% of the Federal Poverty Level (FPL).

Recipients in the community settings other than ALF's

The recipient's the personal needs allowance will equal the recipient's income up to the 300% SSI amount.

How is excess income treated?

Excess income is defined as the recipient's income after deductions for personal needs allowance, spousal impoverishment allowance, and reasonable costs of incurred medical and remedial care as detailed in 42 CFR. For community waiver residents not residing in an the ALF setting, all income up to the 300% income limit is protected. For waiver recipients living in ALF's the income protected varies due to the facility specific ALF Basic Room and Board Rate included in the personal needs calculation.

As a Miller Income Trust state, Florida requires waiver applicants to place income over the 300% SSI income level into an approved income trust. Any income placed in the required income trust will be included in the excess income or patient responsibility calculation. Patient responsibility is collected by the LTC plan and applied against home and community-based service costs only. Plans are required to report patient responsibility collections to the state.

The State's process for ensuring recipient responsibility is applied only to home and community-based services. LTC plans are responsible for collecting patient responsibility payments as determined by the State's eligibility agency (Department of Children and Families). DCF notifies the recipient, and the plan of any patient responsibility requirements.

The State established plan capitation rates based on its expected cost of waiver services which excludes patient responsibility payments. Capitation rates therefore reflect the plan's responsibility to organize, and reimburse for waiver services net of patient responsibility. By excluding patient responsibility from the capitation rates, the State ensures plans do not receive duplicate payments from the state and enrollees overall. The state will review the plan's patient responsibility collections annually to ensure enrollee individual responsibility payments are equal to, or less than, the total cost of the home and community based services the enrollee received. If an enrollee's patient responsibility payment is found to be greater than the sum of services received, the state will make payment adjustments on an case-by-case basis to ensure the plan is not overcompensated.

Other

Specify:

ii. Allowance for the spouse only (select one):**Not Applicable**

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

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

The State allows a deduction for the actual amount of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, incurred by a Medicaid recipient for programs involving post-eligibility calculation of a patient responsibility, as authorized by the Medicaid State Plan. The actual amount paid will be used as a deduction subject to the following limit: the highest of a payment/fee recognized by Medicare, commercial payers or any other party payer for the same or similar item. Other enrollee health insurance policies will be treated as first payer and the enrollee will have to demonstrate that 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. Be medically necessary;
- c. Not be a Medicaid compensable expense; and
- d. 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 period after September 30, 2027 (or other date as required by law).

- c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).**

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 period after September 30, 2027 (or other date as required by law).

- d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)**

The state uses the post-eligibility rules of section 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 section 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).

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:

Personal needs allowance is defined as:

For enrollees living in an assisted living facility, the personal needs allowance is calculated according to the following formula: Three meals per day and the semi-private room rate (ALF Basic Room and Board Rate) + 20% of the Federal Poverty Level (FPL).

For community waiver participants not residing in the assisted living setting, the personal needs allowance will equal the participant's income up to the 300% SSI amount. In addition, excess income is defined as the recipient's income after deductions for personal needs allowance, spousal impoverishment allowance, and reasonable costs of incurred medical and remedial care as detailed in 42 CFR. For community waiver residents all income up to the 300% SSI income limit is protected.

As a Miller Income Trust state, Florida requires waiver applicants to place income over the 300% SSI income level into an approved income trust. Any income placed in the required income trust will be included in the excess income or patient responsibility calculation. Patient responsibility is collected by the LTC plan and applied against home and community-based service costs only. Plans are required to report patient responsibility collections to the state. The collections are reviewed during the annual plan reconciliation to verify the application of the patient responsibility funds to reduce home and community based services only.

- 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 or 42 CFR § 435.735:**

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).**

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- f. Regular Post-Eligibility Treatment of Income: 209(b) State – January 1, 2014 through September 30, 2027 (or other date as required by law).**

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).**

The state uses the post-eligibility rules of section 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).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

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:

Department of Elder Affairs

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

The Comprehensive Assessment and Review for Long-Term Care Services (CARES) Unit under the jurisdiction of the Department of Elder Affairs is designated by state statute to perform level of care evaluations for all individuals seeking entrance to the Florida Medicaid LTC Waiver requiring a nursing facility or hospital level of care (Sections 409.979 and 409.985, Florida Statutes). The CARES Unit is composed of a licensed physician (M.D. or D.O.), licensed registered nurses (licensed in Florida), and trained assessors with appropriate degrees and certifications. Assessors must have a bachelor's degree or higher in social work or a related field, or a combination of education and professional experience totaling four or more years. All Registered Nurses and Assessors are certified to administer the comprehensive assessment instrument. The unit's nurses or assessors complete the level of care evaluation based on a comprehensive assessment instrument and medical certification form. The Notification of Level of Care form (DOEA-CARES Form 603) is signed by a physician (M.D. or D.O.)

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

The level of care criteria used to evaluate and reevaluate whether an individual needs waiver services are as follows:

To qualify for placement in a nursing facility, the applicant or recipient must require intermediate care services including 24-hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and services provided in a hospital or that meets the criteria of skilled services. Individuals requiring intermediate care services must meet the following criteria in order for services to qualify as Intermediate Level I or Intermediate Level II.

To be classified as requiring intermediate care services, the nursing or rehabilitation service must be:

- (1) Ordered by and remain under the supervision of a physician;
- (2) Medically necessary and provided to an applicant or recipient whose health status and medical needs are of sufficient seriousness as to require nursing management, periodic assessment, planning or intervention by licensed nursing or other health professionals;
- (3) Required to be performed under the supervision of licensed nursing or other health professionals;
- (4) Necessary to achieve the medically desired results and to ensure the comfort and safety of the applicant or recipient;
- (5) Required on a daily or intermittent basis;
- (6) Reasonable and necessary to the treatment of a specific documented medical disorder, disease, or impairment; and
- (7) Consistent with the nature and severity of the individual's condition or the disease state or stage.

LEVEL I - Intermediate Care Services Level I is extensive health related care and services required by an individual who is incapacitated mentally or physically.

LEVEL II -Intermediate Care Services Level II is limited health related care and services required by an individual who is mildly incapacitated or ill to a degree to require medical supervision. Individuals requiring this level of care shall:

1. Be ambulatory, with or without assistive devices;
2. Demonstrate independence in activities of daily living;
3. Not require the administration of psychotropic drugs on a daily or intermittent basis or exhibit periods of disruptive or disorganized behavior requiring 24-hour nursing supervision; and
4. Require the constant availability of medical and nursing treatment and care on a routine basis.

The level of care instruments are available to CMS upon request.

Hospital Level of Care:

CARES program staff conduct the assessment based upon a state approved tool. Based on the patient's medical history and current condition, a licensed physician certifies that this individual is disabled and there is reasonable indication that this individual might require hospitalization in the absence of home and community based services provided through a Medicaid waiver program. CARES staff review the completed comprehensive assessment instrument and medical certification to determine the level of care, and then complete the Notification of Level of Care form to document whether the waiver applicant met the level of care requirements.

- 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:

CARES program staff conduct the initial assessment and level of care determination for waiver applicants using a state approved comprehensive assessment instrument and state approved medical certification form. CARES program staff review the completed comprehensive assessment instrument and medical certification to determine level of care, and then complete the Notification of Level of Care form to document whether waiver applicants meet level of care requirements.

The Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program staff review previously completed comprehensive assessments along with the current assessment and Plan of Care Summary submitted by the LTC Plan. The current assessment must have been completed within the last 90 days. Any inconsistencies are clarified with the enrollee and/or case manager. If it appears that an enrollee does not continue to meet level of care criteria, a face-to-face assessment is completed by CARES Program staff with the enrollee.

Additionally, CARES Supervisors complete monthly case file reviews to verify that the level of care (LOC) is correct and accurate. Each CARES Program office is monitored annually by a Registered Nurse from the Department of Elderly Affairs' (DOEA) Long-Term Care and Support Bureau to verify that the enrollee or applicant meets the criteria for the recommended program and that the LOC is correct.

The reevaluation process is the same as for evaluations except LTC plan staff conduct the assessment interviews for current enrollees. The complete state approved assessment instrument is submitted to DOEA CARES staff for review and determination that the enrollee continues to meet the required level of care for the program.

LTC plan case management and nursing staff receive the same training as the CARES staff in completing assessment forms. LTC plan case managers and nursing staff complete the same online assessment instrument training from a web-based training curriculum as CARES staff. Before administering the state approved comprehensive assessment instrument, case managers and nursing staff must receive a passing test score to be certified assessors.

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

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

The qualifications are different.

Specify the qualifications:

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

LTC Plans receive an enrollee roster report from AHCA that identifies the level of care date. The LTC plans use this report to track level of care dates and prompt case managers to request level of care reevaluations. This system ensures that reevaluations take place in a timely manner.

- 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:

Electronically retrievable documentation of all evaluations and reevaluations are maintained in the Department of Elder Affairs' computerized management system. In addition, LTC Plans also maintain electronic copies of records.

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:

Percentage of new applicants receiving a level of care evaluation prior to enrollment

N: Number of new applicants receiving a level of care prior to enrollment D: Number of new applicants

Data Source (Select one):

Other

If 'Other' is selected, specify:

Health Track

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%
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:

%of annual LOC redeterminations conducted between 60 and 30 days prior to the 1 yr anniversary of the previous LOC determination that are completed correctly via the contractual process
 N:# of annual LOC redeterminations conducted between 60 and 30 days prior to the 1 yr anniversary of the previous LOC determination that are completed correctly via the contractual process
 D:# of files 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%
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:

Percentage of enrollees having a current level of care based on the state approved

assessment tool N: Number of enrollees having a level of care based on the state approved assessment tool D: Number of enrollees in the program

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTC 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 = 95%
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

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

- 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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

If enrollees do not have a current level of care based upon the state approved assessment tool, the LTC plan is required to correct the issue within a specified time frame. If the LTC plan does not correct the issue within the specified time frame, the LTC plan could be assessed for liquidated damages.

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	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).

As part of the LTC enrollment process, the program's enrollment broker informs the prospective enrollee of his or her managed care provider options along with information on the various plans' service provider choices and benefits. The enrollment broker offers telephonic or in-person counseling options to assist the enrollee in making their LTC plan choice. Once the enrollee makes their plan choice, the enrollment broker informs the plan of the new enrollee. Upon receipt of the new enrollee information, the LTC plan assigns a care manager and contacts the enrollee about an appointment for their assessment for use in care plan development. During the initial assessment appointment, the care manager obtains the enrollee's Freedom of Choice form that memorializes the plan member's choice of institutional or home and community-based services (HCBS) placement.

Each plan member has a case manager, and the case manager must discuss with the enrollee his/her individual needs and develop the initial plan of care. The case manager is responsible for authorizing, coordinating, and monitoring the provision of waiver services according to the enrollee's written plan of care. The plan of care form includes a statement which confirms the plan of care has been discussed with and agreed to by the enrollee, and the enrollee understands he/she has the right to appeal if services are denied or reduced, or if the enrollee is denied a choice of qualified providers. A Fair Hearing may be requested after the enrollee completes the health plan's appeal process. The LTC plan must provide an enrollee with procedures to follow if they choose to complete the appeal process and/or the Fair Hearing process.

All LTC plans provide the same HCBS, however expanded benefit service offerings may vary. The Agency posts service information on its website. Additionally, the enrollment broker counsels enrollees on the various plans' services in writing, by telephone, and in-person if requested.

LTC Plan case managers confirm enrollees' choice of institutional setting or HCBS by obtaining a signed Freedom of Choice form during the initial assessment meeting. LTC plan case managers review service options with enrollees as part of the person-centered planning process. The plan of care form includes a statement which confirms the plan of care has been discussed with, and agreed to by, the enrollee (or his or her authorized representative), and the enrollee understands he or she has the right to request a fair hearing if services are denied or reduced, or if the enrollee is denied a choice of qualified providers.

- 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.

LTC plans maintain plan members' Freedom of Choice forms in the member's case records.

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):

The State and LTC plans are required to develop and make available appropriate foreign language versions of all materials available to recipients. The State and LTC plans are required to provide interpreter services in person where practical, but otherwise by telephone, for recipients whose primary language is a foreign language. Foreign language versions of materials are required if, as determined annually by AHCA, the population speaking a particular foreign (non-English) language in a county is greater than five percent.

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	Adult Day Health Care		
Statutory Service	Case Management		
Statutory Service	Homemaker		
Statutory Service	Respite		
Extended State Plan Service	Attendant Care		
Extended State Plan Service	Intermittent and Skilled Nursing		
Extended State Plan Service	Medical Equipment and Supplies		
Extended State Plan Service	Occupational Therapy		
Extended State Plan Service	Personal Care		
Extended State Plan Service	Physical Therapy		
Extended State Plan Service	Respiratory Therapy		
Extended State Plan Service	Speech Therapy		
Extended State Plan Service	Transportation		
Other Service	Adult Companion		
Other Service	Assisted Living		
Other Service	Behavior Management		
Other Service	Caregiver Training		
Other Service	Home Accessibility Adaptations		
Other Service	Home Delivered Meals		
Other Service	Medication Administration		
Other Service	Medication Management		
Other Service	Nutritional Assessment and Risk Reduction		
Other Service	Personal Emergency Response System (PERS)		

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:

Service:

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Services provided pursuant to Chapter 400, Part V, Florida Statutes. For example, services furnished in an outpatient setting, encompassing both the health and social services needed to ensure optimal functioning of an enrollee, including social services to help with personal and family problems, and planned group therapeutic activities. Adult day health services include nutritional meals. Meals are included as a part of this service when the patient is at the center during meal times. Adult day health care provides medical screening emphasizing prevention and continuity of care including routine blood pressure checks and diabetic maintenance checks. Physical, occupational and speech therapies indicated in the enrollee's plan of care are furnished as components of this service. Nursing services which include periodic evaluation, medical supervision and supervision of self-care services directed toward activities of daily living and personal hygiene are also a component of this service. The inclusion of physical, occupational and speech therapy services and nursing services as components of adult day health services does not require the LTC plan to contract with the adult day health provider to deliver these services when they are included in an enrollee's plan of care. The LTC plan may contract with the adult day health provider for the delivery of these services or the LTC plan may contract with other providers qualified to deliver these services pursuant to the terms of the LTC managed care contract. All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

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

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Remote/via Telehealth****Specify whether the service may be provided by (check each that applies):****Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Adult Day Care Center
Agency	Assisted Living Facility

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

Service Name: Adult Day Health Care**Provider Category:**

Agency

Provider Type:

Adult Day Care Center

Provider Qualifications**License (specify):**

Adult day care centers providing adult health care services in the LTC Waiver must be licensed under Section 429, Part III, Florida Statutes, to be a qualified service provider.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA

Frequency of Verification:

Annually or more frequently as needed

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Adult Day Health Care****Provider Category:**

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications**License (specify):**

Assisted living facilities providing adult day health services in the Long-term Care (LTC) Waiver must be licensed under Section 429, Part I, Florida Statutes. Section 429.918, Florida Statutes permits a licensed assisted living facility to provide services during the day which include, but are not limited to, social, health, therapeutic, recreational, nutritional, and respite services, to adults who are not residents.

Certificate (specify):**Other Standard (specify):**

LTC plans may contract with assisted living facilities to provide these services if the facility has adequate staffing and space per Rule 58A-5.023(30(a)2, F.A.C. and Rule 58A-5.019, F.A.C.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA

Frequency of Verification:

Annually or more frequently as needed

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):**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Services that assist enrollees in gaining access to needed waiver and other State Plan services, as well as other needed medical, social, and educational services, regardless of the funding source. Case management services contribute to the coordination and integration of care delivery through the ongoing monitoring of service provision as prescribed in each enrollee's plan of care.

For enrollees choosing participant direction, the case manager is responsible for assisting the enrollee, by arranging for training and through ongoing support, with the following duties: recruiting workers; ensuring that worker qualifications are verified and criminal background check completed; defining additional qualifications and duties within the scope of waiver definitions to meet the enrollee's specific needs; scheduling workers; training workers; supervising workers; evaluating worker performance; verifying time worked and timesheets; and, if necessary, dismissing workers and arranging for implementation of the Emergency Back-up Plan.

The State will assure conflict free case management and participant protections by reviewing sampled care plans,

participating in Fair Hearings, and reviewing focused managed care plan reviews targeted at managed care plans with significant numbers of care plan related complaints. Managed care plans must be in compliance with program contract standards for case management and care planning. Failure to meet these standards subjects the managed care plan to enrollment moratoriums and liquidated damages.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

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

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Centers for Independent Living
Individual	Case managers employed or contracted by LTC plans
Agency	Case Management Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License (*specify*):

Centers for Independent Living as defined under Section 413.371, F. S., who employ case managers with the following qualifications may provide LTC Waiver case management

Case Managers can be qualified in one of the following ways and must also have a minimum of two (2) years of relevant experience:

(a) Bachelor's degree in social work, sociology, psychology, gerontology or a related social services field;

- (b) Registered nurse, licensed to practice in the state; or
- (c) Bachelor's degree in a field other than social science.

Case managers can also be qualified as a Licensed Practical Nurse in Florida with a minimum of four years of relevant experience.

Case Managers without the aforementioned educational qualifications may substitute professional human service experience on a year-for-year basis for the educational requirement. Case Managers without a bachelor's degree must have a minimum of six (6) years of relevant experience.

Case managers with a Master's degree in one of the aforementioned degree fields may substitute up to one (1) year of the two year experience requirement through a combination of experience through a practicum, internship, or clinical rotation.

All case managers must have at least four hours of in-service training annually in the identification and reporting of Abuse, Neglect, and Exploitation.

Certificate (specify):

--

Other Standard (specify):

Centers for Independent Living as defined under Section 413.371, F. S., who employ case managers with the following qualifications may provide LTC Waiver case management services.

Case Managers can be qualified in one of the following ways and must also have a minimum of two (2) years of relevant experience:

- (a) Bachelor's degree in social work, sociology, psychology, gerontology or a related social services field;
- (b) Registered nurse, licensed to practice in the state; or
- (c) Bachelor's degree in a field other than social science.

Case managers can also be qualified as a Licensed Practical Nurse in Florida with a minimum of four years of relevant experience.

Case Managers without the aforementioned educational qualifications may substitute professional human service experience on a year-for-year basis for the educational requirement. Case Managers without a bachelor's degree must have a minimum of six (6) years of relevant experience.

Case managers with a Master's degree in one of the aforementioned degree fields may substitute up to one (1) year of the two year experience requirement through a combination of experience through a practicum, internship, or clinical rotation.

All case managers must have at least four hours of in-service training annually in the identification and reporting of Abuse, Neglect, and Exploitation. All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently if necessary.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management**Provider Category:**

Individual

Provider Type:

Case managers employed or contracted by LTC plans

Provider Qualifications**License (specify):**

N/A

Certificate (specify):**Other Standard (specify):**

Case Managers employed by LTC plans can be qualified in one of the following ways and must also have a minimum of two (2) years of relevant experience:

- (a) Bachelor's degree in social work, sociology, psychology, gerontology or a related social services field;
- (b) Registered nurse, licensed to practice in the state; or
- (c) Bachelor's degree in a field other than social science.

Case managers can also be qualified as a Licensed Practical Nurse in Florida with a minimum of four years for relevant experience.

Case Managers without the aforementioned educational qualifications may substitute professional human service experience on a year-for-year basis for the educational requirement. Case Managers without a bachelor's degree must have a minimum of six (6) years of relevant experience.

Case managers possessing a Master's degree in one of the aforementioned degree fields may substitute up to one (1) year of the two year experience requirement through a combination of experience through a practicum, internship, or clinical rotation.

All case managers must have at least four hours of in-service training annually in the identification and reporting of Abuse, Neglect, and Exploitation.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Case management providers contracted with LTC plans are not providers of other HCBS.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA

Frequency of Verification:

Annually or more frequently as needed

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Case Management****Provider Category:**

Agency

Provider Type:

Case Management Agency

Provider Qualifications

License (specify):

The case management agency must be designated a Community Care for the Elderly Lead Agency by the DOEA in accordance with Section 430, Florida Statutes, or other agency meeting comparable standards as determined by the DOEA.

Certificate (specify):

Other Standard (specify):

LTC Waiver Case Managers employed by Community Care for the Elderly Lead Agencies can be qualified in one of the following ways and must also have a minimum of two (2) years of relevant experience:

- (a) Bachelor's degree in social work, sociology, psychology, gerontology or a related social services field;
- (b) Registered nurse, licensed to practice in the state; or
- (c) Bachelor's degree in a field other than social science.

Case managers can also be qualified as a Licensed Practical Nurse in Florida with a minimum of four years of relevant experience.

Case Managers without the aforementioned educational qualifications may substitute professional human service experience on a year-for-year basis for the educational requirement. Case Managers without a bachelor's degree must have a minimum of six (6) years of relevant experience.

Case managers with a Master's degree in one of the aforementioned degree fields may substitute up to one (1) year of the two year experience requirement through a combination of experience through a practicum, internship, or clinical rotation.

All case managers must have at least four hours of in-service training annually in the identification and reporting of Abuse, Neglect, and Exploitation.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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:

Homemaker

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

General household activities (meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Service includes pest control. Socialization is not the primary function of this service.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

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

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Each plan member has a case manager who must develop a plan of care based on the recipient's needs including non-duplicative services that best meet the recipient's needs. The case manager is responsible for authorizing, coordinating, and monitoring the provision of waiver services according to the enrollee's written plan of care. Florida Medicaid does not, and, by extension, managed care plans do not pay for duplicate services. Managed care plans can also implement authorization processes to mitigate duplicate services.

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Remote/via Telehealth****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	PDO-Homemaker
Agency	Community Care for the Elderly (CCE) Providers
Agency	Centers for Independent Living
Agency	Health Care Service Pools
Agency	Nurse Registry
Agency	Homemaker/Companion Agency
Agency	Home Health Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Homemaker****Provider Category:**

Individual

Provider Type:

PDO-Homemaker

Provider Qualifications**License (specify):**

N/A

Certificate (specify):

N/A

Other Standard (specify):

PDO homemakers must have a Level II background screening and execute the Participant Direction Service Work Agreement.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee

Frequency of Verification:

Annually or more frequently if necessary

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Homemaker****Provider Category:**

Agency

Provider Type:

Community Care for the Elderly (CCE) Providers

Provider Qualifications**License (specify):**

Community Care for the Elderly providers are defined in Section Chapter 410 and 430, Florida Statutes. Homemakers employed by Community Care for the Elderly providers and provide homemaker services to LTC recipients must have experience serving elderly and disabled adults.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA

Frequency of Verification:

Annually or more frequently as needed

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Homemaker****Provider Category:**

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications**License (specify):**

Centers for Independent Living are defined under section 431.371, F. S. and may provide homemaker services to LTC waiver recipients must have experience in serving elderly and disabled adults.

Certificate (specify):

N/A

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently if necessary.

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

Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Health Care Service Pools

Provider Qualifications**License (specify):**

Health service pools providing services in the LTC Waiver must be licensed under Section 400, Part IX, F.S. Homemakers employed by health service pools must have experience serving elderly and disabled adults.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently if necessary.

Appendix C: Participant Services

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

Service Type: Statutory Service**Service Name: Homemaker****Provider Category:**

Agency

Provider Type:

Nurse Registry

Provider Qualifications**License (specify):**

Nurse registries participating in the LTC waiver must be licensed under Section 400.506, Florida Statutes. Homemakers employed by the nurse registries and providing homemaker services to LTC recipients must have experience serving elderly and disabled adults.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA

Frequency of Verification:

Annually or more frequently as needed

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Homemaker/Companion Agency

Provider Qualifications

License (specify):

Homemaker, sitter and companion agencies participating in the LTC Waiver must be registered in accordance with Section 400.509, Florida Statutes. Homemakers employed by homemaker, sitter and companion agencies who provide homemaker services to LTC waiver recipients must have experience serving elderly and disabled adults.

Certificate (specify):

N/A

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA

Frequency of Verification:

Annually or more frequently as needed

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Home health agencies participating in the LTC Waiver must be licensed under Section 400, Part III, Florida Statutes. Homemaker service providers must have experience serving elderly and disabled populations.

Certificate (specify):

Other Standard (specify):

Optional to meet Federal Conditions of Participation under 42 CFR 484

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA

Frequency of Verification:

Annually or more frequently as needed

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

The provision of respite services on a short-term basis due to the absence of, or need to relieve, the enrollee's natural supports on a planned or emergent basis.

Respite care can be provided in the enrollee's home or in an adult day care center. The LTC program benefit does not include coverage for respite care services for enrollees residing in a nursing facility or an assisted living facility (ALF) but can be provided for non-residents within a nursing facility or an assisted living facility.

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

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Nursing Facility
Agency	Homemaker/Companion Agency
Agency	Community Care for the Elderly (CCE) Providers
Agency	Assisted Living Facility
Agency	Adult Day Care Center
Agency	Centers for Independent Living
Agency	Home Health Agency
Agency	Nurse Registry

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Nursing Facility

Provider Qualifications

License (specify):

Nursing Facilities providing respite services to LTC recipients must be licensed under Section 400, Part II, Florida Statutes.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it

to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed

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/Companion Agency

Provider Qualifications
License (specify):

Homemaker and Companion agencies providing respite care services to LTC Waiver recipients must have registered in accordance with Chapter 400.509, Florida Statutes and have experience serving elderly and disabled adults.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications
Entity Responsible for Verification:

AHCA

Frequency of Verification:

Annually or more frequently as needed

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Community Care for the Elderly (CCE) Providers

Provider Qualifications
License (specify):

Community care for the Elderly providers are defined in Section 410 or 430, Florida Statutes. Respite service provider employed by Community Care for the Elderly providers must have experience serving elderly or disabled adults.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications**License (specify):**

Assisted Living Facilities providing respite services to LTC Waiver recipients must be licensed under Section 429, Part I, Florida Statutes.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency

Provider Type:

Adult Day Care Center

Provider Qualifications**License (specify):**

Adult Day Care Centers must be licensed under Section 429, Part III, Florida Statutes to provide respite services under the LTC Waiver.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA

Frequency of Verification:

Annually or more frequently as needed

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications**License (specify):**

Centers for Independent Living are defined under Section 413.371, F. S. Respite service providers employed by Centers for Independent Living must have experience serving elderly and disabled adults.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Home health agencies must be licensed under Section 400, Part III, Florida Statutes.

Certificate (specify):

Other Standard (specify):

Optional to meet Federal Conditions of Participation under 42 CFR 484

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA

Frequency of Verification:

Annually or more frequently as needed

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):

Nurse registries must be licensed under Section 400.506, Florida Statutes to participate in the LTC Waiver as a respite service provider.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it

to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA

Frequency of Verification:

Annually or more frequently as needed

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:

Attendant Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

In accordance with Rule 59G-4.261, F.A.C., for enrollees under the age of 21 years. To provide nursing care of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped enrollee over the age of twenty (20) years who requires more individual and continuous care than an intermittent nursing visit. The scope and nature of these services do not otherwise differ from private duty nursing services furnished to persons under the age of 21.

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

There are no limits for medically necessary service for enrollees under 21. Attendant Care services under the waiver are authorized based upon the medical necessity of the plan member's care needs reflected in the approved care plan designed to maintain the plan member in a safe and healthy manner in the least restrictive residential setting possible. Attendant Care Services can be authorized as necessary to manage the medically necessary care needs of the plan member.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place.

Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Each plan member has a case manager who must develop a plan of care based on the recipient's needs including non-duplicative services that best meet the recipient's needs. The case manager is responsible for authorizing, coordinating, and monitoring the provision of waiver services according to the enrollee's written plan of care. Florida Medicaid does not, and, by extension, managed care plans do not pay for duplicate services. Managed care plans can also implement authorization processes to mitigate duplicate services.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Registered Nurse, Licensed Practical Nurse
Agency	Nurse Registry
Agency	Centers for Independent Living

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Home health Agencies providing attendant care services to LTC waiver recipients must be licensed under section 400, Part III, Florida Statutes and must have experience serving elderly and disabled adults.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA

Frequency of Verification:

Annually or more frequently as necessary.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service****Service Name: Attendant Care****Provider Category:**

Individual

Provider Type:

Registered Nurse, Licensed Practical Nurse

Provider Qualifications**License (specify):**

Registered Nurses and Licensed Practical Nurses providing attendant care services to LTC waiver recipients must be licensed under Section 464, Florida Statutes and have experience serving elderly and disabled adults.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as necessary.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service****Service Name: Attendant Care****Provider Category:**

Agency

Provider Type:

Nurse Registry

Provider Qualifications**License (specify):**

Nurse registries providing attendant care services to LTC waiver recipients must be licensed under Section 400.506, Florida Statutes. Direct service providers assigned by nurse registries to provide attendant care services to LTC Waiver recipients must be licensed under Section 464, Florida Statutes. They must have experience serving elderly and disabled adults.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as necessary.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service****Service Name: Attendant Care****Provider Category:**

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications**License (specify):**

Centers for Independent Living are defined in Section 413, Florida Statutes. All direct service providers of attendant care employed by Centers for Independent Living must be licensed under Chapter 464, F.S and have experience serving elderly and disabled adults.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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:

Service Title:

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

In accordance with Rule 59G-4.130, F.A.C. This service includes the provision of skilled nursing services at intervals of more than one hour apart, and for the length of time necessary to complete the service, for enrollees who do not require continuous nursing care (see attendant nursing care services).

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

There are no limits for medically necessary services for enrollees under age 21. Intermittent and Skilled Nursing Services can be authorized as necessary to manage the medically necessary care needs of the enrollee in the least restrictive residential setting possible.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	PDO - Intermittent and Skilled Nursing

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Intermittent and Skilled Nursing

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Home health agencies providing services to LTC Waiver recipients must be licensed under Section 400, Part III, Florida Statutes. Direct service providers assigned by home health agencies must have experience serving elderly and disabled adults and be licensed under Section 464, Florida Statutes.

Certificate (specify):

Other Standard (specify):

Home health agencies may also meet Federal Conditions of Participation under 42 CFR 484.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Intermittent and Skilled Nursing

Provider Category:

Individual

Provider Type:

PDO - Intermittent and Skilled Nursing

Provider Qualifications

License (specify):

Nurses and Licensed Practical Nurses providing PDO Intermittent and Skilled Nursing services to LTC Waiver recipients must be licensed under Section 464, Florida Statutes and have experience serving elderly and disabled adults.

Certificate (specify):

N/A.

Other Standard (specify):

Service may be provided by a relative or legal guardian who is licensed under Section 464, Florida Statutes.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or as needed.

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:

Medical Equipment and Supplies

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Services that are provided when medical equipment and supplies under the approved State Plan are exhausted. Medical equipment and supplies, specified in the plan of care, include: (a) devices, controls, or appliances that enable the enrollee to increase the ability to perform activities of daily living; (b) devices, controls, or appliances that enable the enrollee to perceive, control, or communicate with the environment in which he or she lives; (c) items necessary for life support or to address and enrollee's physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State Plan that is necessary

to address enrollee functional limitations; and (e) necessary medical supplies not available under the State plan, including consumable medical supplies such as adult disposable diapers.

Items reimbursed under the waiver are in addition to any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the enrollee. All items shall meet applicable standards of manufacture, design and installation. This service also includes repair of such items as well as replacement parts.

The case manager in consultation with a medical professional will authorize this service. All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

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

There are no limits for medically necessary services for enrollees under age 21. Medical Equipment and Supplies services under the waiver are authorized based upon the medical necessity of the enrollee's care needs reflected in the approved care plan designed to maintain the enrollee in a safe and healthy manner in the least restrictive residential setting possible.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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 Medical Equipment Company
Agency	Home Health Agency
Individual	Pharmacy

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Home Medical Equipment Company

Provider Qualifications

License (specify):

Home Medical Equipment Companies providing Medical Equipment and Supplies services to LTC Waiver recipients must be licensed under Section 400, Part VII, Florida Statutes.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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

Service Type: Extended State Plan Service

Service Name: Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications**License (specify):**

Home health agencies providing Medicaid Equipment and Supplies services to LTC Waiver recipients must be licensed under Section 400, Florida Statutes.

Certificate (specify):

Other Standard (specify):

Home health agencies providing Medical Equipment and Supplies to LTC Waiver recipient may also meet Federal Conditions of Participation under 42 CFR 484.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Medical Equipment and Supplies

Provider Category:

Individual

Provider Type:

Pharmacy

Provider Qualifications

License (specify):

Pharmacies providing Medical Equipment and Supplies services to LTC Waiver recipients must be licensed under Section 465, Florida Statutes.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Occupational Therapy services under the waiver are provided when occupational services furnished under the approved State Plan are exhausted. These services include treatment to restore, improve, or maintain impaired functions, which are aimed at increasing or maintaining the enrollee's ability to perform those tasks required for independent functioning as determined through a multidisciplinary assessment to improve an enrollee's capability to live safely in the home setting.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

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

Occupational Therapy services through the waiver are provided when the limits of the State Plan service are exhausted. There are no limits on medically necessary services for enrollees under age 21. Occupational Therapy services under the waiver are authorized based upon the medical necessity of the enrollee's care needs reflected in the approved care plan designed to maintain the plan member in a safe and healthy manner in the least restrictive residential setting possible.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Remote/via Telehealth****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	Nursing Facility
Agency	Centers for Independent Living
Individual	Occupational Therapist Assistant
Individual	Occupational Therapist
Agency	Outpatient Hospital Unit
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Nursing Facility

Provider Qualifications

License (specify):

Nursing Facilities who employ occupational therapists who are assigned to provide occupational therapy services to LTC Waiver recipients must be licensed under Section 400, Part II, Florida Statutes. Occupational therapists employed by nursing facilities who are assigned to provide occupational therapy services to LTC Waiver recipients must be licensed under Section 468, Florida Statutes.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License (specify):

Occupational therapists employed by Centers for Living providing Occupational Therapy services to LTC Waiver recipients must be licensed under Section 468, Part III, F. S.

Certificate (specify):

Other Standard (specify):

Centers for Independent Living are defined under Section 413.371, F. S.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it

to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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 Assistant

Provider Qualifications**License (specify):**

Occupational Therapist Assistants providing occupational therapy services to LTC Waiver recipients must be licensed under Section 468, Part III, Florida Statutes and supervised by an Occupational therapist licensed under Section 468, Part III. Florida Statutes.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed

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):**

Occupational therapists providing occupational therapy services to LTC Waiver recipients must be licensed under Section

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468, Part III, Florida Statutes.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Outpatient Hospital Unit

Provider Qualifications

License (specify):

Outpatient hospital units providing occupational therapy services to LTC Waiver recipients must be licensed under Section 395, Part I or 408, Part II, Florida Statutes. Occupational therapists employed by the outpatient hospital unit and assigned to provide occupational therapy services to LTC Waiver recipients must be licensed under Section 468 Florida Statutes.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or mre frequently as needed.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications**License (specify):**

Home health agencies providing services to LTC Waiver recipients must be licensed under Section 400, Part III, Florida Statutes. Occupational Therapists employed home health agencies and assigned to provide occupational therapy services to LTC Waiver recipients must be licensed under Section 468, Part III, F. S.

Certificate (specify):**Other Standard (specify):**

Home health agencies providing Occupational Therapy services to LTC Waiver recipients may meet Federal Conditions of Participation under 42 CFR 484.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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:

Personal Care

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

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

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

Service Definition (Scope):

Services that are provided when personal care services furnished under the approved State Plan limits are exhausted. Services include assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the enrollee, rather than the enrollee's family.

The Agency maintains a list of qualified personal care direct support professionals. The Provider Network and Qualifications Report, which is a quarterly report submitted by the plans, lists all qualified providers by service type and their license number if applicable.

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

There are no limits on medically necessary services for enrollees under age 21. Personal Care services under the waiver are authorized based upon the medical necessity of the enrollee's care needs reflected in the approved care plan designed to maintain the enrollee in a safe and healthy manner in the least restrictive residential setting possible.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Each plan member has a case manager who must develop a plan of care based on the recipient's needs including non-duplicative services that best meet the recipient's needs. The case manager is responsible for authorizing, coordinating, and monitoring the provision of waiver services according to the enrollee's written plan of care. Florida Medicaid does not, and, by extension, managed care plans do not pay for duplicate services. Managed care plans can also implement authorization processes to mitigate duplicate services.

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Remote/via Telehealth****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	PDO-Personal Care
Agency	Centers for Independent Living
Agency	Home Health Agency
Agency	Community Care for the Elderly (CCE) Providers
Agency	Nurse Registry

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Personal Care

Provider Category:

Individual

Provider Type:

PDO-Personal Care

Provider Qualifications

License (specify):

N/A.

Certificate (specify):

N/A.

Other Standard (specify):

PDO personal care providers must have a Level II background screening, execute Participant Direction Service Work Agreement, and may be a legal guardian or relative.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Plan - monthly

AHCA or its designee - annually

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License (specify):

Centers for Independent Living are defined under Section 413.371, F. S. Personal care service providers employed by Centers for Independent Living and serve LTC waiver providers must have experience serving elderly and disabled adults.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service****Service Name: Personal Care****Provider Category:**

Agency

Provider Type:

Home Health Agency

Provider Qualifications**License (specify):**

Home health agencies are licensed under Section 400, Part III, Florida Statutes. Personal care service providers employed by home health service providers must have experience serving elderly and disabled adults.

Certificate (specify):**Other Standard (specify):**

Optional to meet Federal Conditions of Participation under 42 CFR 484

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service****Service Name: Personal Care****Provider Category:**

Agency

Provider Type:

Community Care for the Elderly (CCE) Providers

Provider Qualifications**License (specify):**

Community Care for the Elderly agencies are defined in Chapter 410 or 430, Florida Statutes. Personal care service providers employed by Community Care for the Elderly and serve LTC Waiver recipients must have experience serving elderly and disabled adults.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA

Frequency of Verification:

Annually or more frequently as needed

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Nurse Registry

Provider Qualifications

License (specify):

Nurse registries are licensed under Section 400.506, Florida Statutes and assign nurses, licensed practical nurses, home health aides to requests for services received through their intake offices. Registered nurses and Licensed Practical Nurses receiving assignments through nurse registries must be licensed under Section 464, F. S.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA

Frequency of Verification:

Annually or more frequently as needed

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

03/03/2026

Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Physical Therapy services under the waiver are provided when Physical Therapy services furnished under the approved State Plan are exhausted. Physical Therapy services provide treatment to restore, improve, or maintain impaired functions by the use of physical, chemical, and other properties of heat, light, electricity or sound, and by massage and active, resistive, or passive exercise. The services must be performed by a qualified physical therapist. There must be an explanation that the enrollee's condition will be improved significantly (the outcome of the therapies must be measurable by the attending medical professional) in a reasonable (and generally predictable) period of time based on an assessment of restoration potential, or a determination that services are necessary to a safe and effective maintenance program for the enrollee.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

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

There are no limits for medically necessary services for enrollees under age 21. Enrollees 21 and older may receive a specific amount of Physical Therapy through the State Plan in an outpatient setting as described in the Hospital Services Coverage and Limitations Handbook. The waiver will provide additional Physical Therapy treatments based upon the medical necessity of the enrollee's care needs reflected in the approved care plan designed to serve the enrollee in a safe and healthy manner in the least restrictive residential setting possible.

It is the state's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Nursing Facilities
Individual	Physical Therapist
Agency	Outpatient Hospital Unit
Individual	Physical Therapy Assistant
Agency	Centers for Independent Living

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):

Home health agencies employing physical therapists or physical therapist assistants that may provide physical therapy services to LTC Waiver recipients must be licensed under Section 400, Part III, Florida Statutes. The physical therapist or physical therapist assistant providing physical therapy services to LTC Waiver recipients must be licensed under Section 486, Florida Statutes.

Certificate (specify):

Other Standard (specify):

Home health agencies may meet Federal Conditions of Participation under 42 CFR 484.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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:

Nursing Facilities

Provider Qualifications**License (specify):**

Nursing Facilities employing physical therapists or physical therapist assistants assigned to provide physical therapy services in a non-nursing facility setting must be licensed under Section 400, Part II, F. S. Physical therapists and physical therapist assistants employed by the nursing facilities and may be assigned to provide physical therapy services to LTC Waiver recipients must be licensed under Section 486, F. S.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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):**

Physical therapists providing physical therapy services to LTC Waiver recipients must be licensed under Section 486, Florida Statutes.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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:

Outpatient Hospital Unit

Provider Qualifications**License (specify):**

Outpatient hospital units employing physical therapists and assistants to provide physical therapy services to LTC Waiver recipients must be licensed under Section 395, Part I or 408, Part II, Florida Statutes. The direct service providers employed by these outpatient hospital units that provide physical therapy services to LTC Waiver recipients must be licensed as physical therapists or physical therapy assistants under Section 486, Florida Statutes.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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):**

Physical therapy assistants providing physical therapy services to LTC waiver recipients must be licensed under Section 486, F. S.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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:

Centers for Independent Living

Provider Qualifications**License (specify):**

Centers for Independent Living are defined in Section 413.371, F. S. Physical therapists employed by Centers for Independent Living and assigned to provide physical therapy services to LTC Waiver recipients must be licensed under Section 486, F. S.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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:

03/03/2026

Extended State Plan Service

Service Title:

Respiratory Therapy

HCBS Taxonomy:**Category 1:**

11 Other Health and Therapeutic Services

Sub-Category 1:

11110 respiratory therapy

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Respiratory therapy services are provided under the waiver after respiratory therapy services available through the State Plan are exhausted. These services include evaluation and treatment related to pulmonary dysfunction. Examples are ventilatory support; therapeutic and diagnostic use of medical gases; respiratory rehabilitation; management of life support systems and bronchopulmonary drainage; breathing exercises and chest physiotherapy.

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

There are no limits for medically necessary services for enrollees under age 21. Enrollees 21 and older may receive a specific amount of Physical Therapy through the State Plan in an outpatient setting as described in the Hospital Services Coverage and Limitations Handbook. The waiver will provide additional Physical Therapy treatments based upon the medical necessity of the enrollee's care needs reflected in the approved care plan designed to serve the enrollee in a safe and healthy manner in the least restrictive residential setting possible.

It is the state's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the state will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The state will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Nursing Facility

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):

Home health agencies employing respiratory therapists who may provide respiratory therapy services to LTC Waiver recipients must be licensed Section 400, Part III, F. S. Respiratory therapists employed by home health agencies and assigned to provide respiratory therapy services to LTC Waiver recipients must be licensed under Section 468, F. S.

Certificate (specify):

Other Standard (specify):

The waiver will provide additional respiratory therapy treatments based upon medical necessity of the plan member's care needs reflected in the approved care plan designed to serve the member in a safe and healthy manner in the least restrictive setting possible.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Respiratory Therapy

Provider Category:

Individual

Provider Type:

Respiratory Therapist

Provider Qualifications

License (specify):

Respiratory therapists providing service to LTC Waiver recipients must be licensed under Section 468, F. S.

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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:

Nursing Facility

Provider Qualifications**License (specify):**

Nursing Facilities employing respiratory therapists who may be assigned to provide respiratory therapy service to LTC Waiver recipients in a non-nursing facility setting must be licensed under Section 400, Part II, F. S. Respiratory therapists or assistants employed by nursing facilities who may be assigned to provide respiratory services to LTC Waiver recipients must be licensed under Section 468, F. S.

Certificate (specify):**Other Standard (specify):**

The waiver will provide additional respiratory therapy treatments based upon medical necessity of the plan member's care needs reflected in the approved care plan designed to serve the member in a safe and healthy manner in the least restrictive setting possible.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Speech Therapy services under the waiver are provided when Speech Therapy services furnished under the approved State Plan are exhausted. Speech Therapy is the identification and treatment of neurological deficiencies related to feeding problems, congenital or trauma related maxillofacial anomalies, autism, or neurological conditions that affect oral motor functions. Therapy services include the evaluation and treatment of problems related to oral motor dysfunction.

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

There are no service limits for enrollees under age 21. Speech Therapy services under the waiver are authorized based upon the medical necessity of the enrollee's care needs reflected in the approved care plan designed to maintain the enrollee in a safe and healthy manner in the least restrictive residential setting possible.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Remote/via Telehealth****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	Centers for Independent Living
Individual	Speech-Language Pathologist

Provider Category	Provider Type Title
Agency	Hospital Outpatient Unit

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):

Home health agencies providing speech therapy services to LTC Waiver recipients must be licensed under Section 400, Part III, Florida Statutes. Speech-language pathologists and their assistants who directly provide the speech therapy services to the LTC Waiver recipients must be licensed under Section 468, Part I, Florida Statutes.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA

Frequency of Verification:

Annually or more frequently as needed

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:

Centers for Independent Living

Provider Qualifications

License (specify):

Centers for Independent Living employing speech pathologists and speech pathology assistants to provide speech therapy services to LTC waiver recipients. The direct service providers must be licensed under section 468, Part I, F. S.

Certificate (specify):

Other Standard (specify):

Centers for Independent Living are defined under Section 413.371, F. S.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or frequently if needed.

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):**

Speech-language pathologists and speech-language pathologist assistants providing speech therapy services to LTC Waiver recipients must be licensed under Section 468, Part I, Florida Statutes.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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:

Hospital Outpatient Unit

Provider Qualifications**License (specify):**

Hospital outpatient units providing speech therapy to LTC Waiver recipients must be licensed under Section 395, Part I or Chapter 408, Part II, F. S. Speech-language pathologists and speech-language pathologist assistants employed by hospital outpatient units and providing waiver services to LTC Waiver recipients must be licensed under Section 468, Part I, F. S.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Extended State Plan Service

Service Title:

Transportation

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Service offered in order to enable enrollees to gain access to waiver services specified by the plan of care. This service is

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

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee's independence, inclusion, and integration into the community.

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

There are no service limits for individuals under age 21.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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 auto, 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*):

The Community Transportation Coordinator must be licensed under Section 316 or 322, F. S.

Certificate (*specify*):

Other Standard (*specify*):

The Community Transportation Coordinator must comply with Rule 41-2, Florida Administrative Code.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as necessary

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 auto, wheelchair van, bus, taxi)

Provider Qualifications

License (specify):

Independent transportation providers to LTC Waiver recipients must be licensed under Section 322, Florida Statutes. Residential facility transportation providers must comply with the requirements of Section 427, Florida Statutes.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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:

Adult Companion

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform discrete services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

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

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Community Care for the Elderly (CCE) Providers
Individual	PDO-Adult Companion
Agency	Health Care Service Pools
Agency	Centers for Independent Living
Agency	Nurse Registries
Agency	Homemaker/Companion Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Adult Companion

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Home health agencies providing waiver services to LTC Waiver recipients must be licensed under Section 400, Part III, Florida Statutes.

Certificate (specify):

Other Standard (specify):

Adult companions employed by home health agencies serving LTC Waiver recipients must have experience serving elderly and disabled adults.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Adult Companion

Provider Category:

Agency

Provider Type:

Community Care for the Elderly (CCE) Providers

Provider Qualifications**License (specify):**

Community Care for the Elderly providers are defined in Section 410 or 430, Florida Statutes. Adult companions employed by community Care for Elderly providers must have experience serving elderly and disabled adults.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as necessary.

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

Service Type: Other Service

Service Name: Adult Companion

Provider Category:

Individual

Provider Type:

PDO-Adult Companion

Provider Qualifications**License (specify):**

N/A

Certificate (specify):

N/A

Other Standard (specify):

Participant Direction Option (PDO) adult companions must have a Level II background screening, execute a Participant Direction Service Work Agreement and may be provided by a legal guardian.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Managed care plan - ongoing.

AHCA or its designee - annually

Frequency of Verification:

Annually or as needed

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

Service Type: Other Service

Service Name: Adult Companion

Provider Category:

Agency

Provider Type:

Health Care Service Pools

Provider Qualifications**License (specify):**

Health Care Service Pools serving LTC Waiver recipients must be licensed under Section 400, Part IX, F.S.

Certificate (specify):**Other Standard (specify):**

Adult Companions employed by health care service pools must have experience serving elderly and disabled adults.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

If a service provider has been involuntarily terminated from the Medicaid program for reasons of inactivity, the provider is considered to be in good standing.

A Health Care Services Pool as defined under Chapter 400.980, Florida Statutes, means any person, firm, corporation, partnership, or association engaged for hire in the business of providing temporary employment in health care facilities, residential facilities, and agencies for licensed, certified, or trained health care personnel including, without limitation, nursing assistants, nurses' aides, and orderlies. Chapter 409.982, Florida Statutes, requires health care services pools to be included in the LTC Managed Care Plan (MCP) provider network. They may provide Home Health Aides to recipients requiring Adult Companion services.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as necessary.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Adult Companion****Provider Category:**

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications**License (specify):**

Centers for Independent Living are defined in Section 413.371, F. S. Adult companions employed by Centers for Independent Living must have experience serving elderly and disabled adults.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the

provider was suspended or involuntarily terminated from the Florida Medicaid program. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

If a service provider has been involuntarily terminated from the Medicaid program for reasons of inactivity, the provider is considered to be in good standing.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee

Frequency of Verification:

Annually or more frequently as necessary.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Adult Companion****Provider Category:**

Agency

Provider Type:

Nurse Registries

Provider Qualifications**License (specify):**

Nurse registries providing waiver services to LTC Waiver recipients must be licensed under Section 400.506, F. S.

Certificate (specify):**Other Standard (specify):**

Adult companions employed by nurse registries must have experience serving elderly and disabled adults.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

If a service provider has been involuntarily terminated from the Medicaid program for reasons of inactivity, the provider is considered to be in good standing.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Adult Companion****Provider Category:**

Provider Type:

Provider Qualifications**License (specify):**

Homemaker/Companion Agencies serving LTC Waiver recipients must register in accordance with Section 400.409, Florida Statutes. Adult companions employed by homemaker/companion agencies serving LTC Waiver recipients must have experience serving elderly and disabled adults.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Frequency of Verification:

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:

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:**Sub-Category 4:****Service Definition (Scope):**

Personal care services, homemaker services, chore services, attendant care, companion services, medication oversight, and therapeutic social and recreational programming provided in a home-like environment in an assisted living facility licensed pursuant to Chapter 429, Part I, Florida Statutes.

This service does not include the cost of room and board furnished in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Individualized care is furnished to persons who reside in their own living units (which may include dual occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The resident has a right to privacy. Living units may be locked at the discretion of the resident, except when a physician or mental health professional has certified in writing the resident is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door and all protections have been met to ensure individuals' rights have not been violated. The facility must have a central dining room, living room or parlor, and common activity areas, which may also serve as living rooms or dining rooms. The resident retains the right to assume risk, tempered only by a person's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each resident to facilitate aging in place.

Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect. Assisted living services may also include medication administration, periodic nursing evaluations and respite. The LTC plan may arrange for other authorized service providers to deliver care to enrollees residing in assisted living facilities in the same manner as those services would be delivered to an enrollee in their own home. ALF administrators, direct service personnel and other service personnel have a responsibility to encourage enrollees to take part in social, educational and recreational activities as they are capable of enjoying.

All services provided by the assisted living facility must be included in a care plan maintained at the facility with a copy provided to the enrollee's case manager. The LTC plan shall be responsible for placing enrollees in the appropriate assisted living facility setting. All direct service professionals providing LTC waiver services have the requisite responsibility to encourage plan members' independence, inclusion, and integration into the community.

Plans must include appropriate facilities in their provider network and are required to ensure facilities have a clear understanding of the requirement to operate according to the HCB characteristics as described the Appendix C of the waiver application. The State has provided language which must be incorporated into the plans' provider contracts. Plans are required to credential and monitor providers on their compliance with the HCB characteristics.

When an enrollee requires residential services, the plan will ensure recipients exercise their right to choice of network providers, and to receive assisted living services in an appropriate ALF that meets the waiver requirements, and can serve the enrollee's needs through:

- Person-centered care planning: The enrollee and the case manager will work together to identify the services the individual needs, identify the enrollee's goals and assess the choice of providers to determine which setting is most suitable. Any limitations placed on an individual's rights will be documented in the person-centered care plan along with alternate methods attempted and frequency of ongoing evaluation of need.
- Home-like environment standards: Implemented by facilities and monitored by the plans and the State on an on-going basis.
- Continual information and contact: Plans are required to ensure enrollees are informed about the services available and their rights by a variety of means. Furthermore, case managers are required to maintain monthly contact with their enrollees to, among other requirements, determine the on-going validity and adequacy of the enrollee's services and living environment.

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

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place.

Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assisted Living

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License (specify):

Assisted living facilities serving LTC Waiver recipients must be licensed under Section 429, Florida Statutes.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Additional qualifications: As a condition of Medicaid payment, ALFs must offer facility services to Long-Term plan members with the following home-like characteristics as medically appropriate: a) access to typical facilities in a home such as a kitchen with cooking facilities; (b) provide privacy options in the living unit; (c) access to resources and activities in the community; (d) provide individuals with the option to assist in choosing what ALF activities will be conducting and (f) ensure individuals are allowed to conduct/hold unscheduled activities of their choosing.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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 Management

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

This service provides an enrollee with persistent problematic behavior an evaluation of the origins and triggers of the problem behavior, development of strategies to address the behavior, implementation of an intervention by the provider and orientation and assistance for the caregiver to be able to intervene to improve the behavior and maintain the improved behavior.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

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

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to

explain any such aberrations or face penalties.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Centers for Independent Living
Agency	Adult Day Care Centers
Individual	Clinical Social Worker, Mental Health Counselor
Agency	Home Health Agencies
Individual	Registered Nurse
Agency	Nurse Registries
Agency	Community Mental Health Centers
Individual	Psychologist

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavior Management

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License (*specify*):

Behavior Management service providers employed by Centers for Independent Living must be licensed as either a registered nurse licensed under Section 464, F. S., a psychologist licensed under Section 491, F. S. or a clinical social worker or mental health counselor under Section 491, F. S.

Certificate (*specify*):

Other Standard (*specify*):

Centers for Independent Living are defined in Section 413.371, F. S.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Behavior Management****Provider Category:**

Agency

Provider Type:

Adult Day Care Centers

Provider Qualifications**License (specify):**

Adult Day Care Centers providing behavior management services to LTC waiver recipients must be licensed under Section 429, Part III, Florida Statutes

Certificate (specify):**Other Standard (specify):**

To provide specialized Alzheimer's services, an adult day care center must provide center participants with a program for dementia-specific, therapeutic activities, including but not limited to, physical, cognitive, and social activities appropriate for the participant.

The operator of an adult day care center that provides specialized Alzheimer's services is required to meet one of the following qualifications:

- Have at least a bachelor's degree in health care services, social services, or a related field, one year of staff supervisory experience in a social services or health care services setting, and a minimum of one year of experience in providing services to persons who have dementia;
- Be a registered or practical nurse licensed in this state, have one year of staff supervisory experience in a social services or health care services setting, and have a minimum of one year of experience in providing services to persons who have dementia; or
- Have five years of staff supervisory experience in social services or health care services setting and a minimum of three years of experience in providing services to persons who have dementia.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as necessary.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Behavior Management****Provider Category:**

Provider Type:**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Behavior Management****Provider Category:****Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavior Management

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License (specify):

Registered nurses providing behavior management services to LTC Waiver recipients must be licensed under Section 464, Part 1, Florida Statutes.

Certificate (specify):

Other Standard (specify):

Individual nurses who provide this service must have a minimum of two years of direct experience working with adult populations who are diagnosed with Alzheimer's disease or other dementias or persistent behavior problems.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavior Management

Provider Category:

Agency

Provider Type:

Nurse Registries

Provider Qualifications

License (specify):

Nurse registries providing behavior management services to LTC Waiver recipients must be licensed under Section 400.506, F. S. Nurses provided by nurse registries to provide behavior management services to LTC Waiver recipients must be licensed under section 464, F. S.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the

provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently if necessary.

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

Service Type: Other Service

Service Name: Behavior Management

Provider Category:

Agency

Provider Type:

Community Mental Health Centers

Provider Qualifications**License (specify):**

Community Mental Health Centers providing behavior management services to LTC Waiver recipients must be licensed under Section 394, Florida Statutes.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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

Service Type: Other Service

Service Name: Behavior Management

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications**License (specify):**

Psychologists providing behavior management services to LTC Waiver recipients must be licensed under Section 490, Florida Statutes.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as necessary.

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:

Caregiver Training

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to recipients. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or

co-worker who provides uncompensated care, training, guidance, companionship or support to a person served on the waiver. This service may not be provided in order to train paid caregivers. Training includes instruction about treatment regimens and other services included in the plan of care, use of equipment specified in the plan of care, and includes updates as necessary to safely maintain the enrollee at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the enrollee. All training for individuals who provide unpaid support to the enrollee must be included in the enrollee's plan of care.

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

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Registered Nurse, Licensed Practical Nurse
Agency	Centers for Independent Living
Individual	Clinical Social Worker, Mental Health Counselor
Agency	Community Care for the Elderly (CCE) Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Caregiver Training

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Home health agencies providing Caregiver Training services must be licensed under Section 400, Part III, Florida Statutes.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed

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

Service Type: Other Service

Service Name: Caregiver Training

Provider Category:

Individual

Provider Type:

Registered Nurse, Licensed Practical Nurse

Provider Qualifications**License (specify):**

Registered Nurses and Licensed Practical Nurses providing Caregiving Training services to companions, relatives, legal guardians, and families of LTC Waiver recipients must be licensed under Section 464, Florida Statutes.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA

Frequency of Verification:

Annually or more frequently as needed

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

Service Type: Other Service

Service Name: Caregiver Training

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications**License (specify):**

Centers for Independent Living providing Caregiver Training services to LTC Waiver recipients are defined under Section 413.371, F. S. Direct service providers of Caregiver Training services and are employed by Centers for Independent Living must be licensed either as registered or licensed practical nurses under Chapter 464, F. S. or clinical social workers or mental health counselors under Chapter 491, F. S.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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

Service Type: Other Service

Service Name: Caregiver Training

Provider Category:

Individual

Provider Type:

Clinical Social Worker, Mental Health Counselor

Provider Qualifications**License (specify):**

Clinical Social Workers and Mental Health Counselors providing Caregiver Training services to LTC Waiver recipients must be licensed under Section 491, Florida Statutes.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service**Service Type: Other Service****Service Name: Caregiver Training****Provider Category:**

Agency

Provider Type:

Community Care for the Elderly (CCE) Provider

Provider Qualifications**License (specify):**

Community Care for the Elderly (CCE) providers are defined under Section 410 or 430, Florida Statutes. Caregiver Training service providers employed by must have experience serving elderly and disabled adults. Health care professionals who provide this service and are employed by CCE providers must be licensed as registered nurses, or licensed practical nurses under Section 464, F. S.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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:

Home Accessibility Adaptations

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Physical adaptations to the home required by the enrollee's plan of care which are necessary to ensure the health, welfare and safety of the enrollee or which enable the enrollee to function with greater independence in the home and without which the enrollee 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 electric and plumbing systems to accommodate the medical equipment and supplies which are necessary for the welfare of the enrollee. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the enrollee, such as carpeting, roof repair, or central air conditioning. Adaptations which add to the total square footage of the home are not included in this benefit. All services must be provided in accordance with applicable state and local building codes.

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

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Remote/via Telehealth****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	General Contractor
Agency	Centers for Independent Living

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

Service Name: Home Accessibility Adaptations**Provider Category:**

Individual

Provider Type:

General Contractor

Provider Qualifications**License (specify):**

General contractors employed by Centers for Independent Living to provide home accessibility adaptations services to LTC Waiver recipients must be licensed by the Department of Professional Regulation (DPR) under Section 489.131, Florida Statutes and locally under Section 205, F.S.

Certificate (specify):**Other Standard (specify):**

Centers for Independent Living are defined in Section 413.371, F. S.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Home Accessibility Adaptations****Provider Category:**

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications**License (specify):**

All direct service providers employed by Centers for Independent Living who provide home accessibility adaptations services to LTC Waiver recipients must be licensed by the Department of Professional Regulation (DPR) under Section 489, F.S. and locally under Section 205, F. S.

Certificate (specify):**Other Standard (specify):**

Centers for Independent Living are defined under Section 413.371, F. S.

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA and its designee.

Frequency of Verification:

Annual or more frequently as necessary.

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:

Home Delivered Meals

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Nutritionally sound meals to be delivered to the residence of an enrollee who has difficulty shopping for or preparing food without assistance. All meals must provide a minimum of 33 1/3% of the current Dietary Reference Intake (DRI). The meals meet the current Dietary Guidelines for Americans, the USDA My Pyramid Food Intake Pattern and reflect the predominant statewide demographic.

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

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care. The home-delivered meals service is not intended to be 100% of a recipient's daily nutritional regimen, rather it is intended

to be a supplement for the enrollee if they are dependent on a caregiver, either professional, family member, or friend, to make or provide them meals. This service will not constitute a full day's nutritional regimen.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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 Care for the Elderly (CCE) Providers
Agency	Older American's Act Providers
Agency	Food Service Establishment
Agency	Food Establishment

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Community Care for the Elderly (CCE) Providers

Provider Qualifications

License (specify):

Community care for the Elderly (CCE) providers are defined in Section 410 or 430, Florida Statutes.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Older American's Act Providers

Provider Qualifications

License (specify):

Older American Act providers are defined in Rule 58A-1, Florida Administrative Code.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Food Service Establishment

Provider Qualifications

License (specify):

Food Service Establishments providing home delivered meals to LTC Waiver recipients must be licensed under Section 509.241, Florida Statutes.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Home Delivered Meals****Provider Category:**

Agency

Provider Type:

Food Establishment

Provider Qualifications**License (specify):**

Food establishments providing home delivered meal services to LTC Waiver recipients must have a permit issued under Section 500.12, Florida Statutes.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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:

Medication Administration

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Pursuant to 400.4256, Florida Statutes, assistance with self-administration of medications, whether in the home or a facility, includes taking the medication from where it is stored and delivering it to the recipient; removing a prescribed amount of medication from the container and placing it in the enrollee's hand or another container; helping the enrollee by lifting the container to their mouth; applying topical medications; and keeping a record of when an enrollee receives assistance with self-administration of their medications.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

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

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Remote/via Telehealth****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	Unlicensed Staff Member Trained Per 58A-5.0191(5), F.A.C.
Agency	Nurse Registry

Provider Category	Provider Type Title
Individual	Registered Nurse, Licensed Practical Nurse

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Medication Administration

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Home health agencies providing Medication Administration services to LTC Waiver recipients must be licensed under Section 400, Part III, F. S.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently if necessary.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Medication Administration

Provider Category:

Individual

Provider Type:

Unlicensed Staff Member Trained Per 58A-5.0191(5), F.A.C.

Provider Qualifications

License (specify):

Unlicensed staff member trained per Rule 58A-5.0191(5), F.A.C. and demonstrating ability to accurately read and interpret a prescription label. The unlicensed staff member must be currently employed by the assisted living facility or the adult family care home where the LTC Waiver recipient is receiving the medication resides.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the

provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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

Service Type: Other Service

Service Name: Medication Administration

Provider Category:

Agency

Provider Type:

Nurse Registry

Provider Qualifications**License (specify):**

Nurse registries providing Medication Administration services to LTC Waiver recipients must be licensed under Section 400.506, F. S. Nurses assigned by nurse registries to provide Medication Administration services to LTC Waiver recipients must be licensed under Section 464, F. S.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently if necessary.

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

Service Type: Other Service

Service Name: Medication Administration

Provider Category:

Individual

Provider Type:

Registered Nurse, Licensed Practical Nurse

Provider Qualifications

License (specify):

Registered nurses and Licensed Practical Nurses providing Medication Administration services to LTC Waiver recipients must be licensed under Section 464, Florida Statutes.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as necessary.

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:

Medication Management

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Review by a licensed nurse or pharmacist of all prescriptions and over-the-counter medications taken by the enrollee, in

conjunction with the enrollee's physician on at least an annual or on as needed basis upon a significant change in the plan member's condition. The purpose of the review is to assess whether the enrollee's medication is accurate, valid, non-duplicative and correct for the diagnosis; that therapeutic doses and administration are at an optimum level; that there is appropriate laboratory monitoring and follow-up taking place; and that drug interactions, allergies and contraindications and being assessed and prevented.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

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

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Pharmacist
Agency	Home Health Agencies
Agency	Nurse Registries
Individual	Registered Nurse, Licensed Practical Nurse

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Medication Management

Provider Category:

Individual

Provider Type:

Pharmacist

Provider Qualifications

License (specify):

Pharmacists providing Medicaid Management services to LTC Waiver recipients must be licensed under Section 465, Florida Statutes.

Certificate (specify):

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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

Service Type: Other Service

Service Name: Medication Management

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications**License (specify):**

Home health agencies providing Medication Management Services to LTC Waiver recipients must be licensed under Section 400, Part III, F.S. Nurses assigned by home health agencies to provide Medication Management service to LTC Waiver recipients must be licensed under Section 464, F.S.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually, or more frequently if necessary.

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

Service Type: Other Service

Service Name: Medication Management

Provider Category:

Agency

Provider Type:

Nurse Registries

Provider Qualifications

License (specify):

Nurses registries providing Medication Administration services to LTC Waiver recipients must be licensed under Section 400.506, F. S. Nurses assigned by nurse registries to provide Medication Administration services to LTC Waiver recipients must be licensed under Section 464, F.S.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually, or more frequently if necessary.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Medication Management

Provider Category:

Individual

Provider Type:

Registered Nurse, Licensed Practical Nurse

Provider Qualifications

License (specify):

Registered nurses and Licensed Practical Nurses providing Medicaid Management services to LTC Waiver recipients must be licensed under Section 464, Florida Statutes.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as necessary.

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:

Nutritional Assessment and Risk Reduction

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

An assessment, hands-on care, and guidance to caregivers and enrollees with respect to nutrition. This service teaches caregivers and enrollees to follow dietary specifications essential to the enrollee's health and physical functioning, to prepare and eat nutritionally appropriate meals and promote better health through improved nutrition. This service may include instructions on shopping for quality food and on food preparation.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

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

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Dietician/Nutritionist or Nutrition Counselor
Agency	Home Health Agency
Agency	Centers for Independent Living
Agency	Nurse Registry
Agency	Community Care for the Elderly (CCE) Providers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nutritional Assessment and Risk Reduction

Provider Category:

Individual

Provider Type:

Dietician/Nutritionist or Nutrition Counselor

Provider Qualifications

License (specify):

Dietitians, Nutritionists or Nutrition Counselors providing Nutritional Assessment and Risk Reduction services to LTC Waiver recipients must be licensed under Section 468, Part X, Florida Statutes.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nutritional Assessment and Risk Reduction

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications**License (specify):**

Home health agencies providing Nutritional Assessment and Risk Reduction services to LTC Waiver recipients must be licensed under Section 400, Part III, F. S. Direct service providers of these services assigned by the home health agencies such as registered or licensed practical nurses must be licensed under Section 464, F. S. or nutritional counselors and nutritionists must be licensed under Section 468, Part X., F.S.

Certificate (specify):**Other Standard (specify):**

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently if necessary.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Nutritional Assessment and Risk Reduction****Provider Category:**

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications**License (specify):**

Centers for Independent Living are defined in Section 413.371, F. S. All direct service providers of Nutritional Assessment and Risk Reduction services employed by Centers for Independent Living and providing services to LTC Waiver recipients must be licensed as either as a Dietician or Nutritionist or Nutrition Counselor under Section 468, Part X, F.S.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nutritional Assessment and Risk Reduction

Provider Category:

Agency

Provider Type:

Nurse Registry

Provider Qualifications

License (specify):

Nurse registries providing Nutritional Assessment and Risk Reduction services to LTC Waiver recipients must be licensed under Section 400.506, F. S. Health care professionals such as registered nurse or licensed practical nurses must be licensed under Section 464, F.S. and Nutritional Counselors or Dieticians must be licensed under Section 468, Part X, F.S.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually, or more frequently if necessary.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nutritional Assessment and Risk Reduction

Provider Category:

Agency

Provider Type:

Community Care for the Elderly (CCE) Providers

Provider Qualifications

License (specify):

Community Care for the Elderly (CCE) providers are defined under Section 410 or 430, F.S.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

AHCA

Frequency of Verification:

Annually or more frequently as needed

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 (PERS)

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

The installation and maintenance of an electronic device that enables enrollees at high risk of institutionalization to secure help in an emergency. The PERS is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The enrollee may also wear a portable "help" button to allow for mobility.

All direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

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

PERS services are generally limited to those enrollees who live alone or who are alone for significant parts of the day and who would otherwise require extensive supervision.

It is the State's intention that the long-term care managed care plans have the maximum flexibility needed to ensure the individual receives the services necessary to maintain health, safety, and welfare and to remain in a community setting. The

State will require that plans provide management oversight of services, and the State will oversee to ensure this takes place. Incentives have been put into place for the plans to manage the program efficiently and ensure that inappropriate duplication of services does not occur. Since the State will pay most managed care plans a capitated monthly fee for each recipient, for which the plan will be responsible for ensuring the recipient receives appropriate services congruent with the plan of care.

The State will analyze encounter data to detect aberrant billing practices and unusual spending and will require plans to explain any such aberrations or face penalties.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Alarm System Contractor
Individual	Low-Voltage Contractors and Electrical Contractors

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System (PERS)

Provider Category:

Individual

Provider Type:

Alarm System Contractor

Provider Qualifications

License (specify):

N/A.

Certificate (specify):

Alarm System Contractors providing Services to LTC Waiver recipients must be certified under Section 489, Part II, Florida Statutes.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System (PERS)

Provider Category:

Individual

Provider Type:

Low-Voltage Contractors and Electrical Contractors

Provider Qualifications

License (specify):

Low voltage contractors and electrical contractors are exempt from licensure in accordance with Section 489.503(15)(a-d), Florida Statutes and Section 489.503(16), Florida Statutes.

Certificate (specify):

N/A.

Other Standard (specify):

All service providers must be in good standing with the Florida Medicaid program. A provider is not in good standing if the provider was suspended or involuntarily terminated from the Florida Medicaid program, other than for reason of inactivity. A provider terminated for these reasons does not regain good standing until such time as the Medicaid agency authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

Annually or more frequently as needed.

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 section 1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.

As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.

As an administrative activity. Complete item C-1-c.

As a primary care case management system service under a concurrent managed care authority. Complete item C-1-c.

As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management). 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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

The waiver operates through a managed care service delivery model. Long-term Care (LTC) plan employees or other case management providers enrolled in the plan's provider network's employees assess each member's care needs, develop the care plan to address the identified care needs with the assistance of the member or his or her designated representative.

- d. Remote/Telehealth Delivery of Waiver Services.** Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

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):

(a) and (b): LTC plans and subcontractors are subject to mandatory criminal history background screenings. For each LTC plan, all owners, officers, directors, and managers must complete a Level II criminal history background screening as part of the Medicaid provider enrollment and re-enrollment processes whether or not they own a percentage of the company. The screening requirements listed below apply to the following health care facility or provider types which are licensed by AHCA and included as providers under this waiver program: Adult Day Care Centers; Assisted Living Facilities; Home Health Agencies; Homemaker, Sitter, Companion Agencies; Home Medical Equipment Providers; Nurse Registry; and Nursing Facilities. Each of these provider types is subject to screening as required by Florida Statutes as listed below.

Direct Care Staff - Level II Criminal History Screening

Owner/Administrator - Level II Criminal History Screening

Financial Officer - Level II Criminal History Screening

A Level II Criminal History Screening consists of a fingerprint check of State and Federal arrest and criminal history information conducted through the Florida Department of Law Enforcement (FDLE) and the Federal Bureau of Investigation (FBI).

(c) The LTC plan will be required to ensure that providers and requisite staff have a current Level 2 Criminal History and/or background investigation. The LTC Plan shall keep a record of all background checks to be available for Agency review upon request. Plans are required to keep this information in provider credentialing and re-credentialing files which the State will assess for compliance during the readiness review period, and during annual monitoring thereafter. Additionally, to ensure all background screening requirements have been met, interpretive guidelines for annual licensure surveys require state surveyors to conduct personnel record reviews to verify that facilities have evidence of required screening.

- 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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

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

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Family Care Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Speech Therapy	
Adult Companion	
Physical Therapy	
Respite	
Caregiver Training	
Personal Emergency Response System (PERS)	
Personal Care	
Case Management	
Homemaker	
Intermittent and Skilled Nursing	
Home Delivered Meals	
Medication Management	
Respiratory Therapy	
Home Accessibility Adaptations	
Adult Day Health Care	

Waiver Service	Provided in Facility
Attendant Care	
Medication Administration	
Medical Equipment and Supplies	
Transportation	
Nutritional Assessment and Risk Reduction	
Assisted Living	
Behavior Management	
Occupational Therapy	

Facility Capacity Limit:

Up to four individuals.

Scope of Facility Standards. 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:

Space used to include more information about AFCH's and ALF's

An Adult Family Care Home is statutorily defined as having five or fewer residents in a full-time, family-type living arrangement, in a private home, under which a person who owns or rents the home provides room, board, and personal care, on a 24-hour basis, for no more than five disabled adults or frail elders who are not relatives.

Please see Main Module, Attachment #2 for a complete explanation of the State's home-like environment and community inclusion characteristics.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Speech Therapy	
Adult Companion	
Physical Therapy	
Respite	
Caregiver Training	
Personal Emergency Response System (PERS)	
Personal Care	
Case Management	
Homemaker	
Intermittent and Skilled Nursing	
Home Delivered Meals	
Medication Management	
Respiratory Therapy	
Home Accessibility Adaptations	
Adult Day Health Care	
Attendant Care	
Medication Administration	
Medical Equipment and Supplies	
Transportation	
Nutritional Assessment and Risk Reduction	
Assisted Living	
Behavior Management	
Occupational Therapy	

Facility Capacity Limit:

Facility specific and subject to State approval.

Scope of Facility Standards. 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:

Space used to include more information about AFCH's and ALF's

An Adult Family Care Home is statutorily defined as having five or fewer residents in a full-time, family-type living arrangement, in a private home, under which a person who owns or rents the home provides room, board, and personal care, on a 24-hour basis, for no more than five disabled adults or frail elders who are not relatives.

An Assisted Living Facility is statutorily defined as having six or more residents in any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24-hours to one or more adults who are not relatives of the owner or administrator.

Please see Main Module, Attachment #2 for a complete explanation of the State's home-like environment and community inclusion characteristics.

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 or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "*extraordinary care*", exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and

welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring 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.*

Per Attachment II, Exhibit II-B, Section VI.A.3.a.(1) of the Statewide Medicaid Managed Care (SMMC) Long-Term Care Contract, the managed care plan must ensure the Participant Directed Option (PDO) is available to all enrollees who have one or more of the following services on their plan of care and who live in their own home or family home: adult companion care, attendant nursing care, homemaker services, intermittent and skilled nursing, or personal care. Recipients may select a person legally responsible to provide these services. The legally responsible individuals may include any person who has a duty under Florida 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.

The amount of Participant Direction services reimbursed shall be limited to the executed Participant Direction Service Work Agreement.

The SMMC Long-Term Care case manager must offer the enrollee the PDO initially, annually, and upon reassessment per Attachment II, Exhibit II-B, Section VI.A.3.b.(2)(a).

When a LTC enrollee is interested in PDO, they are assigned a LTC case manager trained in PDO (Attachment II, Exhibit II-B, Section VI.A.3.b.(1)) to determine if the enrollee qualifies to be a PDO participant. The assessment process is detailed in the PDO Manual. If the enrollee qualifies, the LTC case manager and the PDO participant develop a plan of care based on medical necessity. The approved plan of care authorizes the maximum number of hours per week for each medically necessary PDO service. The LTC case manager also trains the PDO participant and/or their representative initially, and as needed, on employer responsibilities such as: creating job descriptions, interviewing, hiring, training, supervising, evaluating job performance, and terminating employment of the direct service worker(s) to ensure they understand their roles and responsibilities.

Participant Direction Option (PDO) for Enrollees Receiving LTC Benefits:

- Consent Form
- Evaluation
- Guidelines
- Pre-Screening Tool

Participant Direction Option (PDO) for Plans Providing LTC Benefits:

- Manual
- Training Webinar Presentation

The following provisions are contained in Attachment II, Exhibit II-B, Section VIII.C.2.e of the SMMC contract: Participant Direction Option.

For the purposes of this Section, “enrollee” means the enrollee or their representative.

(1)Enrollees may hire any individual who satisfies the minimum qualifications set forth in Section VIII., Provider Services, including but not limited to

neighbors, family members, or friends. The Managed Care Plan shall not restrict an enrollees’ choice of direct service worker(s) or require them to choose

providers in the Managed Care Plan’s provider network.

(2)The enrollee shall have employer authority. An enrollee may delegate their employer authority to a representative. The representative can neither be paid for

services as a representative, nor be a direct service worker.

(3)The Managed Care Plan shall inform enrollees, upon choosing the PDO, of the rate of payment for the PDO services. If the rate of payment changes for any PDO

service, the Managed Care Plan shall provide a written notice to the applicable enrollees and direct service workers, at least thirty (30) days prior to the change.

(4)The Managed Care Plan shall ensure enrollees update their Participant/Direct Service Worker Agreement indicating any changes in rate of payment.

The managed care plan may not restrict PDO participants’ choice of direct service worker(s) or require them to choose providers in the managed care plan’s provider network. The PDO participant may select a person legally responsible for their care to provide services when the individual is age eighteen (18) years and older, obtains a satisfactory Level II background screening, signs/dates a Participant/Direct Service Worker Agreement, and meets

the minimum provider qualifications listed in Attachment II, Exhibit II-B, Section VIII.C.4., Table 3.

In the Participant Direction Option (PDO) Representative Agreement form there is a line item that states “I know that I cannot be a direct service worker for the participant”. The Representative agreement is a required document per the PDO Manual. The scheduled work hours are set in the plan of care. Time is monitored by Electronic Visit Verification (EVV). There needs to be a check in at the beginning and end of each visit. A Registered Nurse or Licensed Practical Nurse must provide attendant care or intermittent/skilled nursing services. Adult companion, homemaker, or personal care services providers do not require a license or certification.

- 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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures 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 and legal guardians may be paid for waiver services covered only by the PDO service option and for those persons who have executed a PDO Work Agreement. The PDO service options are Adult Companion, Homemaker, Attendant Care, Intermittent and Skilled Nursing, and Personal Care.

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:

Not applicable. The waiver operates in combination with a waiver granted under 1915(b)(4) authority.

- g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act.** Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one:*

No, the state does not choose the option to provide HCBS in acute care hospitals.

Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions. By checking the boxes below, the state assures:

The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;

The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;

The HCBS must be identified in the individual's person-centered service plan; and

The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.

And specify:(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

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:

Percentage of new licensed service providers, by type, within LTC plan provider network that meets provider qualifications prior to delivering services N: Number of new licensed service providers by type, in LTC plan provider network, that meets waiver service provider qualifications prior to delivering services D: Number of new licensed service providers, by type, in LTC plan provider network

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTC Plan 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

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:

Performance Measure:

Percentage of current licensed service providers, by type, within the LTC plan provider network that meets service provider qualifications continuously N: Number of current licensed service providers, by type, in LTC plan provider network that meets waiver service provider qualifications continuously D: Number of current licensed service providers, by type, in LTC provider network

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTC Plan 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
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:

% of non-licensed/non-certified service providers, by type, within the LTC provider network satisfying waiver service provider qualifications prior to service delivery N:# of non-licensed/certified service providers by type within the LTC plan that meets waiver service qualifications prior to service delivery D:# of non-licensed/certified service providers by type in LTC plan provider network

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTC Plan 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:

Performance Measure:

% of current non-licensed/non-certified service providers by type within LTC network meeting waiver service provider qualifications continuously
N: # of current non-licensed/non-certified service providers by type within LTC network meeting service provider qualifications continuously
D: # of current non-licensed/non-certified service providers by type in LTC plan provider network

Data Source (Select one):**Other**

If 'Other' is selected, specify:

LTC Plan Ad Hoc 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

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

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

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

Performance Measure:

Percentage of service providers with staff mandated to report abuse, neglect, and exploitation, verified by LTC plan that staff had received appropriate training N:

Number of service providers, with staff mandated to report abuse, neglect and exploitation, verified by LTC plan that staff has received appropriate training D:

Number of service providers with staff that are mandated reporters

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTC Plan Annual 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

Percentage of LTC plan case managers satisfying Alzheimer's disease and dementia training requirements N: Number of LTC plan case managers satisfying Alzheimer's disease and dementia training requirements D: Number of case managers employed by or under contract with the LTC plan

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTC Plan Ad Hoc Reports

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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.

Plans are required to ensure providers are in good standing with the state and maintain proof of this in the required credentialing and re-credentialing files. Plans also have access to the Agency's Florida Health Finder website which lists provider's status and adverse licensure actions. Additionally, the Agency's Health Quality Assurance division will continue to follow its licensing and monitoring protocols to ensure providers are in compliance with statutory licensing and facility requirements. The Agency notifies plans if a licensure action is taken against a provider, or if a provider is terminated from

Medicaid for reasons other than inactivity. The Agency will require plans to remove a provider from its network if necessary.

Plans are required to notify affected enrollees in an appropriate formal communication, and via the case manager. The plans must then work with the affected enrollee to find an alternate provider and develop a transition plan as appropriate. The enrollee retains all of the rights described in this response and throughout the waiver application during the transition process.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The LTC plans evaluate their licensed service providers, by type, within the plan provider network to ensure they meet provider qualifications prior to delivering services and continuously. Any deficiencies found must be corrected within time frames based upon enrollee health and safety risks. The LTC plans are required to submit at least quarterly provider network lists detailing new service providers. The LTC plans are responsible for enrolling qualified service providers. If the State's review determines a LTC plan's service providers are unqualified, the LTC plan must correct the deficiency.

The LTC plans evaluate their non-licensed/non-certified service providers, by type, within the plan provider network to ensure they meet provider qualifications prior to delivering services and continuously. Any deficiencies found must be corrected within time frames based upon enrollee health and safety risks. The LTC plans are required to submit at least quarterly provider network lists detailing new service providers. The LTC plans are responsible for enrolling qualified service providers. If the State's review determines a LTC plan's service providers are unqualified, the LTC plan must correct the deficiency.

The LTC plans verify service providers with staff mandated to report abuse, neglect and exploitation have received appropriate training. During an annual review, the Agency reviews the LTC plan reports for compliance with staff training requirements. The LTC plans found with staff training deficiencies must ensure the staff receives appropriate training within 45 days.

The LTC plans are required to provide case management services through case managers employed by the LTC plan or their subcontractors. The LTC plan contract requires case managers satisfy Alzheimer's Disease and dementia training requirements. The monitoring staff reviews case management training files as part of their desk review to ensure that all case managers receive contractually required trainings. The LTC plans found with staff training deficiencies must ensure the staff receives appropriate training within 45 days.

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(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings in which 1915(c) HCBS are received. *(Specify and describe the types of settings in which waiver services are received.)*

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

3. By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:

The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. *(see Appendix D-1-d-ii)*

Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

Facilitates individual choice regarding services and supports, and who provides them.

Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

No, the waiver does not include provider-owned or controlled settings.

Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

Each individual has privacy in their sleeping or living unit:

Units have entrance doors lockable by the individual.

Only appropriate staff have keys to unit entrance doors.

Individuals sharing units have a choice of roommates in that setting.

Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Individuals have the freedom and support to control their own schedules and activities.

Individuals have access to food at any time.

Individuals are able to have visitors of their choosing at any time.

The setting is physically accessible to the individual.

Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan(see *Appendix D-1-d-ii of this waiver application*).

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of care

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. (*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. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:*

The State will monitor plan of care development and implementation to ensure that plans of care are developed in the best interest of the enrollee. LTC plans are required to develop quality assurance tools and protocols that include internal safeguards for plan of care development in addition to the external monitoring by the State. The care planning process is person-centered, with the enrollee directing the care plan development process with the help of the case manager, his authorized representative, or any other individuals he would like included. The enrollee may invite anyone of his choosing (family members, authorized representatives, friends, etc.) to participate in his care planning process. This includes allowing the enrollee to make decisions about service options and identification of personal goals. If none of these individuals are available for an enrollee, the State expects the case manager to solicit input from enrollee-approved individuals who are familiar with the enrollee's care needs and preferences. The plan of care will be specific to the enrollee's needs and goals that are identified using, at a minimum, the level of care assessment form(s) provided to the long-term care managed care plan. The enrollee or legal guardian and the guardian advocate, caregiver, primary care physician or authorized representative must be consulted in the development of the plan of care. The plan of care will include goals and objectives, service schedules, medication management strategies, barriers to progress, and detail of interventions. When service needs are identified, the enrollee must be given information about the available network providers so that an informed choice of providers can be made. The entire care planning process is to be documented in the case record. If the enrollee disagrees with the assessment and/or authorization of placement/services (including the amount and/or frequency of a service), the case manager must provide the participant with a written Notice of Adverse Benefit Determination that explains the enrollee's right to file an appeal. The case manager assists the enrollee with filing for an appeal.

Per the State's current contract with LTC plans, as approved by CMS, LTC plans are required to follow strict requirements specifying the timeframe in which plans of care must be completed and their content. Additionally, the contract specifies plans of care must be person-centered and approved by the enrollee, or his or her authorized representative, whenever there is a change. Case managers are required to avail enrollees of all of their available choices, authorize services consistent with the plan of care, and review them with the enrollee at regular prescribed intervals. LTC plans are required to monitor plans of care to ensure they are reflective of an enrollees' needs, preferences, goals, and service authorizations. Additionally, LTC plans are required to provide extensive training on care plan development and service options.

The SMMC Long-Term Care contract includes a conflict of interest provision in Attachment II, Exhibit II-B, Section XV.A. This provision states that:

1. The Managed Care Plan shall not contract with the same entity to provide case management services/functions and any other LTC covered services for an enrollee unless the Managed Care Plan demonstrates all of the following:

- a)The entity is the only willing and qualified entity to provide case management services in a geographic area;
- b)The entity is a provider of LTC services, without which the managed care plan is unable to meet minimum provider network standards for the service; and
- c)The managed care plan must utilize an independent entity, qualified by training and experience, to process and resolve conflicts between the enrollee and the case management provider.

2. Prior to implementing a Contract under the above conditions, the Managed Care Plan shall submit to the Agency procedures that demonstrate the conflict of interest protections that are place for enrollees receiving case management services from a provider of other HCBS services, including separation of case management responsibilities from provider functions, and the process that enrollees may use to file a complaint through the Managed Care Plan's alternative dispute resolution process.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a

- clear and accessible alternative dispute resolution process;
- Direct oversight of the process or periodic evaluation by a state agency;
- Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
- Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

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.

(a) Services and supports included in the plan of care are determined by the LTC Managed Care Plan (MCP) in conjunction with the initial assessment information provided by the CARES Unit (as part of the level of care assessment) in consultation with the enrollee or his or her representative. The plan of care addresses all health and social service needs of the enrollee identified through the assessment. LTC plans are responsible for ensuring that the periodic review of the plan of care is performed through face-to-face contact at least every third month with the enrollee to determine the appropriateness and adequacy of services. During a periodic review, the LTC plan must involve the enrollee or representative in assessing whether the services furnished are consistent with the nature and severity of the enrollee's needs. Revisions to the plan of care must be done in consultation with the enrollee in addition to the caregiver and primary care provider when applicable.

(b) Enrollees have the authority to determine who is included in the development, review, and revision of their plan of care. This includes the enrollee's representative and/or family, caregivers, and physicians.

The person-centered care plan is an agreement between the two or three parties, if the enrollee has a representative, to provide the services agreed upon. The case manager conducts activities that assist the enrollee in determining his or her desired outcomes. To achieve these outcomes, the case manager, in coordination with the enrollee, designs the person-centered care plan.

During the support planning meeting, conducted at least every third month, the case manager assists the enrollee, family or guardian, or primary caregiver, to:

- Identify the enrollee's desired outcomes, personal goals and needs, and the supports necessary to achieve or meet them.
- Update the support plan, which is then completed with the signatures of those present during the meeting along with the enrollee/guardian's signature.

Appendix D: Participant-Centered Planning and Service Delivery

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

- d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. 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):

Each enrollee will have one person-centered plan of care. The managed care plan is required to develop an individualized written plan of care in a format approved by the State, for every enrollee within 5 business days of the effective date of enrollment for those enrolled in a community setting (any exceptions beyond this timeframe must be documented).

The LTC program will use an Individualized Person-Centered Care Plan development process. The provision of the long-term care services in the LTC waiver will be guided by the creation and implementation of the individualized, person-centered care plan. The person-centered care plan is based on a comprehensive assessment that identifies an individual's physical, functional, and psychosocial needs by assessing the individual's health status, physical and cognitive functioning, environment, social supports, end-of-life decisions, and his or her desired outcomes and preferences (herein referred to as personal goals). The enrollee directs the person-centered planning process. The person-centered care plan fosters the participation of family members and others chosen by the individual, as appropriate, in the care planning and service delivery process. By identifying barriers and exploring potential solutions with the enrollee, the person-centered care plan attempts to enhance an individual's independence and quality of life through community presence, choice, competence, respect, and community participation. Examples of personal goals that an enrollee may choose to focus on include (but, are not limited to):

- Deciding where and with whom to live.
- Making decisions regarding supports and services.
- Choosing what activities are important.
- Maintaining relationships with family and friends.
- Deciding how to spend each day.

Enrollee Information

Enrollees will be informed of the benefits and services available in the waiver through the enrollment packet that will be provided to each enrollee through the enrollment broker prior to implementation. The enrollment packet will provide a comparison of benefits between plans and the services available by each managed care plan. Upon enrollment, each plan will provide its members with an enrollee handbook that includes plan network information and services. Managed care plan network information will also be made available online and by contacting the enrollment broker's call center. In addition, during the development of the enrollee's plan of care, the long-term care managed care plan and/or case manager will inform the enrollee of the services available in the plan and work with the enrollee and/or the enrollee's designated representative in developing a plan of care that best meets the enrollee's long-term care needs.

The Comprehensive Assessment

Prior to developing the person-centered care plan, the case manager is required to conduct a comprehensive assessment. When developing the initial care plan, the case manager is not only required to complete an MCP-specific assessment, but is also expected to use the initial eligibility and level of care assessment conducted by the state via CARES assessors. The comprehensive assessment includes evaluations of the plan member's health status, physical and cognitive functioning, environment, social supports, end-of-life decisions, and personal goals, while also considering the enrollee's medical history. Case managers are also required to assess the immediacy of the enrollee's service needs and personal goals.

The case manager is responsible for conducting the initial comprehensive assessment which guides the development of the person-centered care plan. Following an initial orientation, the case manager is required to contact the enrollee at least once a month by telephone, and visit the enrollee face-to-face once every 90 days, in addition to being available on a 24 hour basis, if needed. As a routine, the case manager and the plan member discuss, evaluate, and revise if necessary the plan of care monthly and during the 90-day face-to-face visits. Immediate and intermittent needs (including service needs or personal goals) may be addressed at any time when an enrollee contacts the MCP or case manager. The case manager is also required to update the enrollee's person-centered care plan following a significant change in their health or functional status. Additionally, the case manager is responsible for authorizing the enrollee's services and coordinating their care on an ongoing basis.

Care Plan Development

To ensure that the care planning process is person-centered, the enrollee directs the care plan development process with the help of the case manager, his authorized representative, or any other individuals he would like included. The enrollee may invite anyone of his choosing (family members, authorized representatives, friends, etc.) to participate in his care planning process. This includes allowing the enrollee to help make decisions about service options and

identification of personal goals. If none of these individuals are available for an enrollee, the state expects the case manager to solicit input from enrollee-approved individuals who are familiar with the enrollee's care.

When developing the care plan for all enrollees, LTC case managers are required to:

- Assess the immediacy of the enrollee's service needs and personal goals, and include a description of the enrollee's condition, as identified through an appropriate comprehensive assessment and a medical history review.
 - Recognize and support the enrollee's self-care capabilities.
 - Identify any existing care plans and service providers and assess the adequacy of current services.
 - Ensure continuity of care by providing for continuous care to the new enrollee if the enrollee is receiving services and supports prior to the effective date of enrollment.
 - Ensure that the care plan contains information about the enrollee's medical condition, the type of services to be furnished, the amount, frequency and duration of each service, and the type of provider to furnish each service (regardless of whether Medicaid is the primary payer source) for all enrollees whether they reside at home or in an assisted living facility.
 - Ensure that service interventions address identified problems, needs, and conditions.
 - Encourage integration of formal and informal supports including the development of an informal volunteer network of caregivers, family, neighbors, and others to assist the enrollee or primary caregiver with services. These services will be integrated into an enrollee's care plan when it is determined through multi-disciplinary assessment and care planning that these services would improve the enrollee's capability to live safely in the home or community setting and are agreed to and approved by the enrollee or the enrollee's authorized representative.
 - Determine whether enrollees have advance directives, health care powers of attorney, do not resuscitate orders, or a legally appointed guardian. This information will become part of the enrollee's case record and these orders and preferences will be integrated into the care coordination process. For enrollees who do not have advance directives or do not resuscitate orders, the case manager will discuss with the enrollee the importance of these documents and note the enrollee's response in the case file.
 - Establish personal goals and engage in ongoing personal goal planning activities.
- Goals address the enrollee's physical, functional, and psychosocial needs, and are built on the enrollee's strengths. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination processes, and the care plan includes steps that the enrollee will take to achieve the goal.

Enrollee goals must:

- Be measurable;
- Specify a plan of action/interventions to be used to meet the goals;
- Include a timeframe for the attainment of the desired outcome; and
- Be reviewed at each 90-day face-to-face visit and progress must be documented in the enrollee's case record.

Progress means information regarding whether interventions to achieve a goal were successful, potential barriers, changes that need to be made to the goal, changes that need to be made to the intervention, if the goal has been achieved, and the reasons for continuing the goal after it has been achieved (if it was a one-time goal). Personal goal planning activities are included in the care plan development process. Through these activities, the state ensures that the enrollee's personal goals are incorporated into the care plan and that, in addition to meeting physical and functional needs, his psychosocial needs (including participation and integration with his community) are also met. This process is directed by the enrollee with the help of the case manager, any authorized representative, or any other individuals he would like included in the care planning process. The purpose of the personal goal planning process is to identify activities or interventions that promote the enrollee's ability to participate in his community and that foster his independence and autonomy within his community. Examples of these types of activities could include arranging for transportation to the local senior center; arranging for a homemaker companion to visit an enrollee for a game of chess in his home twice a week; or helping an enrollee remember to call her daughter twice a week.

When developing or reviewing an enrollee's care plan, the case manager and the enrollee will discuss the goals that the enrollee would like to accomplish to be integrated and connected to his community. This discussion shall include identifying the goals and any barriers that exist to achieving those goals. The case manager will then work with the enrollee, authorized representative, family members or others who care about the enrollee, all other home and community-based service providers, and the ALF (for those enrollees residing in an ALF) to implement interventions to overcome the identified barriers, and will follow up with the enrollee at least monthly to determine the status of his goals. At every 90 day face-to-face visit, the case manager and enrollee will discuss the status of his goals, and will

again work to identify any new goals and barriers. As with all other care planning activities, all identified goals, barriers, interventions, and status updates must be documented in the enrollee's case record. Additionally, any discussions that the case manager has with the ALF or other service providers that contribute to implementing an intervention must be documented in the case record.

Because case managers are also required to assess the immediacy of the enrollee's service needs and personal goals, the enrollee may contact his case manager at any time during the month for any reason. If contacted, the case manager will follow up with the enrollee regarding his inquiry or request in a timely manner. The community integration goal setting process attempts to ensure that waiver enrollees remain integrated with their communities, and that they maintain their independence and autonomy. Case managers are therefore expected to provide enrollees with the tools to exercise their independence and to seek out community activities on their own if they so choose, as well as to facilitate participation on behalf of enrollees who cannot do so for themselves.

Care Plan Implementation

Managed Care Plan case managers are tasked with developing and implementing care plans using a person-centered approach. The case manager is responsible for ensuring it is implemented appropriately. LTC managed care plan case managers are the lead case managers for individuals receiving Medicaid services. As such, they are responsible for:

- Working with the enrollee to develop a plan of care that includes all services needed, regardless of payor source, and that identifies the source of all resources needed to meet personal goals.
- Ensuring the requisite service authorizations are approved, regardless of payor source (e.g., commercial health insurance, Medicare, or Medicaid medical).
- Assisting the enrollee to access services by helping to find providers, set appointments, arrange transportation, etc.
- Monitoring implementation of the plan of care through at least monthly contact to ensure that services are being delivered as planned and are meeting the enrollee's needs.
- Adjusting the care plan as needed to accommodate changes in enrollee needs, goals, health status, etc.

Monitoring Activities by the State for the Care Planning Process

On an ongoing basis throughout the calendar year, state quality assurance (QA) clinical monitors review a random, representative sample of current enrollee files for each MCP, organized by planning and service area. As part of this review, the QA monitors evaluate the enrollee's care plans to ensure that the MCP case managers are performing the required care planning activities, including the required elements in the care plan, and that those activities are being documented in the case record by the case manager. For all deficiencies cited by the clinical monitors, upon receipt of the findings, MCPs have 15 business days to fix the deficiencies and submit accompanying documentation to the state, and to submit a corrective action to the state detailing their ongoing actions to ensure future deficiencies do not occur. As a part of the CAP submission, the MCPs will be required to identify evidence-based practices that will yield improved performance. During the remediation process, the MCO shall submit progress reports to the state with data that demonstrates improvement.

The monitors will evaluate the following elements related to the care plan and care planning process:

- Whether care plan services provided by the MCP and through informal supports meet the enrollee's assessed needs and personal goals
- Whether the care plan includes documentation of interventions and services provided to enrollee from all sources
- Whether the following events are documented in the case record:
 - o Orientation, including a discussion of the enrollee's appearance and demeanor, medical diagnoses, cognitive deficits, ADL and IADL deficits, the enrollee's environment, and how care plan needs are addressed
 - o Every 90 day face-to-face care plan review
 - o Monthly contact (telephone or face-to-face)
 - o Updates on the enrollee's medical conditions, hospitalizations and placement in facilities
 - o Annual reviews including the documentation of the completion of the state assessment tool
 - o Documentation of service receipt, and enrollee satisfaction with services and supports

To better ensure that the MCPs case managers are conducting and properly documenting community integration goal planning activities, the state also requires the MCLTC MCPs to audit a random representative sample of currently enrolled enrollee's case records for the following elements specifically related to community integration goal planning activities:

- Identified goals

- Identified barriers to achieving goals
- Identified interventions for overcoming barriers
- Identified timeframes for goal attainment

Progress updates

Progress means information regarding whether interventions to achieve a goal were successful, potential barriers, changes that need to be made to the goal, changes that need to be made to the intervention, if the goal has been achieved, and the reasons for continuing the goal after it has been achieved (if it was a one-time goal).

On a quarterly basis, MCPs are required to collect, aggregate and submit data regarding the above activities to the state for review. The state will use this data and the data obtained by the clinical monitors to determine if barriers exist across enrollee experience and if trends exist across particular settings and to resolve any issues revealed by the data.

Services included in the plan of care will be driven by the plan member's goals in conjunction with the initial assessment information provided by the CARES Unit, in consultation with the enrollee or representative and must be necessary to address all health and social service needs of the enrollee identified through the assessment. (42 CFR 438.208 (c) (3) and (c) (4))

The plan of care must be based on a comprehensive assessment of the enrollee's health status, physical and cognitive functioning, environment, social supports, and end-of-life decisions. The following minimum components must be included in the plan of care:

1. Enrollee's name,
2. Enrollee's Medicaid ID number,
3. Plan of care effective date,
4. Plan of care review date,
5. Services needed, including routine medical and waiver services,
6. Begin date and end date,
7. Providers,
8. Amount, frequency, and duration,
9. Case manager's signature and
10. Enrollee signature & date.

Each LTC plan will have the flexibility to design a plan of care form or system that includes these minimum components and is subject to the review and approval of the State.

The plan of care must clearly identify barriers to the plan member and caregivers, if applicable. The case manager must discuss barriers and explore potential solutions with the plan members, and caregivers when applicable. The plan of care must detail all interventions designed to address specific barriers to independent functioning. The plan of care may include services provided through the plan member's own informal network or by volunteers from community social service agencies or other organizations. Primary caregivers, family, neighbors and other volunteers will be integrated into an plan member's plan of care when it is determined through multi-disciplinary assessment and care planning that these services would improve the enrollee's capability to live safely in the home setting and are agreed to by the enrollee.

The plan of care must be: (1) developed by the plan member's case manager in conjunction with the plan member participation and consultation with any providers caring for the plan member where appropriate; (2) approved by the LTC plan in a timely manner, if the LTC plan requires an approval; and (3) developed in accordance with any applicable State quality assurance and utilization review standards. Copies of the plan of care must be forwarded to the plan member's primary care provider and, if applicable, to the facility where the plan member resides within 10 days of development.

Revisions must be done in consultation with the enrollee, the caregiver, and when feasible, the primary care provider (PCP). If the primary care provider is not under contract with the LTC plan, an effort must be made by the case manager to obtain the PCP's input regarding plan of care revisions. Changes in service provision resulting from a plan of care review must be implemented within five business days of the review date.

If services are needed while the plan of care is being developed, the case manager works with the enrollee to select a provider that can be providing waiver services immediately.

- ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:

A specific and individualized assessed need for the modification.

Positive interventions and supports used prior to any modifications to the person-centered service plan.

Less intrusive methods of meeting the need that have been tried but did not work.

A clear description of the condition that is directly proportionate to the specific assessed need.

Regular collection and review of data to measure the ongoing effectiveness of the modification.

Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

Informed consent of the individual.

An assurance that interventions and supports will cause no harm to the individual.

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.

As part of person-centered care planning the enrollee, their advocates, primary care provider and the case manager will develop a back-up plan congruent with the individual's primary plan of care. Additionally, risk mitigating services are included as waiver services (e.g., nutritional needs assessment and home delivered meals). While enrollees retain the right to refuse to participate in developing a mitigation plan, the managed care plan is required to develop overall emergency back-up plans and the case manager is required to inform recipients of any risks identified and invite them to participate in developing a mitigation plan to address them. Aspects of this, such as alternate contacts in the event of a natural or man-made disaster, are automatically incorporated into the recipient's service plan and communicated to enrollees by their case manager, and via the managed care plan's written materials whether the enrollee engages or not. System-wide emergency back up plans are submitted by each LTC plan on an annual basis to the State. In addition, the plan of care development process includes the identification of procedures for enrollees to follow if service providers are unavailable or other emergent conditions arise.

A risk assessment is completed during the care plan development process using the 701b Comprehensive Assessment. The case manager is responsible for completing and analyzing the assessment to mitigate risk related to the recipient's physical and mental health, caregiver burnout, recipient living environment, and other variables. Depending on the type of risk identified, the case manager suggests services and supports to mitigate the potential risk, and the recipient may choose the provider to supply that service or support.

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.

Each LTC MCP is required to develop printed and online provider network directories to assist enrollees in selecting from qualified providers. These directories are available to the enrollment broker. LTC plans also make trained staff available that can link enrollees to waiver providers in their area. Case managers are trained to provide unbiased information regarding qualified providers of waiver services to each enrollee. Enrollees are free to select among any available provider in the LTC plan's network. Prior to implementation, the network sufficiency of each LTC plan will be assessed to ensure that there is an adequate number of available waiver providers in the network.

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 Agency will monitor the plans through desk reviews on an annual basis. Annual monitoring will check the accuracy of the various plans' reports and determine whether they are performing according to contractual obligations and the State's performance measure set forth in the waiver application.

The Agency will require remediation of any issues discovered during these monitoring activities and will impose penalties and/or sanctions as appropriate. The LTC plans shall ensure that the service plans are developed and updated timely. The Agency will have the primary responsibility to conduct the case reviews and will be responsible for making sure that a representative number of case reviews have been completed in a timely manner, and that any remediation has been adequately addressed.

To ensure a representative sample, parameters will be set for a specified time period at a 95% confidence level, a 5.0% margin of error and 50% response distribution, in order to draw a representative sample at the program level. This random sample will then be apportioned across the LTC plans so that the percent of the sample drawn randomly from each LTC plan matches the percent of the overall population served by that LTC. Proportionate random sampling ensures that all LTC plans are represented in the sample, and helps to minimize bias.

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, when the individual's circumstances or needs change significantly, or at the request of the individual, 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:

Many LTC plans that bid on the managed long term care contract have secure, centralized electronic case management systems that are the repository for all information about enrollees. If paper records are required, they are to be secured at the LTC plan's/case manager's local office. Case management records are maintained in secure filing cabinets and in HIPAA compliant electronic filing systems.

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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Desk reviews will be conducted by the Agency. The LTC plan will review the quality of care for its enrollees. The Agency will review a representative sample of care plans as part of the case record review on a quarterly basis. The Agency conducts retrospective reviews of a representative sample of plans of care to ensure plans have been developed in accordance with applicable policies, ensure the health and welfare of enrollees, and are used to effectively deliver waiver services that are furnished in accordance with the plan on a quarterly basis.

LTC plans are required to report missed services to the State. The State reviews these reports to identify trends and determine any remediation or compliance actions. Case managers work to identify and link enrollees with non-Medicaid services when developing the person-centered care plan with the enrollee. All services, including non-waiver services must be addressed in the service plan.

Participant access to services (including non-waiver and healthcare services) identified in the plan:

Medicaid Managed Care plans are required to maintain a region-wide network of providers in sufficient numbers to meet the access standards for LTC services for all plan enrollees. Provider ratios and provider-specific geographic standards are required for urban and rural counties.

Plan shall identify the LTC service needs of enrollees in an Agency-developed plan of care template. The Plan shall use a person-centered approach regarding the enrollee assessment and needs, taking into account not only covered services, but also other needed services and community resources, regardless of payor source, as applicable.

Ensure that participants are exercising free choice of provider:

Enrollees receive information from the plan about available providers in order to make informed decisions.

Plans are required to provide, and enrollee or representative sign, Freedom of Choice Certification Form.

Plans must report LTC Waiver Performance Measures, including percentage of enrollees with Freedom of Choice Certification form in their case records indicating choice of setting.

Ensuring services are meeting the participant's needs:

Plans must develop a person-centered plan of care with personalized goals and objectives, services and supports and standards for ongoing (re)assessment and minimum contacts with plan staff.

The effectiveness of backup plans:

Plans are required to verify and document delivery of services, including anticipated and unforeseen gaps in service delivery. Provisions contain timeliness standards for plans to respond to enrollee needs. Plans must report monthly on missed services.

The participant's health and welfare:

Plans must meet minimum standards for telephonic and face-to-face contact with enrollees to ensure plan of care goals and objectives are obtained, if (re)assessment needs to occur, and to develop new plan of care as needed.

In the event an area of non-compliance is identified by the Agency, the Agency will contact the managed care plan that is non-compliant and provide an opportunity for the plan to remedy the issue. The Agency will monitor the managed care plan until the non-compliance is corrected or the staff is appropriately trained. The Agency continues to monitor the plan through routine desk reviews. However, if the area of non-compliance is not adequately addressed by the managed care plan consistently over time, or the managed care plan continues to have areas of non-compliance identified, the Agency will complete a targeted monitoring project consisting of an intensive desk review. The managed care plan may be placed on a corrective action plan for a specified period of time and must report on their compliance more frequently to the Agency until the issue is resolved. The Agency may also apply liquidated damages and sanctions, up to and including termination, for chronic non-compliance.

- b. Monitoring Safeguard.** Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the

participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation. *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

The State requires that responsibility for monitoring plan of care implementation and enrollee health and welfare within the plan be independent of any direct waiver services to avoid conflicts of interest.

LTC plans must separate responsibility for development and monitoring of care plans. Case managers who develop care plans cannot be given the responsibility for monitoring waiver care plans. LTC plans failing to separate the development of and monitoring care plans are subject sanctions.

The State's desk review and on-site monitoring review LTC plan staff monitoring and developing care plans. When an overlap is discovered the plan will have to develop a corrective action plan to address the overlap and be subject to more frequent desk reviews of care plans.

LTC plans must separate responsibility for care plan development and monitoring. LTC Plans must audit case manager activities, including enrollee plans of care. In accordance with the State's contract with LTC Plans, as approved by CMS:

The Managed Care Plan shall implement a systematic method of monitoring its case management program to include, but not be limited to conducting quarterly case file audits and quarterly reviews of the consistency of enrollee assessments/service authorizations (inter-rater reliability). The Managed Care Plan shall compile reports of these monitoring activities to include an analysis of the data and a description of the continuous improvement strategies the Managed Care Plan has taken to resolve identified issues. This information shall be submitted to the Agency on a quarterly basis, thirty (30) days after the close of each quarter.

The Agency reviews a random sample from the Case File Audit Report quarterly and validates the data that is submitted to the Agency. The EQRO does not validate this report.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

Direct oversight of the process or periodic evaluation by a state agency;

Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and

Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

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:

Percentage of enrollees with care plans addressing all identified needs and risks N:

Number of enrollees with care plans addressing all identified needs and risks D:

Number of records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTC Plan Enrollee Files

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%
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

	Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Percentage of enrollees with care plans documenting personal goal setting and community integration goal setting N: Number of enrollees with care plans documenting personal goal setting and community integration goal setting D: Number of records reviewed

Data Source (Select one):**Other**

If 'Other' is selected, specify:

LTC Plan Enrollee Files

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

Data Aggregation and Analysis:

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

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

- b. Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.**

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:

Percentage of enrollees plans of care distributed within ten days of development to primary care physician N: Number enrollees plan of care distributed within ten days of development to primary care physician D: Number of enrollee records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTC Plan Enrollee Files

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%
Other	Annually	Stratified

Specify: 		Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Percentage of enrollees plans of care where enrollee participants is verified by signatures N: Number enrollees plans of care where enrollee participation is verified by signatures D: Total number of enrollee care plans reviewed

Data Source (Select one):**Other**

If 'Other' is selected, specify:

LTC Plan Enrollee Files

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%
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: 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:

Percentage of enrollees whose care plans are updated when needs change N: Number of enrollees whose care plans are updated when needs change D: Number of records indicating a significant change

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTC Plan Enrollee Files

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%
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Percentage of enrollees plans of care reviewed on a face-to face basis at least every three months N: Number of enrollees plans of care reviewed on a face-to face basis at

least every three months D: Number of enrollee records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTC Plan Enrollee Files

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%
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measure:

Percentage of enrollees care plans updated at least annually N: Number of enrollee care plans updated at least annually D: Number of enrollee records reviewed

Data Source (Select one):**Other**

If 'Other' is selected, specify:

LTC Plan Enrollee Files

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%
Other Specify: 	Annually	Stratified Describe Group:

	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

d. 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:

Percentage of enrollee services delivered according to the plan of care as to service type, amount, frequency, duration and scope N: Number of enrollee services delivered according to the care plan as to service type, amount, frequency, duration and scope D: Total number records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTC Plan Enrollee Files

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%
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

e. Sub-assurance: 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.

Performance Measure:

Percentage of all new enrollees with signatures on the care plan indicating a choice of services and service providers
N: Number of all new enrollees with signatures on the care plan indicating choice of services and service providers
D: Number of records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTC Plan Enrollee Files

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):
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State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95%
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measure:

Percentage of new enrollees with freedom of choice forms indicating choice between waiver services and institutional care in their case records
N: Number of new enrollees with freedom of choice forms indicating choice between waiver services and institutional care in their case records
D: Number of case records reviewed

Data Source (Select one):**Other**

If 'Other' is selected, specify:

LTC Plan Enrollee Files

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%
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other	

	Specify: 	
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Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

By contract, approved care plans must address all assessed needs including risk factors.

The LTC plans must use an integrated care planning process that encourages the enrollees to set personal goals and pursue community interests. During quarterly desk reviews, care plans are reviewed to verify enrollee goals and community interests are included. If the LTC plan is out of compliance, documentation will be requested that shows there is a personal goal in the care plan. If there is not a personal goal in the care plan, the case manager should meet with the enrollee to develop a personal goal(s) and submit a revised copy of the care plan for review. In addition, the LTC plan must submit a signed training attestation that the case manager has been trained on the importance of personal goal planning during the care planning process.

The LTC plans must ensure the care plans are distributed to the primary care physician within ten business days of development, or when updated. During quarterly desk reviews, a sample of enrollee case files are reviewed. If it is

determined the LTC plan is out of compliance, the most recent copy of the care plan must be sent to the primary care physician and the case manager must be trained on the importance of forwarding the care plan to the enrollee's primary care physician within 10 business days of development/update. The LTC plan must submit a signed and dated attestation that the care plan was submitted to the primary care physician and the training occurred.

The LTC program requires care plans to be signed by enrollees to verify their participation in the development of the document. During quarterly desk reviews, a sample of enrollee case files are reviewed. If it is determined the LTC plan is out of compliance, the case manager must be trained on the importance of obtaining enrollee or enrollee representative's signature and date on the care plans. The LTC plan must submit a signed and dated attestation that the training occurred and a signed and dated copy of the care plan.

By contract, LTC plans must review enrollees' care plans following the report of a significant change. During quarterly desk reviews, a sample of enrollee case files are reviewed. If it is determined the LTC plan is out of compliance and a necessary review is still outstanding, a face-to-face review should be completed immediately with the enrollee. The LTC plan must confirm that the face-to-face meeting occurred. The case manager must be trained on the importance of reviewing the care plan face-to-face more frequently than once every three months if the enrollee's condition changes or requires it. The LTC plan must submit a signed and dated attestation that the training occurred.

By contract, approved plans of care must be updated at least annually. During quarterly desk reviews, a random sample of enrollee case files are reviewed. If it is determined the LTC plan is out of compliance with the annual care plan update and the care plan update has still not occurred, the case manager will meet with the enrollee to create an updated care plan. The LTC plan must submit evidence of remediation. The case manager must be trained on the importance of updating the care plan annually and the LTC plan must submit a signed and dated attestation that the training occurred.

LTC plan case managers must review the care plan face-to-face with the enrollee at least every three months. During quarterly desk reviews, a random sample of enrollee case files are reviewed. If it is determined the LTC plan is out of compliance with the care plan review every three months, and the care plan review has still not occurred, the case manager will meet with the enrollee to review the care plan. The LTC plan must submit evidence of remediation. The case manager must be trained on the importance of reviewing the care plan within every three months. The LTC plan must submit a signed and dated attestation that the training occurred.

During quarterly desk reviews, a sample of enrollee case files are reviewed to verify enrollees are receiving services in accordance with the care plan. If the LTC plan is out of compliance, the Agency will request the LTC plan provide an explanation as to why the enrollee is not receiving the service according to the care plan as to service type, amount, frequency, duration, and scope. Updated service authorizations that match the care plan must be submitted by the LTC plan.

The LTC program contract requires enrollees to have freedom of choice forms indicating choice between waiver services and institutional care in their enrollment packets. During quarterly desk reviews, a sample of enrollee case files are reviewed. If the file does not contain a signed freedom of choice form, the LTC plan case manager should assist the enrollee with completing the form and submit a copy of the signed form. The LTC plan must submit evidence of remediation. The case manager must be trained on the importance of ensuring the enrollee completes a freedom of choice form and the LTC plan must submit a signed and dated attestation that the training occurred.

During quarterly desk reviews, a sample of enrollee case files are reviewed to verify enrollee or enrollee representative signature and date is on the care plan. If it is determined the LTC plan is out of compliance, the case manager must be trained on the importance of obtaining enrollee or enrollee representative's signature and date on the care plan. The LTC plan must submit evidence of remediation. The LTC plan must submit a signed and dated attestation that the training occurred and a signed and dated copy of the care plan.

ii. Remediation Data Aggregation

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

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

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

Appendix E: Participant Direction of Services

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

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

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

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participant direction is offered to all enrollees who live in their own personal home or the home of a family member and who have a participant direction eligible service on their authorized plan of care. Enrollees wishing to participate in participant direction, but who do not have the capacity to manage services may choose a representative willing to take on these duties. Individuals enrolling in the waiver are presented with information about the participant directed option (PDO), both as part of the enrollment broker process and during the care planning process. The State expects 10% of the population will choose participant direction; this expectation is based on enrollment in the State's Consumer-Directed Care Plus (CDC+) program, authorized under a Section 1915(j) State plan amendment (SPA).

The PDO is offered for five of the waiver services: Adult Companion, Homemaker, Attendant Care, Intermittent and Skilled Nursing, and Personal Care. The participant is responsible for training direct service workers, setting hours during which services will be provided, and submitting timesheets to the LTC plan.

Supports for the enrollee are offered in the form of a case manager, who trains, or arranges for training, in all aspects of the participant direction process. The LTC plan is responsible for Fiscal/Employer Agent (F/EA) functions and must process, file, and pay all state and federal taxes on behalf of participants and their direct service workers. The LTC plan must operate as a Vendor Fiscal/Employer Agent (F/EA) or subcontract this function. The F/EA is required by contract to operate in accordance with Section 3504 of the Internal Revenue Code, per Revenue Procedure 70-6 and Section 3504 Agent Employment Tax Liability proposed regulations (REG-137036-08) issued by the IRS on January 13, 2010. The F/EA must meet all applicable participant direction-related federal and state requirements. These requirements were assessed as part of the Plan Readiness Review by the State prior to providing participant directed services to recipients.

Also, ongoing monitoring of all LTC plans and their approved subcontractors will ensure these requirements are maintained. Enrollees may also choose a representative to handle participant direction responsibilities. Potential conflict of interest is mitigated by prohibiting the representative from also serving as a paid caregiver for the enrollee they represent.

The waiver does not require participant direction in order to receive services from the program. An enrollee who chooses the PDO, may elect to terminate it at any time and will be assisted by the case manager to transition to provider managed services without any lapse in service. In specific circumstances (i.e., a representative is necessary for participation but is not available or consumer health or safety is at risk), an enrollee may be involuntarily disenrolled from participant direction. In such a case, the enrollee's case manager will be responsible for ensuring transition to provider managed services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*

Participant: Employer Authority. As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

Participant: Budget Authority. As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

- c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

Waiver is designed to support only individuals who want to direct their services.

The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Any enrollee wishing to participate in the PDO and their chosen representative, if applicable, must first complete the PDO Pre-Screening Tool with the case manager. The enrollee and representative, if applicable, must also complete the participant direction training and submit accurately completed documents to the LTC plan.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Information about participant direction opportunities, including the benefits, responsibilities, and potential liabilities of participant-direction, will be provided to enrollees at various times.

For both individuals gaining eligibility for HCBS at the same time as Medicaid and those already Medicaid eligible, this information will be presented by the case manager during the care planning process.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Process for appointment of a representative:

- The enrollee must indicate to the case manager that he or she wishes to choose a representative to manage the Participant Direction Option (PDO).
- The potential representative will meet with the case manager to complete a PDO pre-assessment tool, which will be used to inform the prospective representative of all responsibilities and also provide critical thinking exercises for the prospective representative to determine if he or she is willing and able to manage all the enrollee's responsibilities under the PDO.
- Each prospective representative will be Level 2 background screened to ensure that there are no disqualifying offenses as per Chapter 435 and section 408.809, F.S.
- The participant-chosen representative must sign a Representative Agreement indicating the willingness to manage the PDO responsibilities on behalf of the participant.
- Once appointed, the representative can hire and fire workers and sign worker timesheets.

Safeguards:

- The representative may not be paid to act as the representative or be a paid provider of the enrollee's waiver services.
- The enrollee may change representatives at any time by notifying the case manager.
- The case manager remains involved as part of the enrollee's care team and continues to facilitate the care planning process and maintain regular contact with the enrollee. This provides oversight of the representative to ensure there is not an abuse of authority.
- There is also monitoring of the representative's responsibilities by the managed care plan, and the State.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Adult Companion		
Personal Care		
Homemaker		
Intermittent and Skilled Nursing		
Attendant Care		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

Yes. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The LTC plans may contract with qualified entities to furnish FMS.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

LTC plans compensate FMS entities for the activities they perform, if they subcontract this function.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies):*

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

The FMS agency will assume responsibility for verifying and reviewing the results of background screening.

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

- iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The State conducts on-site monitoring of the plan on an annual basis or more frequently as needed. The plan submits encounter data to the State that details utilization of participant directed services and FMS. The plan is responsible for monitoring all sub-contracted FMS entities, if applicable, to ensure the integrity of the financial transactions they perform. Through the retrospective review of service plans and paid timesheet records, the State ensures that plans of care have been developed in accordance with applicable policies and that both FMS and participant directed waiver services are furnished in accordance with the plans of care.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case managers provide this function for enrollees.

Case managers assist enrollees in gaining access to needed waiver and other State plan services, as well as other needed medical, social, and educational services, regardless of the funding source. Case management services contribute to the coordination and integration of care delivery through the ongoing monitoring of service provisions as prescribed in each enrollee plan of care. For enrollees choosing participant direction, the case manager is responsible for assisting the enrollee, by arranging for training and through ongoing support, with the following duties: recruiting workers; ensuring that worker qualifications are verified and criminal background check completed; defining additional qualifications and duties within the scope of waiver definitions to meet the enrollee's specific needs; scheduling workers; training workers; supervising workers; evaluating worker performance; verifying time worked and timesheets; and, if necessary, dismissing workers and arranging for implementation of the Emergency Back-up Plan.

Waiver Service Coverage.

Information and assistance in support of

participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Speech Therapy	
Adult Companion	
Physical Therapy	
Respite	
Caregiver Training	
Personal Emergency Response System (PERS)	
Personal Care	
Case Management	
Homemaker	
Intermittent and Skilled Nursing	
Home Delivered Meals	
Medication Management	
Respiratory Therapy	
Home Accessibility Adaptations	
Adult Day Health Care	
Attendant Care	
Medication Administration	
Medical Equipment and Supplies	
Transportation	
Nutritional Assessment and Risk Reduction	
Assisted Living	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Behavior Management	
Occupational Therapy	

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (select one).

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

An enrollee may voluntarily terminate participant direction at any time. The enrollee will work with his or her case manager to find providers for the services within the LTC plan's network as Emergency Back-up providers. Since the LTC plan is required to maintain a full network of service providers at all times and the Emergency Back-up Plan is updated annually, providers will be available to serve the enrollee in a timely manner. The care manager will work with the participant directed providers and the network providers to develop a transition plan so that continuity of care is assured and there is no lapse in services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The State may involuntarily terminate the use of participant direction under certain circumstances. The State will review the documentation and make a determination of whether to terminate upon recommendation by the LTC plan. The LTC plan may not terminate participation without prior approval by the State.

The State may involuntarily terminate participant direction for the following reasons:

- Enrollee health or safety is at risk;
- Enrollee is unable to employ or manage workers;
- Enrollee is admitted to a long-term care facility;
- Enrollee moves out of the State;
- Enrollee loses Medicaid eligibility;
- Enrollee fails to choose a representative, when needed; or
- Enrollee submits inaccurate time sheets to the managed care plan.

If the enrollee is not able to employ or manage workers, or if they submit inaccurate time sheets, the managed care plan and the State will require the enrollee choose a representative if they do not have one. If the enrollee already has a representative and is unable to meet all necessary criteria for participant direction, the State and the managed care plan will require them to choose a different representative. If the enrollee refuses to choose a representative, the managed care plan and the State will involuntarily terminate them from the participant directed option.

If the enrollee is terminated from the participant directed option, then they must transition back to utilizing home and community-based waiver services from the managed care plan's network of service providers. The case manager is central to assisting the enrollee to implement their Emergency Back-up Plan, and to ensuring there is no interruption in services.

All enrollees choosing the participant directed option will have an emergency back-up plan in place which is developed in coordination with the case manager. Providers identified for the backup plan are chosen from the currently enrolled home and community-based waiver service providers available to all enrollees from the managed care plan's network provider list. The use of service providers that are currently enrolled in the plan network will assure quick access and prevent a gap in service delivery during the transition from participant-direction to traditional home and community based services delivery.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	10511	
Year 2	10788	
Year 3	11061	
Year 4	13690	
Year 5	14360	

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in

Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

LTC plans are required to pay for the cost of background screenings for 1 provider per eligible service per year (up to 5 services) and for the representative (if appointed). If an enrollee hires multiple providers for 1 service, the excess providers are responsible for paying for the background screening.

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iii. **Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

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 State provides Fair Hearings under 42 CFR Part 431 subpart E, 42 CFR 438.400(a)(I) and 42 CFR 438.404. Each enrollee is informed of his or her right to a Fair Hearing when action has been taken regarding his/her Florida Medicaid eligibility, or when services are denied, terminated, reduced, or suspended. Individuals receive a Notice of Case Action form from DCF for actions related to decisions regarding Florida Medicaid eligibility including, determinations that an applicant does or does not meet Florida Medicaid financial eligibility, or when an individual fails to act in a timely manner. Individuals receive a similar notice from the Agency for Health Care Administration, Office of Appeals, for actions related to service or clinical eligibility determinations.

In accordance with 42 CFR 438.402, all LTC plans are required to develop an internal appeal process related to Medicaid Fair Hearing rights, including the Grievance and Appeal System, which states the enrollee has the right to request a Fair Hearing at any time after completion of the plans’ grievance process. Parties to the Fair Hearing include the LTC plan as well as the enrollee and his or her representative, or the representative of a deceased enrollee's estate. The case manager is required to notify enrollees of any adverse decisions and the Fair Hearing process, which includes the continuation of services through the appeals process. The plan is also required to notify enrollees of any adverse decisions by mail and provide Fair Hearing informational materials. Copies of these notices are kept in the enrollee's case file. All enrollee grievances are reported to the State on a monthly basis. Fair Hearings may be requested verbally or in writing. No specific form is required.

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

- 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.

Do not complete this item.

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**

- **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

The Agency maintains an enrollee and provider complaint hub. LTC enrollees and providers access the complaint hub through the Agency web site or a toll free telephone number. Complaints are reviewed and resolved by Agency staff. Hub metrics are maintained by the Agency and reviewed periodically.

- **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

For the complaint hub, enrollees and providers access the Agency website, complete an on-line complaint form, and submit the electronic complaint to the Agency. Complaint hub staff contact Agency units responsible for the complaint area and seek direction on the resolution of the complaint or if necessary Agency subject matter specialist are contacted to resolve the complaint. Service provider complaints are usually resolved through contacting the LTC plan involved about the complaint.

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 Florida Department of Children and Families (DCF) receives reports of abuse, neglect, and exploitation of vulnerable adults through its management of the statewide abuse reporting hotline. DCF responds to critical events or incidents through referrals to the Adult Protective Services program or local law enforcement for investigation as required by Chapter 415, F.S. Plans are required to report critical incidents related to enrollees to AHCA. Managed care plan contracts and subcontracts specify incident reporting format, requirements, processes and timeframes for responding to critical events or incidents, including conducting investigations. Through the State's ongoing monitoring activities, plans' adherence to these requirements will be monitored and observed for any necessary remediation.

The LTC plan shall report suspected abuse, neglect, and exploitation of participants to the Agency immediately. The long-term care plan shall require providers to report critical/adverse incidents to the plan within forty-eight (48) hours of the incident. A Critical Incident Report shall be reported in written form via email. A Critical Incident Report Summary shall be reported monthly and aggregated quarterly and annually in written form via email. Timeframes and reporting formats will be the same for each LTC managed care plan.

Critical incidents include:

- Death by suicide, homicide, abuse/neglect or that is otherwise unexpected
- Injury or major illness as a result of care provider
- Sexual battery
- Medication errors
- Suicide attempts
- Altercations requiring medical intervention
- Elopement

- 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.

LTC plans are required to submit reports to AHCA regarding critical incidents affecting enrollees, including allegations of abuse, neglect, or exploitation. In addition, plans or their subcontractors must include educational information in enrollee materials on the various types of abuse and available reporting mechanisms. This may include the posting of information on how to report allegations of abuse, neglect, or exploitation to Florida's toll-free abuse reporting hotline operated by the Department of Children and Families. (1-800-96-ABUSE). Plans or their subcontractors are also required to train direct care staff to report incidents of abuse, neglect or exploitation.

Participant training is conducted as often as necessary based upon the recipients situation and training needs.

- 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.

LTC plan providers are required to report critical incidents related to enrollees to AHCA. Plan contracts and subcontracts specify incident reporting formats and requirements, as well as processes and timeframes for responding to critical events or incidents, including conducting investigations. Through the State's ongoing monitoring activities, plans' adherence to these requirements will be monitored and observed for any necessary remediation.

Critical Incident reports are evaluated as follows:

- The LTC plan shall identify and track critical incidents and review and analyze critical incidents to identify and address/eliminate potential and actual quality of care and/or health and safety issues. If the LTC plan fails to comply with this requirement, the Agency will require corrective action within time frames that are based upon the severity of the deficiency. If the managed care plan fails to implement the corrective action timely, the plan is subject to sanctions ranging from enrollment suspension to larger on site case file reviews.
- Adverse incidents involving health and safety issues are reported to the Department of Children and Family's Adult Protective Services (APS) for investigation and resolution. The managed care plan must assist as necessary to address health and safety issues. If the managed care plan fails to comply, sanctions ranging from enrollment suspension to contract termination may be assessed.
- If APS reports are not investigated within 24 hours, the Agency contacts the APS office for an explanation for the delay. Unexplained delays are reported to APS management. If the APS delays are not timely corrected the Agency will report the unexplained delay to the Department of Children and Families management division responsible for the APS program.

AHCA must submit a report annually to the Florida Legislature on ALF adverse incidents by category of types of incidents, the type of staff involved, types of liability claims filed, and disciplinary action taken against staff. Incidents that relate to persons licensed under Chapter 458, Chapter 459, Chapter 461, or Chapter 465 of the Florida Statutes are reviewed by AHCA to determine whether any of the incidents involved the conduct of a health professional who is subject to disciplinary action in accordance with 456.037, F.S. AHCA may investigate, as it deems appropriate, any such incident and prescribe measures that must be taken in response.

Impacted enrollees are sent a Notice of Conclusion when the investigation is finalized.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

AHCA is responsible for overseeing the reporting of and response to critical incidents or events that affect enrollees. In addition, the Department of Children and Families and the Florida Department of Law Enforcement are responsible for overseeing the reporting of and response to critical incidents or events for all Floridians, including managed care plan enrollees.

The Agency will collaborate with the Department of Children and Families – Adult Protective Services and other State agencies. The Agency will foster increased oversight of the long-term care managed care plans and providers regarding critical incidents and other health, safety and welfare sub-assurances required for the successful operation of the long-term care waiver program. The State has developed performance measures for capturing and reporting critical incidents. These performance measures may be found in Appendix G (Quality Improvement) of the waiver application.

Furthermore, the State's LTC managed care contract requires health, safety, and welfare issues, be reported to the Agency by the plan. If the managed care plan fails to comply with this contract requirement, the State will require corrective action within time frames that are based upon the severity of the deficiency. If the managed care plan fails to implement the corrective action timely, the managed care plan is subject to sanctions ranging from enrollment suspension to increased on-site case file reviews. The managed care plan must ensure enrollees involved with the reported health, safety and welfare issues are contacted and necessary services are provided to address the problem. Adverse incidents involving health and safety issues are reported to Adult Protective Services (APS) for investigation and resolution. Managed care plans must assist as necessary with services to address the health, safety and welfare issues. If the managed care plan fails to comply with the reporting requirement and assistance with enrollee services, sanctions ranging from enrollment suspension to contract termination may be assessed.

If Adult Protective Service (APS) reports are not investigated within 24 hours, the Agency will contact the APS office for an explanation for the delay. Unexplained delays will be reported to APS management. Enrollees will be monitored for service provision and health and safety issues. The managed care plans must assist with services necessary to address health, safety and welfare needs as well as plan of care services. If the APS delays are not corrected timely, the Agency will report the unexplained delays to Department of Children and Families Division management responsible for the APS program. For APS reports that are not investigated, the Agency will request from the Department of Children and Families management an explanation of the decision to not investigate the report.

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).

Florida State Statute and the Florida Administrative Code, as set by the Florida Legislature, outline parameters for use of physical and chemical restraints. The current definition, under Florida Statute 429.02, for physical restraint excludes any device that the resident chooses to use and is able to remove or avoid independently, or any bandage material used for the purpose of binding a wound or injury. State Statute does directly prohibit the Posey Restraint (straightjackets).

Per the State Statute and Administrative Rule citations below, the following types of restraints would be permitted:

- a. Manual restraint
- b. Mechanical restraint
- c. Chemical restraint
- d. Behavioral protective devices
- e. Medical protective devices

Florida Statute 429.02:

(19) "Physical restraint" means a device that physically limits, restricts, or deprives an individual of movement or mobility, including any device that is not specifically manufactured as a restraint but is altered, arranged, or otherwise used for that purpose. The term does not include any device that the resident chooses to use and is able to remove or avoid independently, or any bandage material used for the purpose of binding a wound or injury.

(7) "Chemical restraint" means a pharmacologic drug that physically limits, restricts, or deprives an individual of movement or mobility, and is used for discipline or convenience and not required for the treatment of medical symptoms.

The licensed facility is responsible for screening and admitting residents they can safely serve within their scope of practice. An individual who is a danger to themselves or others and who requires frequent use of seclusion and restraint would not meet the admission and continued residency criteria detailed in Florida Administrative Code 59A-36.006.

While Florida Statute 429.02 defines chemical restraints as "a pharmacologic drug that physically limits, restricts, or deprives an individual of movement or mobility, and is used for discipline or convenience and not required for the treatment of medical symptoms," the Long-Term Care Waiver only permits the use of these restraints when their use is consistent with a recipient's diagnosis and is specifically prescribed and monitored by a physician in the following manner.

While Florida Statute 429.02 defines chemical restraints as "a pharmacologic drug that physically limits, restricts, or deprives an individual of movement or mobility, and is used for discipline or convenience and not required for the treatment of medical symptoms," the Long-Term Care Waiver only permits the use of these restraints when prescribed and monitored by a physician in the following manner.

For restraints to be used, a physician must prescribe, as medically necessary to treat the resident's condition, a specific physical restraint including the duration, frequency, and scope. Once a physical restraint has been prescribed by a physician, the facility is obligated to perform the required care planning, monitoring, and reporting to the physician as prescribed in 429.41(1)(j), Florida Statutes. Additionally, the physician must review the use of the physical restraints prescribed on an annual basis, and at that time, the physician determines whether to continue the use of the prescribed physical restraint. The recipient's plan of care must be approved by the enrollee, or his or her authorized representative per the Long-Term Care Plan Contract.

Florida Statute 429.41(1)(j):

(j)The use of physical or chemical restraints. The use of Posey restraints is prohibited. Other physical restraints may be used in accordance with agency rules when ordered by the resident's physician and consented to by the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. Such rules must specify requirements for care planning, staff monitoring, and periodic review by a physician. The use of chemical restraints is limited to prescribed dosages of medications authorized by the resident's physician and must be consistent with the resident's diagnosis. Residents who are receiving medications that can serve as chemical restraints must be evaluated

by their physician at least annually to assess:

- 1.The continued need for the medication.
- 2.The level of the medication in the resident's blood.
- 3.The need for adjustments in the prescription.

Florida Administrative Code 59A-36.007:

(8) PHYSICAL RESTRAINTS. Residents for whom a physician has prescribed a physical restraint must have a written care plan for the use of the physical restraint. The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident.

(a) The care plan must specify:

1. The device prescribed for use;
2. The maximum amount of time the resident is to have the restraint applied each day; and,
3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of depression, or decline in mobility or function related to the use of the prescribed restraint.

(b) Facility staff must ensure that the device is applied appropriately and safely.

(c) The resident's physician must review the appropriateness of the continued use of the physical restraint annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical restraint and all requirements of this subsection apply.

- 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:

AHCA's Health Quality Assurance surveyors conduct biennial facility surveys that examine compliance with all aspects of assisted living facility resident care. During these survey reviews, the use of physical restraints approved by resident's physician is reviewed and approved by the resident or the resident representative. Surveyors cite facilities that are not in compliance with the use of physical restraints as permitted by Section 429.41, F. S. and Rule 58A-5.0182(6)(g), FAC.

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:

For enrollees living in their homes, case managers review care standards with enrollees and caregivers. Case managers must conduct face-to-face care plan reviews with enrollees and caregivers at least once every three months. Case managers are responsible for reporting the use of restrictive interventions to the State's Adult Protective Services program, and the plan is responsible for submitting adverse incident reports on enrollees who are being subjected to restrictive interventions against their will. Upon receipt of the adverse incident report, AHCA verifies the Adult Protective Services reporting and works with this program to correct the enrollee's living situation.

AHCA's Health Quality Assurance Division surveys licensed assisted living facilities at least biannually. As part of the licensing survey, facilities must indicate their policies on the use of restrictive interventions. Facilities with survey violations involving the use of restrictive interventions are subject to fines and loss of licensure. The State conducts biennial facility licensure surveys that review the use of seclusion.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete

Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The State conducts biennial facility licensure surveys that review the use of seclusion.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable (do not complete the remaining items)

Yes. This Appendix applies (complete the remaining items)

• **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.

Medication administration, supervision and assistance may be provided to enrollees as long as qualified staff are available to render the service. Medication supervision and administration can only be provided by licensed nurses. For assisted living facilities assistance with self-administered medications can be provided either by a licensed nurse or, with a documented request and informed consent, an unlicensed staff member. The unlicensed staff member must be trained to assist residents with self-administered medications, in accordance with Chapter 58A-5.0191(5), Florida Administrative Code, and must demonstrate the ability to accurately read and interpret a prescription label. Pursuant to Chapter 429.256 (3), Florida Statutes, assistance with self-administration of medications, whether in the home or a facility, includes taking the medication from where it is stored and delivering it to the recipient; removing a prescribed amount of medication from the container and placing it in the recipient's hand or another container; helping the recipient by lifting the container to their mouth; applying topical medications; and keeping a record of when a recipient receives assistance with self-administration of their medications. Plans are responsible for delivering all services contained in the enrollee's care plan. Accordingly, plans must ensure medication administration assistance is available to an enrollee as necessary.

The State monitors providers on an annual basis to assess whether managed care plans are in compliance with State and Federal medical management and administration regulations. This may include reviewing medication reports, recipient case files for prescriptions and the provider's critical incident reports as necessary. The State will cross reference its information with the LTC plan's monitoring findings to determine whether the plan is adequately monitoring providers. On an on-going basis, the State monitors medication administration via adverse incident reports. Medication errors are deemed a critical adverse incident and so are required to be reported to the plans, who in turn report them to the State on an ad-hoc and quarterly basis. The State uses the information in these reports to determine trends in medication administration practices and to determine its provider education and training practices. It also uses this information to take punitive action against providers when necessary.

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.

Waiver providers must document all medication errors. In addition, medication errors resulting in an adverse incident for an enrollee must be reported as required per the critical incident reporting requirements.

AHCA's Division of Health Quality Assurance surveys licensed assisted living facilities at least biennially. Medication administration practices are reviewed at this time.

In addition, AHCA is responsible for verifying provider qualifications for all waiver providers, including those involved in assisting enrollees with the self-administration of medications. The monitoring of all waiver services for enrollees living in a community home is completed annually as part of the overall LTC managed care program Quality Management Strategy or more frequently as needed.

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)*

- **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).

Medication administration, supervision and assistance may be provided to enrollees as long as qualified staff is available to render the service component. Medication supervision and administration can only be provided by licensed nurses. Assistance with self-administered medications can be provided either by a licensed nurse or, with a documented request and informed consent, an unlicensed staff member. The unlicensed staff member must be trained to assist residents with self-administered medications, in accordance with Chapter 58A-5.0191(5), Florida Administrative Code, and must demonstrate the ability to accurately read and interpret a prescription label. Plans are required to provide the means for enrollees to receive medications or ensure they move to a more appropriate setting.

Pursuant to 429.256, Florida Statutes, assistance with self-administration of medications, whether in the home or a facility, includes taking the medication from where it is stored and delivering it to the recipient; removing a prescribed amount of medication from the container and placing it in the recipients hand or another container; helping the recipient by lifting the container to their mouth; applying topical medications; and keeping a record of when a recipient receives assistance with self-administration of their medications.

- **Medication Error Reporting.** *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

- (a) Specify state agency (or agencies) to which errors are reported:

- (b) Specify the types of medication errors that providers are required to *record*:

- (c) Specify the types of medication errors that providers must *report* to the state:

Providers responsible for medication administration are required to record medication errors but make

information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

All medication administration errors must be documented. For medication administration errors resulting in an adverse incident for an enrollee, the LTC plan must submit an adverse incident to AHCA within 48 hours of notification.

- **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.

For enrollees residing in assisted living facilities or adult family care homes, AHCA's Division of Health Quality Assurance is responsible for monitoring these facilities. These facilities are responsible for reporting adverse incidents including medication administration errors to their local licensure offices. Adult family care homes are surveyed annually, and assisted living facilities are surveyed at least biannually.

AHCA is responsible for monitoring LTC plans. LTC plans must send in their adverse incident reports quarterly and the annual on-site monitoring verifies the reports received against incident report records. Data concerning medication administration errors and medication management errors will be acquired from adverse incidents reports, and case note reviews. From these data the long-term care managed care program management will determine if any trends or patterns need to be addressed.

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.

i. Sub-Assurances:

- a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

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:

Percentage of enrollees who received a telephone contact from their case manager at least monthly to assess their health status, satisfaction with services and any additional needs
N: Number of enrollees who received a telephone contact from their case manager at least monthly to assess their health status, satisfaction with services and any additional needs
D: Number of records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTC Plan Enrollee Files

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%
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

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

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

Percentage of health, safety and welfare issues reported in critical incident reports within 24 hours
N: Number of health, safety and welfare issues reported in critical incident reports within 24 hours
D: Number of incidents reported

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTC plan 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 = 95%
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:

Percentage of Adult Protective Services (APS) cases of enrollees with substantiated reports of abuse, neglect or exploitation reported by the LTC plan as critical incidents
N: # of APS cases of enrollees with substantiated reports of abuse, neglect or exploitation reported by the LTC plan as critical incidents
D: # of enrollees with substantiated APS reports of abuse neglect or exploitation

Data Source (Select one):

Other

If 'Other' is selected, specify:

Adult Protective Services

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

Data Aggregation and Analysis:

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

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

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

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

Performance Measure:

Percentage of enrollees with reports of the use of prohibited restraints, reported by the LTC plan to Adult Protective Services (APS) within 24 hours of the incident N:
Number of enrollees with reports of the use of prohibited restraints, reported by the LTC plan to Adult Protective Services (APS) within 24 hours of the incident D:
Number of enrollees with reports of prohibited restraints

Data Source (Select one):

Other

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

- 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:

Percent of recipient health status and service concerns expressed during the monthly call that were addressed by the LTC Plan N: Number of recipients health status and service concerns expressed during the monthly call that were addressed by the LTC Plan D: Number of recipients who expressed a health status or concern as part of monthly telephone contact

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTC Plan Enrollee Files

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%

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.

N/A

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

By contract, enrollees must be contacted telephonically at least every month, and these contacts must be documented in the case record. If the case record review determines a deficiency with the monthly telephone contact requirement, the LTC plan must submit a corrective action to address this deficiency. If the LTC plan fails to implement the corrective action timely, the contractor is subject to sanctions.

By contract, enrollees must be contacted telephonically at least every month, and these contacts must be documented in the case record. If during the monthly contact the enrollee expresses a health status concern, the case manager must document the concern in the enrollees case file along with how the concern was addressed. If a health status concern is not addressed, the case manager must address the concern and the LTC plan must provide additional training to the case manager on the importance of addressing health status concerns. The LTC plan must submit a signed and dated attestation that the training occurred.

By contract, health safety and welfare issues must be reported in critical incident reports by the LTC plan to the Agency within 48 hours. The Agency may elect to assess and collect liquidated damages for each occurrence in which the LTC plan failed to timely file the critical incident report. If the LTC plan continues untimely submission of the required reports, the LTC plan is subject to sanctions ranging from enrollment suspension to larger onsite case file reviews. Enrollees with reported health, safety and welfare issues are contacted by the LTC plan and necessary services are provided. The LTC Plan may also arrange for the enrollee to be moved from his/her current location or change providers to accommodate a safe environment and to choose a participating or direct service provider of the recipient's choice. If an investigation of suspected abuse, neglect or exploitation requires the enrollee to move from his/her current location, the LTC plan coordinates with the investigator to find a safe living environment or another participating provider of the enrollee's choice.

Enrollees who are the subject of substantiated reports of abuse, neglect or exploitation must have appropriate follow-up from their LTC plan. During quarterly reviews, a list of substantiated Adult Protective Services (APS) cases are received from APS. If the LTC plan did not submit a critical incident report for the incident, a request for contact is sent to the LTC plan. If the plan has not had contact with the enrollee since the date of the APS report, the plan must conduct a health, safety and welfare check. Follow up must be documented and submitted to the Agency. The LTC plan has seven business days to submit the follow-up information.

If investigations of APS reports are not started within 24 hours of report, a corrective action plan will be put in place, if appropriate.

ii. Remediation Data Aggregation

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

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

No**Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 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 (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The agency established a Quality Improvement Team for the Long-Term Care Program. The team is responsible for reviewing all program reports related to quality improvement activities as well as trending, prioritizing and developing recommendations for implementation of system quality improvements. The team meets at least quarterly to review program data collection and performance measures that aggregate data on a quarterly basis.

For the performance measures with quarterly data collection, the Quality Improvement Team begins their review and trending of the aggregated data after the first three months of program operations. If the completed aggregated data indicate performance rates are outside of the expected rates or other program data indicate the need for changes, the team develops recommendations for addressing the performance rates for consideration by AHCA management. If approved recommendations are implemented based upon the prioritized program improvement schedule. Prioritization of the program improvement schedule is guided by the following considerations: high risk (e.g., possibility of adverse incidents); high volume (e.g., affects a large number of beneficiaries); or high cost (e.g., financial reserve concerns).

With the large number of performance measures, the team may meet more often than quarterly to review the annual performance measures. If the performance measures reveal performance levels below 100% of the expected performance rates, or other program data indicate the need for change, the team develops recommendations to address the reasons for the poor performance. The recommendations are considered by AHCA management. If approved, the recommendations are implemented based upon the program's prioritized improvement schedule. All team meetings keep meeting minutes. The approved meeting minutes are maintained by AHCA. All revisions, additions or deletions to performance measures listed in the application's appendices are submitted for approval by CMS through the waiver amendment process.

Performance measures are reported in the evidentiary report as required by CMS. The evidentiary report is available by request.

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:

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Quality Improvement Team reviews performance measure results to determine if the policy change or other program adjustment resulted in improvement in the identified problem. If the revised policy change or other program adjustment (i. e., new forms, conducting necessary training or improving a program process) has not resulted in improving the problem within six months or one year, the Quality Improvement Team develop recommendations to address performance in the problem area. The team looks at the expected performance rate as contrasted with the actual LTC plan rate for performance measures.

Quality measures involving LTC performance on quality measures will be reviewed by the team and contrasted with the expected performance rates. Should the performance rates not equal the expected rate, the team develops recommendations for consideration and approval by AHCA management. Program management approves new program performance standards for agency quality measures. The Medicaid agency will follow up on program results.

AHCA announces performance measure changes and other program policy changes to enrolled LTC providers through program memorandums and the contract amendment process. All revisions, additions or deletions of performance measures listed Appendices A, B, C, D, G, and I will be submitted to CMS through the waiver amendment process. Changes to the Quality Improvement Strategy (QIS) will also be reported on the annual CMS 372 report.

The annual report will be posted on the AHCA website.

- ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Performance measure results are reviewed periodically to determine if program or plan results indicate improvement is necessary.

Survey parameters are set to achieve a 95% confidence level, a 5.0% margin of error and 50% response distribution, to draw a representative sample at the program level. When necessary, this random sample is apportioned across the LTC plans, so the percent of the sample drawn randomly from each LTC plan matched the percent of the overall population served by that LTC plan. Proportionate random sampling ensures that all Managed Care Plans are represented in the sample, and helps to minimize bias.

Quality Improvement Strategy re-evaluation meetings will be held as necessary to consider revisions to the strategy. The agency will attend these meetings. All evaluation meetings will keep meeting minutes. Approved meeting minutes will be maintained by AHCA.

Based on language approved in the Appendix K amendment associated with this waiver, due to the COVID pandemic, a quality review report was not completed for the previous waiver cycle. Additionally, 372 reports due during the emergency have not been submitted. Upon expiration of the Appendix K amendment, Florida will gather data and submit the quality review in addition to any outstanding 372 reports as quickly as the required information can be gathered and analyzed. If necessary, the state will submit waiver amendments based on identified deficiencies in the quality review report and/or 372 report(s) within 90 days of receiving the final quality review report and 372 report acceptance decision.”

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Financial accountability is assured through the State's Automated Management Accounting System and the Accounting Procedures manuals which include federal reporting requirements. Capitated LTC plans are paid a monthly capitation rate, which is paid prospectively on or around the first of the month. Payments for those individuals whose eligibility is canceled will be recovered. All enrollee, provider, and service utilization/payment data will be available through FMMIS, a federally certified Medicaid Management Information System that is designed and operated by a contracted entity (the State's fiscal agent) and managed by AHCA. Florida's Auditor General is responsible for performing the periodic independent audit of the waiver program under the provisions of the Single Audit Act.

In addition, the Department of Financial Services, Office of Insurance Regulation determines whether LTC plans seeking to be licensed health maintenance organizations meet financial solvency standards and review quarterly financial reports from the HMOs to ensure that solvency standards are maintained. The Department of Financial Services is also responsible for the State financial audit program. For other LTC plans (non-HMOs), AHCA reviews their annual financial statements and also verifies compliance with LTC plans' required insolvency protection and surplus accounts.

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.

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

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:

Percentage of approved monthly capitation payments made in a quarter to capitated LTC plans for qualified recipients N: Number of approved monthly capitation payments made in the quarter to capitated LTC plans for qualified recipients D: Number of monthly capitations made in the quarter

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

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

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:

Percentage of monthly capitation payments made in the quarter to LTC plans for services rendered
N: Number of monthly capitation payments made in the quarter for services rendered
D: Number of monthly capitation payments made in the quarter

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

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

	Ongoing	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.

Florida's certified Medicaid Management Information System is programmed to verify all LTC plan and recipient enrollment eligibility criteria before approving a recipient's enrollment and generating a capitation payment. The Medicaid program has established edits to check LTC plan and recipient eligibility criteria before each payment is made. No capitation payments are made to ineligible LTC plans for ineligible enrollees.

Each managed care plan is required to submit a complete copy of its independently audited financial Statements and the auditor's report (pertaining to its pertinent lines of business, not umbrella or parent company business) to the Agency on an annual basis. Managed care plans must also submit financial reports to the Agency on a quarterly basis. These are reviewed by the Agency's Bureau of Managed Health Care to ensure continued provider solvency, and congruence with payment information contained in the State provider payment system.

The Agency's Medicaid Program Integrity (MPI) analyzes billing data on a weekly basis and conducts provider audits if it detects errant billing practices and, per Florida Statute, randomly audits 5% of Medicaid providers on an annual basis. MPI, along with the Agency's Inspector General investigate financial complaints made against providers by various parties.

Investigations may result in a claims and payment audit.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

AHCA operates the State's Medicaid Management Information System. This system contains the system programming for all LTC plan and recipient eligibility as well as payment rates. If monthly payments are made to a LTC plan for non-qualified enrollees, the system error is researched and necessary programming changes are implemented. LTC plans receiving the improper payments are notified that the payment will be recouped.

If incorrect payments are made to LTC plans, the payment will be researched. Based upon the research findings related to the payment error, the LTC plan will be notified and the incorrect payment would be voided and the correct payment paid. In addition, necessary programming revisions would be made to prevent future payment errors.

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).

LTC Capitation Rate Range Development

The State of Florida's Agency for Health Care Administration (AHCA) contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for the Statewide Medicaid Managed Care (SMMC) Long-term Care (LTC) program for the implementation year (August 1, 2013 – August 31, 2014), and for the second year (September 1, 2014 – August 31, 2015). For the third year, AHCA retained Milliman to develop LTC capitation rates (September 1, 2015 – August 31, 2016). During the rate setting process, AHCA provides several opportunities for public comment. First, we have regular meetings with actuaries and the plans (individually and as a group) to discuss any issues that need to be accounted for in the base data used to develop rates. Second, we share draft rates with the plans, meet with them to discuss case mix of HCBS and non-HCBS enrollees. Case mix is determined by staff in the Medicaid Bureau of Data Analytics using encounter data and assistance category assignments from the Florida Medicaid Management Information System (FMMIS).

Once the case mix is established, AHCA makes an adjustment for the statutorily required HCBS transition percentage. The transition percentage is applied until no more than 35% of MCO's enrollees are placed in institutional settings (non-HCBS). For the third year of the LTC contract, the transition requirement is 3%. In addition, the HCBS certified rate is reduced by a small withholding amount to reimburse plans with a large number of very costly enrollees who receive HCBS. The withholding constitutes a Community High Risk Pool (CHRP), implemented in July 2014, risk mitigation mechanism for the HCBS rate cell. A percentage of HCBS rates is withheld to fund CHRP and varies by region. Seventy-five percent of member expenditures greater than \$7,500 per month ("pooled claims") are eligible to be reimbursed by the CHRP. At the end of the contract period, if CHRP funds are inadequate to reimburse all pooled claims, the pooled claims will be funded on a proportional basis for each MCO. If CHRP funds exceed the level of pooled claims, excess CHRP funds will be returned to MCOs on a PMPM basis.

AHCA then calculates a final blended rate for each plan using the process above.

LTC plan capitation rates are available on the Agency's Web site at the following link:
http://ahca.myflorida.com/medicaid/Finance/data_analytics/actuarial/index.shtml

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The Florida Medicaid Management Information System (FMMIS) has recipient eligibility and provider information. The recipient information is updated as part of the eligibility redetermination process. When a recipient is enrolled in the Long-Term Care Managed Care Program/a LTC plan, this will be reflected on his/her eligibility file. Provider information is established upon enrollment of each LTC plan. Capitated payments flow directly to capitated LTC plans from FMMIS. For each recipient enrolled with a LTC plan, a monthly payment is generated. Capitated LTC plans are responsible for paying provider claims and submitting encounters to the State. Edits in FMMIS are designed to ensure that claims for enrollees for services covered by a capitated LTC plan will be denied.

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.)

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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.)

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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:

Florida's Medicaid Management Information System (FMMIS) has edits to ensure that, prior to generating a payment to a LTC plan, the enrollee is eligible for the Long-Term Care Managed Care Program and is enrolled with the LTC plan.

LTC plans are required to monitor service delivery to ensure services are rendered in accordance with the plan of care. Per the State's contract with LTC plans, as approved by CMS:

The Managed Care Plan shall develop a standardized system for verifying and documenting the delivery of services with the enrollee or enrollee's authorized representative after authorization. The case manager shall verify the Managed Care Plan's documentation of assisted living services components on the individualized plan of care and their delivery as detailed in the plan of care during each face-to-face review.

The Managed Care Plan shall have data collection and analysis capabilities that enable the tracking of enrollee service utilization, cost and demographic information and maintain documentation of the need for all services provided to enrollees.

The Managed Care Plan shall provide reports demonstrating case management monitoring and evaluation as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide. These reports shall include results for the following performance measures but not limited to:

... Number and percentage of plan of care services delivered according to the plan of care as to service type, scope, amount and frequency...

The Managed Care Plan shall develop a recording and tracking system log for enrollee complaints and resolutions and identify and resolve enrollee satisfaction issues, as specified in Core Provision, Section IV, Enrollee Services and Grievance Procedures

The Managed Care Plan shall submit a monthly summary report of all missed facility and non-facility services in accordance with Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide. For months without missed services, the Managed Care Plan shall submit a report explaining that no authorized covered services were missed during the reported month.

The Managed Care Plan shall implement and maintain review procedures to validate encounter data submitted by providers.

- 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:

LTC plans receive monthly capitation payments for caring for their enrollees from the Agency's FMMIS. Service authorizations are sent to service providers to obtain the necessary waiver services for enrollees. After service providers deliver the waiver service, the provider submits a bill to the LTC plan for reimbursement per their subcontract.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

N/A

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.

The payment to capitated LTC plans is not reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid Agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-

c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Assisted living services and assistive care services are furnished in residential settings other than the personal residence of the enrollee, and the following methods exclude Medicaid payment for room and board. Edits are in place in the Florida Medicaid Management Information System (FMMIS) to ensure that all enrollees are blocked out of the fee-for-service payment system for services covered by capitated LTC plans, and the LTC plans only receive the monthly capitation payments. Any payment from a capitated LTC plan to assisted living facilities is made explicitly for the provision of assisted living services as defined by this waiver. As part of the on-going monitoring process of all LTC plans, the State will ensure that payments to assisted living facilities are based solely on service costs.

Other services (e.g., respite services) can be furnished in residential settings other than the enrollee's personal home, but the payment is explicitly for the purpose of the specified service as defined by this waiver and does not include room or board.

NOTE: Adult Day Health Care providers receive payment for services that include board as allowed in 42 CFR §441.310 (a)(2). The Adult Day Health Care service definition includes nutritional meals as a part of this service only when the enrollee is at the center during meal times, which does not constitute the full nutritional regime for enrollees.

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

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the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital, Nursing Facility

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	13941.79	3519.04	17460.83	52466.68	2305.32	54772.00	37311.17
2	14937.85	3582.38	18520.23	54512.88	2346.82	56859.70	38339.47
3	16016.84	3646.86	19663.70	56638.88	2389.06	59027.94	39364.24
4	17186.67	3712.50	20899.17	58847.80	2432.06	61279.86	40380.69
5	18449.36	3779.33	22228.69	61142.86	2475.84	63618.70	41390.01

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:	Level of Care:
		Hospital	Nursing Facility
Year 1	105111	150	104961
Year 2	116195	150	116045
Year 3	120983	150	120833
Year 4	136901	150	136751
Year 5	143603	150	143453

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 period of time for estimating the length of stay is the three-year average for waiver year 2, waiver year 3, and waiver year 4. The source for waiver year 2 is the 372 report. The source for waiver years 3 and 4 are from LTC Enrollee Roster and Facility Residence Reports, as listed in the SMMC Report Guide effective 04012018. The data from the plan reported rosters was used for the estimates in place of the 372 reports for WY3 and WY4, which were not available at the time. The numbers are as follows:

During the waiver year (December 28, 2017 to December 27, 2018)

19,515,814 = Estimated number of unduplicated recipient days.

75,698 = Estimated number of unduplicated recipients.

257.8 = Estimated average length of stay (days).

During the waiver year (December 28, 2018 to December 27, 2019)

23,750,956 = Estimated number of unduplicated recipient days.

86,029 = Estimated number of unduplicated recipients.

276.1 = Estimated average length of stay (days).

During the waiver year (December 28, 2019 to December 27, 2020)

26,002,924 = Estimated number of unduplicated recipient days.

91,970 = Estimated number of unduplicated recipients.

282.7 = Estimated average length of stay (days).

The estimated average length of stay for the three years is 272.2, or approximately 272.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Waiver services (D factor and D prime) have been averaged over 3 years:

Waiver Year 2 116,195

Waiver Year 3 120,983

Waiver Year 4 136,901

Waiver Year 5 143,603

Utilization data for waiver year 2 is from the CMS72 approved by CMS and waiver year 3 is based upon data available as of April 2021. Unduplicated participant counts for Waiver Years 4 and 5 are being updated with this amendment request with data available as of February 2026. Note that the years utilized for these estimates include the two years preceding the pandemic and the first year of the pandemic. At this point, it is unclear how long the changes in service utilization during 2020 and 2021 will persist after the public health emergency ends, or what the new post-pandemic equilibrium will be between community based on congregate services (ex: adult day health care) and in-home services (ex: home delivered meals). Additionally, it is anticipated higher enrollment due to CARES provisions act will persist at least into the first year of the renewal.

Two inflation factors were used. 8.45% was used for services anticipated to be most impacted by the constitutionally required increase of Florida's minimum wage. These services are Adult Companion Care, Adult Day Health Care, Assisted Living Service, Homemaker Services, Personal Care, Respite in Facility, Respite in Home, and Transportation. The second factor used for all other services is 1.8% as published by the U.S. Bureau of Labor Statistics in Table 1, Medical Care Services, Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, by expenditure category, March 2021, at <https://www.bls.gov/news.release/cpi.t01.htm>. Also published by the U.S. Bureau of Labor Statistics in Economic News Release, Consumer Price Index Summary, at <https://www.bls.gov/news.release/cpi.nr0.htm>.

- 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:

The inflation factor for D prime is 1.8% as published by the U.S. Bureau of Labor Statistics in Table 1, Medical Care Services, Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, by expenditure category, March 2021, at <https://www.bls.gov/news.release/cpi.t01.htm>. Also published by the U.S. Bureau of Labor Statistics in Economic News Release, Consumer Price Index Summary, at <https://www.bls.gov/news.release/cpi.nr0.htm>.

- 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:

Institution costs comparison (G factor) is calculated from the combination of inpatient hospital costs for DRG 131 (cystic fibrosis) and nursing facility costs for Waiver Year 3. Calculated rate increase for published Nursing Home rates for the period of 2017 to 2020 is approximately 3.9%. G factor rates have been inflated using this factor, as the unduplicated recipient count for hospital LOC is less than 1% of the total unduplicated recipient count.

- 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:

Non-institution services (G prime) are based on the non-institution costs for nursing facility residents. Hospital inpatient payments are all-inclusive rates. The inflation factor for G prime is 1.8% as published by the U.S. Bureau of Labor Statistics in Table 1 Medical Care Services, Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, by expenditure category, March 2021 at <https://www.bls.gov/news.release/cpi.t01.htm>. Also published in by the U.S. Bureau of Labor Statistics in Economic News Release, Consumer Price Index Summary, <https://www.bls.gov/news.release/cpi.nr0.htm>.

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	
Adult Day Health Care	
Case Management	
Homemaker	
Respite	
Attendant Care	
Intermittent and Skilled Nursing	
Medical Equipment and Supplies	
Occupational Therapy	
Personal Care	
Physical Therapy	
Respiratory Therapy	
Speech Therapy	
Transportation	
Adult Companion	
Assisted Living	
Behavior Management	
Caregiver Training	
Home Accessibility Adaptations	
Home Delivered Meals	
Medication Administration	
Medication Management	
Nutritional Assessment and Risk Reduction	
Personal Emergency Response System (PERS)	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. **Concurrent section 1915(b)/section 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							63439673.99
Adult Day Health Care		15 minute	8404	1477.25	5.11	63439673.99	
Case Management Total:							104937861.16
Case Management		Month	105111	8.56	116.63	104937861.16	
Homemaker Total:							225934612.72
Homemaker		15 minute	54562	875.45	4.73	225934612.72	
Respite Total:							36834299.12
Respite In Home		15 minute	8489	891.53	4.77	36100305.27	
Respite Facility Based		15 minute	416	305.79	5.77	733993.85	
Attendant Care Total:							17504187.93
Attendant Care		Hour	382	4614.55	9.93	17504187.93	
Intermittent and Skilled Nursing Total:							55716525.30
Intermittent and Skilled Nursing		15 minute	1419	1288.21	30.48	55716525.30	
Medical Equipment and Supplies Total:							37534253.49
Medical Equipment and Supplies		Item	48784	973.92	0.79	37534253.49	
Occupational Therapy Total:							5032283.26
Occupational Therapy		15 minute	3960	53.71	23.66	5032283.26	
Personal Care Total:							463186755.63
Personal Care		15 minute	54768	1694.84	4.99	463186755.63	
Physical Therapy Total:							7818062.39
Physical Therapy		Job	5666	55.37	24.92	7818062.39	
Respiratory Therapy Total:							1189796.20
GRAND TOTAL: 1465435187.01 Total: Services included in capitation: 1465435187.01 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 105111 Factor D (Divide total by number of participants): 13941.79 Services included in capitation: 13941.79 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respiratory Therapy		15 Minute	128	205.83	45.16	1189796.20	
Speech Therapy Total:							75557.07
Speech Therapy		15 minute	123	15.91	38.61	75557.07	
Transportation Total:							23009805.19
Transportation		Mile	18811	116.83	10.47	23009805.19	
Adult Companion Total:							90629607.05
Adult Companion		15 minute	19776	950.79	4.82	90629607.05	
Assisted Living Total:							279316748.49
Assisted Living		Day	26062	34.45	311.10	279316748.49	
Behavior Management Total:							2485583.10
Behavior Management		15 minute	1157	190.96	11.25	2485583.10	
Caregiver Training Total:							1205.60
Caregiver Training		15 minute	6	7.42	27.08	1205.60	
Home Accessibility Adaptations Total:							2910934.49
Home Accessibility Adaptations		Job	2355	1.58	782.32	2910934.49	
Home Delivered Meals Total:							41813435.23
Home Delivered Meals		Meal	33852	205.18	6.02	41813435.23	
Medication Administration Total:							165107.80
Medication Administration		Administration	40	138.05	29.90	165107.80	
Medication Management Total:							105002.92
Medication Management		Evaluation	79	74.13	17.93	105002.92	
GRAND TOTAL: 1465435187.01 Total: Services included in capitation: 1465435187.01 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 105111 Factor D (Divide total by number of participants): 13941.79 Services included in capitation: 13941.79 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nutritional Assessment and Risk Reduction Total:							2186.50
Special Drug and Nutritional Assessment Services		15 minute	32	2.40	28.47	2186.50	
Personal Emergency Response System (PERS) Total:							5791702.39
Personal Emergency Response System Maintenance		Daily Maintenance	24350	8.35	28.27	5747927.08	
Personal Emergency Response System Installation		Installation	593	1.03	71.67	43775.32	
GRAND TOTAL: 1465435187.01 Total: Services included in capitation: 1465435187.01 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 105111 Factor D (Divide total by number of participants): 13941.79 Services included in capitation: 13941.79 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							76029034.85
Adult Day Health Care		15 minute				76029034.85	
GRAND TOTAL: 1735703919.51 Total: Services included in capitation: 1735703919.51 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 116195 Factor D (Divide total by number of participants): 14937.85 Services included in capitation: 14937.85 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			9290	1477.25	5.54		
Case Management Total:							118092324.92
Case Management		Month	116195	8.56	118.73	118092324.92	
Homemaker Total:							270882684.49
Homemaker		15 minute	60316	875.45	5.13	270882684.49	
Respite Total:							44137989.67
Respite In Home		15 minute	9385	891.53	5.17	43257436.79	
Respite Facility Based		15 minute	460	305.79	6.26	880552.88	
Attendant Care Total:							19687608.41
Attendant Care		Hour	422	4614.55	10.11	19687608.41	
Intermittent and Skilled Nursing Total:							62717882.23
Intermittent and Skilled Nursing		15 minute	1569	1288.21	31.03	62717882.23	
Medical Equipment and Supplies Total:							42017246.21
Medical Equipment and Supplies		Item	53928	973.92	0.80	42017246.21	
Occupational Therapy Total:							5664579.93
Occupational Therapy		15 minute	4378	53.71	24.09	5664579.93	
Personal Care Total:							555123876.83
Personal Care		15 minute	60543	1694.84	5.41	555123876.83	
Physical Therapy Total:							8799271.94
Physical Therapy		15 minute	6264	55.37	25.37	8799271.94	
Respiratory Therapy Total:							1343604.72
Respiratory Therapy		15 Minute	142	205.83	45.97	1343604.72	
GRAND TOTAL: 1735703919.51 Total: Services included in capitation: 1735703919.51 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 116195 Factor D (Divide total by number of participants): 14937.85 Services included in capitation: 14937.85 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech Therapy Total:							85035.77
Speech Therapy		15 minute	136	15.91	39.30	85035.77	
Transportation Total:							27573270.28
Transportation		Mile	20794	116.83	11.35	27573270.28	
Adult Companion Total:							108711674.23
Adult Companion		15 minute	21862	950.79	5.23	108711674.23	
Assisted Living Total:							334872716.34
Assisted Living		Day	28811	34.45	337.39	334872716.34	
Behavior Management Total:							2796523.27
Behavior Management		15 minute	1279	190.96	11.45	2796523.27	
Caregiver Training Total:							1227.42
Caregiver Training		15 minute	6	7.42	27.57	1227.42	
Home Accessibility Adaptations Total:							3276644.45
Home Accessibility Adaptations		Job	2604	1.58	796.40	3276644.45	
Home Delivered Meals Total:							47067647.73
Home Delivered Meals		Meal	37422	205.18	6.13	47067647.73	
Medication Administration Total:							184898.65
Medication Administration		Administration	44	138.05	30.44	184898.65	
Medication Management Total:							117699.91
Medication Management		Evaluation	87	74.13	18.25	117699.91	
Nutritional Assessment and Risk Reduction							2434.32
GRAND TOTAL: 1735703919.51 Total: Services included in capitation: 1735703919.51 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 116195 Factor D (Divide total by number of participants): 14937.85 Services included in capitation: 14937.85 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Special Drug and Nutritional Assessment Services		15 minute	35	2.40	28.98	2434.32	
Personal Emergency Response System (PERS) Total:							6518042.95
Personal Emergency Response System Maintenance		Daily Maintenance	26918	8.35	28.78	6468745.33	
Personal Emergency Response System Installation		Installation	656	1.03	72.96	49297.61	
GRAND TOTAL: 1735703919.51 Total: Services included in capitation: 1735703919.51 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 116195 Factor D (Divide total by number of participants): 14937.85 Services included in capitation: 14937.85 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							85879529.89
Adult Day Health Care		15 minute	9673	1477.25	6.01	85879529.89	
Case Management							125174722.20
GRAND TOTAL: 1937765196.10 Total: Services included in capitation: 1937765196.10 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 120983 Factor D (Divide total by number of participants): 16016.84 Services included in capitation: 16016.84 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Case Management		Month	120983	8.56	120.87	125174722.20	
Homemaker Total:							305683993.10
Homemaker		15 minute	62801	875.45	5.56	305683993.10	
Respite Total:							49864047.78
Respite In Home		15 minute	9771	891.53	5.61	48869493.32	
Respite Facility Based		15 minute	479	305.79	6.79	994554.45	
Attendant Care Total:							20845352.86
Attendant Care		Hour	439	4614.55	10.29	20845352.86	
Intermittent and Skilled Nursing Total:							66494901.07
Intermittent and Skilled Nursing		15 Minute	1634	1288.21	31.59	66494901.07	
Medical Equipment and Supplies Total:							44295342.48
Medical Equipment and Supplies		Item	56150	973.92	0.81	44295342.48	
Occupational Therapy Total:							6002745.61
Occupational Therapy		15 minute	4558	53.71	24.52	6002745.61	
Personal Care Total:							627146831.41
Personal Care		15 minute	63038	1694.84	5.87	627146831.41	
Physical Therapy Total:							9327810.71
Physical Therapy		15 minute	6522	55.37	25.83	9327810.71	
Respiratory Therapy Total:							1416028.07
Respiratory Therapy		15 Minute	147	205.83	46.80	1416028.07	
Speech Therapy Total:							90391.39
Speech Therapy		15 minute	142	15.91	40.01	90391.39	
GRAND TOTAL: 1937765196.10 Total: Services included in capitation: 1937765196.10 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 120983 Factor D (Divide total by number of participants): 16016.84 Services included in capitation: 16016.84 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:							31137976.72
Transportation		Mile	21651	116.83	12.31	31137976.72	
Adult Companion Total:							122714861.81
Adult Companion		15 minute	22763	950.79	5.67	122714861.81	
Assisted Living Total:							378132439.49
Assisted Living		Day	29998	34.45	365.90	378132439.49	
Behavior Management Total:							2963596.08
Behavior Management		15 minute	1331	190.96	11.66	2963596.08	
Caregiver Training Total:							1457.96
Caregiver Training		15 minute	7	7.42	28.07	1457.96	
Home Accessibility Adaptations Total:							3472707.50
Home Accessibility Adaptations		Job	2711	1.58	810.74	3472707.50	
Home Delivered Meals Total:							49886513.16
Home Delivered Meals		Meal	38964	205.18	6.24	49886513.16	
Medication Administration Total:							196795.80
Medication Administration		Administration	46	138.05	30.99	196795.80	
Medication Management Total:							125337.52
Medication Management		Evaluation	91	74.13	18.58	125337.52	
Nutritional Assessment and Risk Reduction Total:							2619.60
Special Drug and Nutritional Assessment		15 minute	37	2.40	29.50	2619.60	
GRAND TOTAL: 1937765196.10 Total: Services included in capitation: 1937765196.10 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 120983 Factor D (Divide total by number of participants): 16016.84 Services included in capitation: 16016.84 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services							
Personal Emergency Response System (PERS) Total:							6909193.89
Personal Emergency Response System Maintenance		Daily Maintenance	28027	8.35	29.30	6856945.68	
Personal Emergency Response System Installation		Installation	683	1.03	74.27	52248.20	
GRAND TOTAL: 1937765196.10 Total: Services included in capitation: 1937765196.10 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 120983 Factor D (Divide total by number of participants): 16016.84 Services included in capitation: 16016.84 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							105418628.15
Adult Day Health Care		15 minute	10945	1477.25	6.52	105418628.15	
Case Management Total:							144198918.51
Case Management		Month	136901	8.56	123.05	144198918.51	
Homemaker							375144262.16
GRAND TOTAL: 2352872014.52 Total: Services included in capitation: 2352872014.52 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 136901 Factor D (Divide total by number of participants): 17186.67 Services included in capitation: 17186.67 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Homemaker		15 minute	71064	875.45	6.03	375144262.16	
Respite Total:							61154328.04
Respite In Home		15 minute	11057	891.53	6.08	59934495.04	
Respite Facility Based		15 minute	542	305.79	7.36	1219833.00	
Attendant Care Total:							24035160.55
Attendant Care		Hour	497	4614.55	10.48	24035160.55	
Intermittent and Skilled Nursing Total:							76601913.33
Intermittent and Skilled Nursing		15 minute	1849	1288.21	32.16	76601913.33	
Medical Equipment and Supplies Total:							50742361.75
Medical Equipment and Supplies		Item	63538	973.92	0.82	50742361.75	
Occupational Therapy Total:							6914823.05
Occupational Therapy		15 minute	5158	53.71	24.96	6914823.05	
Personal Care Total:							770109602.23
Personal Care		15 minute	71332	1694.84	6.37	770109602.23	
Physical Therapy Total:							10742898.47
Physical Therapy		15 minute	7380	55.37	26.29	10742898.47	
Respiratory Therapy Total:							1637558.78
Respiratory Therapy		15 Minute	167	205.83	47.64	1637558.78	
Speech Therapy Total:							104330.30
Speech Therapy		15 minute	161	15.91	40.73	104330.30	
Transportation Total:							38212172.25
Transportation		Mile	24500	116.83	13.35	38212172.25	
GRAND TOTAL: 2352872014.52 Total: Services included in capitation: 2352872014.52 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 136901 Factor D (Divide total by number of participants): 17186.67 Services included in capitation: 17186.67 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Companion Total:							150616260.24
Adult Companion		15 minute	25758	950.79	6.15	150616260.24	
Assisted Living Total:							464043391.31
Assisted Living		Day	33945	34.45	396.82	464043391.30	
Behavior Management Total:							3413642.97
Behavior Management		15 minute	1506	190.96	11.87	3413642.97	
Caregiver Training Total:							1484.45
Caregiver Training		15 minute	7	7.42	28.58	1484.45	
Home Accessibility Adaptations Total:							4000737.66
Home Accessibility Adaptations		Job	3068	1.58	825.33	4000737.66	
Home Delivered Meals Total:							57445855.26
Home Delivered Meals		Meal	44091	205.18	6.35	57445855.26	
Medication Administration Total:							226484.83
Medication Administration		Administration	52	138.05	31.55	226484.83	
Medication Management Total:							144385.22
Medication Management		Evaluation	103	74.13	18.91	144385.22	
Nutritional Assessment and Risk Reduction Total:							3027.02
Special Drug and Nutritional Assessment Services		15 minute	42	2.40	30.03	3027.02	
Personal Emergency Response System (PERS) Total:							7959787.98
GRAND TOTAL: 2352872014.52 Total: Services included in capitation: 2352872014.52 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 136901 Factor D (Divide total by number of participants): 17186.67 Services included in capitation: 17186.67 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System Maintenance		Monthly Maintenance	31715	8.35	29.83	7899588.06	
Personal Emergency Response System Installation		Installation	773	1.03	75.61	60199.93	
GRAND TOTAL: 2352872014.52 Total: Services included in capitation: 2352872014.52 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 136901 Factor D (Divide total by number of participants): 17186.67 Services included in capitation: 17186.67 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							119909372.26
Adult Day Health Care		15 minute	11481	1477.25	7.07	119909372.26	
Case Management Total:							153974812.84
Case Management		Month	143603	8.56	125.26	153974812.84	
Homemaker Total:							426791697.55
Homemaker		15 minute	74543	875.45	6.54	426791697.55	
Respite Total:							69526404.94
GRAND TOTAL: 2649384013.06 Total: Services included in capitation: 2649384013.06 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 143603 Factor D (Divide total by number of participants): 18449.36 Services included in capitation: 18449.36 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite In Home		15 minute	11598	891.53	6.59	68140368.95	
Respite Facility Based		15 minute	568	305.79	7.98	1386035.99	
Attendant Care Total:							25701843.72
Attendant Care		Hour	522	4614.55	10.67	25701843.72	
Intermittent and Skilled Nursing Total:							81779255.08
Intermittent and Skilled Nursing		15 minute	1939	1288.21	32.74	81779255.08	
Medical Equipment and Supplies Total:							53875959.09
Medical Equipment and Supplies		Item	66649	973.92	0.83	53875959.09	
Occupational Therapy Total:							7383411.65
Occupational Therapy		15 minute	5410	53.71	25.41	7383411.65	
Personal Care Total:							876289633.39
Personal Care		15 minute	74824	1694.84	6.91	876289633.39	
Physical Therapy Total:							11469848.99
Physical Therapy		15 minute	7741	55.37	26.76	11469848.99	
Respiratory Therapy Total:							1746982.12
Respiratory Therapy		15 Minute	175	205.83	48.50	1746982.12	
Speech Therapy Total:							111477.23
Speech Therapy		15 minute	169	15.91	41.46	111477.23	
Transportation Total:							43474957.18
Transportation		Mile	25699	116.83	14.48	43474957.18	
Adult Companion Total:							171348264.72
Adult Companion		15 minute	27019	950.79	6.67	171348264.72	
GRAND TOTAL: 2649384013.06 Total: Services included in capitation: 2649384013.06 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 143603 Factor D (Divide total by number of participants): 18449.36 Services included in capitation: 18449.36 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							527878800.35
Assisted Living		Day	35606	34.45	430.35	527878800.34	
Behavior Management Total:							3644738.94
Behavior Management		15 minute	1580	190.96	12.08	3644738.94	
Caregiver Training Total:							1726.78
Caregiver Training		15 minute	8	7.42	29.09	1726.78	
Home Accessibility Adaptations Total:							4271895.64
Home Accessibility Adaptations		Job	3218	1.58	840.19	4271895.64	
Home Delivered Meals Total:							61301329.04
Home Delivered Meals		Meal	46249	205.18	6.46	61301329.04	
Medication Administration Total:							243879.13
Medication Administration		Administration	55	138.05	32.12	243879.13	
Medication Management Total:							154116.27
Medication Management		Evaluation	108	74.13	19.25	154116.27	
Nutritional Assessment and Risk Reduction Total:							3228.19
Special Drug and Nutritional Assessment Services		15 minute	44	2.40	30.57	3228.19	
Personal Emergency Response System (PERS) Total:							8500377.97
Personal Emergency Response System Maintenance		Monthly Maintenance	33267	8.35	30.37	8436161.90	
GRAND TOTAL: 2649384013.06 Total: Services included in capitation: 2649384013.06 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 143603 Factor D (Divide total by number of participants): 18449.36 Services included in capitation: 18449.36 Services not included in capitation: Average Length of Stay on the Waiver: 272							

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System Installation		Installation	810	1.03	76.97	64216.07	
GRAND TOTAL: 2649384013.06 Total: Services included in capitation: 2649384013.06 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 143603 Factor D (Divide total by number of participants): 18449.36 Services included in capitation: 18449.36 Services not included in capitation: Average Length of Stay on the Waiver: 272							