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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

1. Request Information (1 of 3)

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

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

Comprehensive Intellectual and Developmental Disabilities Managed Care Pilot Program

C. Type of Request: new

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**

☐ **New to replace waiver**

Replacing Waiver Number:

Base Waiver Number:

Amendment Number (if applicable):

Effective Date: (mm/dd/yy)

Waiver Number:FL.2346.R00.00

Draft ID: FL.070.00.00

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

Regular Waiver

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

04/01/24

Approved Effective Date: 04/01/24

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and

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

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs)

approved under the following authorities
Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Florida continues to be committed to individuals with unique abilities and their families to ensure they achieve their God-given potential and thrive. As such, Florida embraces a mission to support individuals with unique abilities and their families in living, learning, and working within their communities by creating multiple pathways to possibilities.

Section 409.9855, Florida Statutes, authorizes an integrated pilot program for persons with developmental disabilities. This pilot program will allow up to 600 individuals deemed eligible by the Agency for Persons with Disabilities (APD) based on a series of criteria outlined in law to voluntarily enroll in the pilot program, and receive all medical, long-term care, and Developmental Disabilities Individual Budgeting (iBudget) Waiver services through a managed care delivery model. The Agency for Health Care Administration (AHCA) will work with the APD to pilot a comprehensive managed care plan model to recipients in certain parts of the State that could be eligible for waiver services through the fee for service delivery system.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- ○ **No**
- ◉ **Yes**

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

- ☒ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

Region D which consists of Hardee, Hillsborough, Highlands, Manatee, and Polk counties; and Region I, which consists of Miami-Dade and Monroe counties.

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver

will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals:

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

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

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

AHCA provided public notice as specified in 42 CFR 441.304(f) to solicit meaningful input from recipients, providers, tribal organizations, and all stakeholders on waiver submissions. The 30-day comment period was from July 28, 2023, to August 27, 2023. On July 28, 2023, the State published the 30-day public notice and comment period in the Florida Administrative Register (FAR), emailed the two tribal representatives, and published a provider alert.

The FAR notice gives AHCA staff phone and mail contact information to request more information about the waiver. Included in the public notice is an AHCA staff member's direct phone number and AHCA's Florida Relay Service TDD and voice numbers. If any interested party requests a printed copy of the waiver materials, AHCA will provide them in the manner requested (printed copy sent by US mail or made available for pickup at an AHCA office). The AHCA website was updated with a dedicated waiver page, which included a complete copy of the waiver in PDF form for the entire 30-day public notice and comment period.

Public comments received are summarized by the following:
•Service provider questions about their eligibility for the Pilot
•Support coordinator questions about future plans for IDD related programs
•Comments about evaluation, risks, and future program manageability
•Comments about dental managed care
•Questions about how this program will be different, and funded, compared to the current Developmental Disabilities Individual Budgeting (iBudget) Waiver
•Recommendations on how the program should be created, evaluated, and managed
•Recommendations on how the pilot program should be structured, recommendations to streamline processes that impact current provider community, recommendations on accountability of the pilot plans for this population and new services, recommendation on payment standards and rate setting.
•Concerns about Consumer Directed Care+ (CDC+), inclusion into community life, and chosen managed care plan's experience with medical and behavioral health of people with IDD
•Recommendations to help clarify the waiver, strengths and weaknesses of the waiver, including elements of long-term care and behavioral health
•Comments addressing current system adequacies; believes case managers, direct care staff, and decision makers on authorizations should have experience with people with IDD; believes waiver sets unclear expectations for voluntary caregivers; believes quality control, data collection and oversight are vague or insufficient; believes it is unclear how "comprehensive" medical services will be provided and how AHCA will oversee adequate delivery.
•Concerns about a managed-care delivery model for the IDD population.
•Provider comments in support of waiver
•Comments about care management process

The State of Florida has one of the most robust government transparency laws in the country, known as Florida's Government in the Sunshine Law, as outlined in Chapter 286 Florida Statutes (F.S.). The Agency utilizes the Florida Administrative Register to notify stakeholders of Medicaid policy actions the Agency takes, including information or actions regarding Medicaid Waiver programs administered by the Agency. This is the established method by which state administrative actions must be noticed to the public in accordance with Chapter 120 F.S. and in alignment with the Sunshine Law. As such, the Agency noticed the intent to submit the Pilot waiver to the public in the Florida Administrative Register. Additionally, as the Agency was directed to pursue the federal authority for this waiver legislatively, the legislation approving the Pilot Program went through the state's legislative session and the associated public engagement processes. The public was invited to participate in several legislative hearings and meetings regarding the development of the Pilot Program legislation, including the opportunity to provide public testimony. In addition to having electronic access to proposed legislation and an invitation to participate in committee hearings, various documents and publications are prepared by the Secretary of the Senate for the public such as: Amendments, Bills, Calendars of current Senate business (daily/weekly), Chamber Documents, Committee Documents, Senate Directories, Handbooks, Manuals, Reports, Floor votes and daily business journals, all of which can be made available for pick up at the Senate Services Center, 301 Capitol, upon request and free of cost. Lastly, the Agency is working closely with its state partner, the Agency for Persons with Disabilities (APD), on the administration of this program, as APD is statutorily named as the primary Agency for services provided to the developmentally disabled population in the State of Florida. Both the Agency and APD attend and participate in stakeholder meetings, including Developmental Disability (DD) Council meetings. Additionally, AHCA and APD participate with Qlarant, the state's quality improvement vendor for the 1915(c) Developmental Disabilities Individual Budgeting Waiver, in a Quality Council. The pilot program has been an agenda topic at each DD Council meeting and Quality Council meeting since the legislative language was first introduced. DD Council and Quality Council meetings include providers, self-advocates, family members, and staff from other partner

agencies. They are also open to the public and the public can make comment during these meetings if they wish to. Additionally, there are regular calls between APD, stakeholder groups, and providers, which have included high-level discussion about the pilot program.

144 comments were received, indicating a thorough response from all interested stakeholders. All comments were thoroughly considered. One update was made to the initial waiver request based on concerns about the care management process: The “agency” provider type was removed from the “Care Coordination” service.

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: McGrath

First Name: Catherine

Title: AHC Administrator

Agency: Agency for Health Care Administration

Address: 2727 Mahan Drive

Address 2: Mail Stop #20

City: Tallahassee

State: **Florida**

Zip: 32308

Phone: (850) 412-4256 **Ext:** ☐ **TTY**

Fax: (850) 414-1721

E-mail: Catherine.McGrath@ahca.myflorida.com

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Florida**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

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

Signature: Jason Weida

State Medicaid Director or Designee

Submission Date: Mar 20, 2024

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

Last Name: Weida

First Name: Jason

Title: Secretary

Agency: Agency for Health Care Administration

Address: 2727 Mahan Drive

Address 2: Mail Stop #8

City: Tallahassee

State: **Florida**

Zip: 32308

Phone: (850) 412-4118 **Ext:** ☐ **TTY**

Fax: (850) 488-2520

E-mail: Jason.Weida@ahca.myflorida.com

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

◉ **The Medical Assistance Unit.**

Specify the unit name:

Agency for Health Care Administration, Medicaid Division

(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 will contract with a Comprehensive Intellectual and Developmental Disabilities Managed Care Pilot (Pilot) Plan in each of the State's two regions to provide services through their provider networks.

The Pilot Plan will be responsible for delivering services congruent with the program 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, in consultation with APD, is responsible for assessment of the quality assurance for the Comprehensive Intellectual and Developmental Disabilities Managed Care Pilot Plan Waiver.

Appendix A: Waiver Administration and Operation

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

The contract with Comprehensive Intellectual and Developmental Disabilities Managed Care Pilot (Pilot) Plans requires Pilot 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 Pilot plans.

The annual contract compliance monitoring process assesses each contract requirement through a process that includes combined desk reviews and on-site visits as well as conducting face-to-face visits with a sample number of plan enrollees to determine satisfaction with program services and plans of care throughout the year. At the conclusion of the annual monitoring, 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. Deficiencies involving plan member life, health, and safety issues must be corrected immediately.

By contract, plans are required to submit performance improvement plans (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.

Section 409.9855, F.S. specifies that AHCA, in consultation with APD, shall conduct audits of the selected plans' implementation of person-centered planning and conduct quality assurance monitoring of the pilot program to include client satisfaction with services, client health and safety outcomes, client well-being outcomes, and service delivery in accordance with the client's care plan.

AHCA, in consultation with APD, shall establish specific measures of access, quality, and costs of the pilot program. The agency may contract with an independent evaluator to conduct such evaluation. The evaluation must include assessments of cost savings; consumer education, choice, and access to services; plans for future capacity and the enrollment of new Medicaid providers; coordination of care; person-centered planning and person-centered well-being outcomes; health and quality-of-life outcomes; and quality of care by each eligibility category and managed care plan in each pilot program site. The evaluation must describe any administrative or legal barriers to the implementation and operation of the pilot program in each region.

AHCA, in consultation with APD, shall submit progress reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives on an annual basis.

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☒	☐
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☐
Level of care evaluation	☒	☒
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☒
Utilization management	☒	☒
Qualified provider enrollment	☒	☒

Function	Medicaid Agency	Contracted Entity
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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percentage of case 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% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of AHCA-reviewed case files that are 100% compliant with contract requirements. N: Number of case files that are 100% compliant. D: Total number of case 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 = 95% +/- 5%
☐ **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:
Number and percentage of Pilot Plans' Performance Improvement Plans (PIPs) validated annually by the External Quality Review Organization (EQRO). N: Number of Pilot Plans' PIPs validated annually by the EQRO. D: Total number of Pilot Plans' PIPs 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:

Performance Measure:
Number and percentage of new settings providers that meet the HCBS settings requirements. N: Number of new settings providers that meet the HCBS settings requirements. D: Total number of all new settings providers.

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

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of ongoing settings providers that meet the HCBS settings requirements at their recredentialing determination. N: Number of recredentialed settings providers that meet the HCBS settings requirements. D: Total number of all settings providers recredentialed.

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

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

Data Aggregation and Analysis:

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

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

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.

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

b. Methods for Remediation/Fixing Individual Problems

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

AHCA and APD monitor that case record reviews were completed in accordance with the approved sampling methodology and overall compliance with contract requirements. If a deficiency is determined, the Pilot Plan is required to develop a corrective action plan to address the deficiency and submit to AHCA and APD for approval.

The contract with the Pilot 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 AHCA and APD for approval.

It is the State's intention that the Pilot 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 the Pilot Plans a capitated monthly fee for each recipient, 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.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **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 Â§441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐

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

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

Eligibility for waiver services is identified in Chapter 393 and Section 409.9855, F.S. Once eligibility is established under Florida Statutes by APD, an individual must meet the waiver level of care criteria to enroll in the waiver. The initial statutory criteria is as follows: "Developmental disability" means a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, or Prader-Willi Syndrome that manifests before the age of 18 and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely. "Autism" means a pervasive, neurologically based developmental disability of extended duration which causes severe learning, communication, and behavior disorders with age of onset during infancy or childhood. Individuals with autism exhibit impairment in reciprocal social interaction, impairment in verbal and nonverbal communication and imaginative ability, and a markedly restricted repertoire of activities and interests. "Cerebral palsy" means a group of disabling symptoms of extended duration which results from damage to the developing brain that may occur before or after birth and that results in the loss or impairment of control over bodily muscles. For the purposes of this definition, cerebral palsy does not include those symptoms or impairments resulting solely from a stroke. "Down Syndrome" means a disorder caused by the presence of an extra chromosome 21. "Intellectual disability" means significantly subaverage intellectual functioning existing concurrently with deficits in adaptive behavior which manifests before the age of 18 and can reasonably be expected to continue indefinitely. for the purposes of this definition, the term: (a) "Adaptive behavior" means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age, cultural group, and community. (b) "Significantly subaverage general intellectual functioning" means performance that is two or more standard deviations from the mean score on a standardized intelligence test specified in the rules of the agency. "Prader-Willi Syndrome" means an inherited condition typified by neonatal hypotonia with failure to thrive, hyperphagia or an excessive drive to eat which leads to obesity usually at 18 to 36 months of age, mild to moderate intellectual disability, hypogonadism, short stature, mild facial dysmorphism, and a characteristic neurobehavior. "Spina bifida" means a person with a medical diagnosis of spina bifida cystica or myelomeningocele. "Phelan-McDermid Syndrome" means a disorder caused by the loss of the terminal segment of the long arm of chromosome 22, which occurs near the end of the chromosome at a location designated q13.3, typically leading to developmental delay, intellectual disability, dolicocephaly, hypotonia, or absent or delayed speech. The criteria for waiver level of care can be found in the waiver application in Appendix B: Participant Access and Eligibility, B-6: Evaluation/Reevaluation of Level of Care. The Agency for Persons with Disabilities (APD) maintains the statewide preenrollment status of individuals eligible but not enrolled for iBudget Waiver services. Enrollment in the Comprehensive Intellectual and Developmental Disabilities Managed Care Pilot Waiver is available only to individuals eligible for Medicaid in an iBudget Waiver preenrollment category 1-6, is age 18 or older, and reside in a Pilot Program region.

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

○ **Other**

Specify:

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	600
Year 2	600
Year 3	600

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

Eligibility for waiver services is identified in Chapter 393 and Section 409.9855, F.S. Once eligibility is established under Florida Statutes, an individual must meet the waiver level of care criteria to enroll in the waiver.

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

The Agency for Persons with Disabilities (APD) maintains the statewide preenrollment status of individuals eligible but not enrolled for iBudget Waiver services. Enrollment in the Comprehensive Intellectual and Developmental Disabilities Managed Care Pilot Waiver is available only to individuals eligible for Medicaid in an iBudget Waiver preenrollment category 1-6, is age 18 or older, and reside in a Pilot Program region.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

2. Miller Trust State.

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

- ( ) **No**

◉ **Yes**

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

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

☐ **Low income families with children as provided in §1931 of the Act**

☒ **SSI recipients**

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

☐ **Optional state supplement recipients**

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

Select one:

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

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

Specify percentage:

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

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

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

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

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

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

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

Specify:

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

○ **Not Applicable (see instructions)**

◉ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

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

◉ **The state establishes the following reasonable limits**

Specify:

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

The medical/remedial care service or item must meet all of the following criteria:
a. Be recognized under state law; and
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 periods before January 1, 2014 or after December 31, 2018.

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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:

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 five-year period beginning January 1, 2014.

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

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 five-year period beginning January 1, 2014.

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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 a government agency under contract with the Medicaid agency.**

Specify the entity:

The Agency for Persons with Disabilities (APD) has an interagency agreement with the Agency for Health Care Administration (AHCA).

○ **Other**

Specify:

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

Agency for Persons with Disabilities (APD) staff shall meet the following minimum qualifications: two years of professional experience in developmental disabilities, special education, mental health, counseling, guidance, social work, or health and human services. A degree can substitute for one year of the required experience.

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

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

The eligibility requirements are set in Chapter 393, Florida Statutes, per the Florida Legislature.

I. Level of Care Eligibility: An individual who has applied for developmental disability Medicaid waiver services who meets one of the following criteria and is eligible to receive the services provided in an ICF/IDD.
(1) The individual's primary disability is intellectual disability with an intelligence quotient (IQ) of 59 or less.
(2) The individual's primary disability is intellectual disability with an IQ of 60-70 inclusive, and has at least one of the Handicapping Conditions listed below OR the individual's primary disability is intellectual disability with an IQ of 60-70 inclusive and the individual has severe functional limitations in at least three of the Major Life Activities listed below.
(3) The individual has a diagnosis of Autism, Cerebral Palsy, Down Syndrome, Spina Bifida, Phelan McDermid Syndrome, or Prader-Willi Syndrome, and the individual has severe functional limitations in at least three of the Major Life Activities listed below.

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

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

AHCA periodically monitors client status and wait-list enrollment to prevent any restriction of access to care for applicants.

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

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

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

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

APD staff will evaluate an individual's level of care (LOC) at initial enrollment, using APD forms (1) Home and Community-Based Services Waiver Eligibility Worksheet, and (2) Support Plan. At the annual LOC redetermination, the Pilot Plan will conduct the review and send the documentation to APD for their final LOC evaluation determination. The same APD forms will be used for the initial and annual LOC determination. Pilot Plan staff will be trained on the two APD forms. During the process, the individual is presented with options for maximum community integration according to their needs in addition to a reevaluation of the LOC.

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

- ○ **Every three months**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**

Specify the other schedule:

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

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

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

Specify the qualifications:

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):*

AHCA monitors the timeliness of level of care reevaluations during records reviews. Additionally, APD may implement a process that allows for the input and tracking of the annual level of care reevaluations.

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

Records of evaluation and reevaluation of level of care are maintained by APD in the recipient's central file.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percentage of new applicants receiving a level of care (LOC) evaluation prior to enrollment. N: Number of new applicants receiving a LOC evaluation prior to enrollment. D: Number of new applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Records transfer

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

Performance Measure:
 # and % of annual level of care (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. 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% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percentage of 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 reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Pilot 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 = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

If enrollees do not have a current level of care based upon the state approved assessment tool, the Pilot Plans are required to correct the issue within a specified time frame. If the Pilot Plans do not correct the issue within the specified time frame, the Pilot 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** 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).

Care coordinators are required to inform applicants of their freedom of choice of institutional, waiver services, and choice of provider. Comprehensive Intellectual and Developmental Disabilities Managed Care Pilot Plans document this choice using a standardized form that requires signatures of the recipient or legal representative.

As part of the Pilot Plan 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 Pilot 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 Pilot Plan assigns a care coordinator and contacts the enrollee about an appointment for their assessment for use in care plan development. During the initial assessment appointment, the care coordinator 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 care coordinator, and the care coordinator must discuss with the enrollee his/her individual needs and develop the initial plan of care. The care coordinator 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 Pilot Plan must provide an enrollee with procedures to follow if they choose to complete the appeal process and/or the Fair Hearing process.

The Pilot Plans provide the same HCBS, however expanded benefit service offerings may vary. AHCA 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.

Pilot Plan care coordinators confirm enrollees' choice of institutional setting or HCBS by obtaining a signed Freedom of Choice form during the initial assessment meeting. Pilot Plan care coordinators 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.

The Pilot Plan maintains all person-centered support plan and level of care (LOC) forms in the enrollee's records. APD also maintains records of evaluation and LOC (initial and redetermination) in the individual's central file.

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 Comprehensive Intellectual and Developmental Disabilities Managed Care Pilot (Pilot) Plans are required to develop and make available appropriate foreign language versions of all materials available to recipients. The State and Pilot Plans are required to provide interpreter services in person where practical, but otherwise by telephone, for recipients whose primary language is not English. 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	**Care Coordination**		
Statutory Service	**Life Skills Development Level 3 - Adult Day Training**		
Statutory Service	**Life Skills Development Level 4 - Prevocational Services**		
Statutory Service	**Residential Habilitation**		
Statutory Service	**Respite**		
Extended State Plan Service	**Adult Dental Services**		
Extended State Plan Service	**Occupational Therapy**		
Extended State Plan Service	**Physical Therapy**		
Extended State Plan Service	**Respiratory Therapy**		
Extended State Plan Service	**Skilled Nursing**		
Extended State Plan Service	**Specialized Medical Equipment and Supplies**		
Extended State Plan Service	**Specialized Mental Health Counseling**		
Extended State Plan Service	**Speech Therapy**		
Extended State Plan Service	**Transportation**		
Other Service	**Assisted Living**		
Other Service	**Behavior Analysis Services**		
Other Service	**Behavior Assistant Services**		
Other Service	**Dietitian Services**		
Other Service	**Environmental Accessibility Adaptations**		
Other Service	**Home Delivered Meals**		
Other Service	**Life Skills Development Level 1 - Companion**		
Other Service	**Life Skills Development Level 2 - Supported Employment**		
Other Service	**Medication Administration**		
Other Service	**Medication Management**		
Other Service	**Personal Emergency Response System (PERS)**		
Other Service	**Personal Supports**		
Other Service	**Private Duty Nursing**		
Other Service	**Residential Nursing**		
Other Service	**Specialized Medical Home Care**		
Other Service	**Supported Living Coaching**		
Other Service	**Unpaid Caregiver Training**		

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:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health Care

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04050 adult day health
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 enrollee is at the center during mealtimes. 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 Pilot 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 Pilot plan may contract with the adult day health provider for the delivery of these services or the Pilot plan may contract with other providers qualified to deliver these services pursuant to the terms of the Pilot Plan contract. All direct service professionals providing Pilot waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

Services are generally furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services may not constitute a "full nutritional regimen" (i.e., up to 2 meals per day and which do not constitute a full nutritional regimen is permitted).

As a Managed Care Plan, the Pilot Plan negotiates rates for covered services with their providers. Non-emergency transportation is a covered waiver 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 services must be authorized in the enrollee’s person-centered support plan.

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

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

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

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

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

Provider Specifications:

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

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 Pilot Waiver must be licensed under Section 429, Part I, F.S. Section 429.918, F.S., 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):*

Pilot 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-5.0l9, 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 or its designee

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: 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 to the Pilot Plan must be licensed under Section 429, Part III, F.S., 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 incapacity. 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Care Coordination

HCBS Taxonomy:

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

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. Care coordination 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.

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

Care coordination includes a family focused, holistic approach that works with and guides the client while building collaboration with all parties at the table. Care coordinators act as an information hub coordinating, maintaining, and monitoring a service plan that focuses on the underlying client and family dynamics and connection to appropriate services to support the health, safety, and well-being of the client and support system as a whole.

Care coordination requires ongoing person-centered service planning in accordance with the requirements set forth in 42 CFR 441.301.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Case managers employed or contracted by Pilot plans

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Care Coordination

Provider Category:

Individual

Provider Type:

Case managers employed or contracted by Pilot plans

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Pilot Plan care coordinators 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.

Care coordinators can also be qualified as a Licensed Practical Nurse in Florida with a minimum of four (4) years of relevant experience.

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

Care coordinators 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 care coordinators 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Life Skills Development Level 3 - Adult Day Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Adult Day Training (ADT) services support the participation of recipients in valued routines of the community, in settings that are age and culturally appropriate. The training, activities, and routine established by the ADT provider must be meaningful to the recipient and provide an appropriate level of variation and interest. This includes the provision of regularly scheduled activities in a non-residential setting, separate from the participant's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living. Meals are not included in this service.

Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice. Services are furnished consistent with the participant's person-centered care plan.

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

As a Managed Care Plan, the Pilot Plan negotiates rates for covered services with their providers. Non-emergency transportation is a covered waiver 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 services must be authorized in the enrollee’s person-centered support plan.

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

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

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

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

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Training Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Life Skills Development Level 3 - Adult Day Training

Provider Category:

Agency

Provider Type:

Adult Day Training Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The provider must meet the following minimum qualifications for staff and staffing ratio:
*The agency manager or director will not have full-time responsibility for providing direct services and will not be included in determining the staffing ratio.
*The program director must possess at a minimum an associate's degree from an accredited college or university and two years, hands-on, related experience.
*Supervisors of direct care staff will have a high school diploma or GED and one year of direct, care-related experience.
*Related experience will substitute on a year-for-year basis for the required college education.
*Direct service staff will work under appropriate supervision.
*The staffing ratio will not exceed 10 recipients per direct service staff for ADT facility-based programs (supervisory and other management staff can be included in determining the direct care staff ratio. Administrative staff and those not providing direct service to the recipient are not considered direct service staff).
*Direct service staff must be age 18 years or older at the time they are hired.

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:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

Life Skills Development Level 4 - Prevocational Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Prevocational services are services that provide training and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are time-limited (36 months, may restart but total 36 months) and with specific outcomes to be achieved, as determined by the individual and his/her service and supports planning team through an ongoing person-centered planning process, to be reviewed not less than annually or more frequently as requested by the individual. Individuals receiving prevocational services must have employment-related goals in their person-centered care plan; the general habilitation activities must be designed to support such employment goals. The successful outcome of prevocational services is competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational services should enable everyone to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills that lead to competitive and integrated employment including the ability to communicate effectively with supervisors, co-workers and customers; adhere to generally accepted community workplace conduct and dress; follow directions; attend to tasks; employ workplace problem solving skills and strategies; adhere to general workplace safety and mobility training.

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

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

As a Managed Care Plan, the Pilot Plan negotiates rates for the covered services with their providers. Non-emergency transportation is a covered waiver 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 services must be authorized in the enrollee’s person-centered support plan. Additionally, prevocational providers are paid separately for transportation services only when the service is authorized in the cost plan, the provider is enrolled as a transportation provider, and transportation is provided between a recipient’s place of residence and the training site. Transportation between prevocational sites, if the activities provided are a part of the respective services, will be included as a component and in the rate paid to the provider of prevocational services.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Training Center
Agency	Prevocational Services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Life Skills Development Level 4 - Prevocational Services

Provider Category:

Agency

Provider Type:

Adult Day Training Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The provider must meet the following minimum qualifications for staff and staffing ratio:
*The agency manager or director will not have full-time responsibility for providing direct services and will not be included in determining the staffing ratio.
*The program director must possess at a minimum an associate's degree from an accredited college or university and two years, hands-on, related experience.
*Supervisors of direct care staff will have a high school diploma or GED and one year of direct, care-related experience.
*Related experience will substitute on a year-for-year basis for the required college education.
*Direct service staff will work under appropriate supervision.
*The staffing ratio will not exceed 10 recipients per direct service staff for ADT facility-based programs (supervisory and other management staff can be included in determining the direct care staff ratio. Administrative staff and those not providing direct service to the recipient are not considered direct service staff).
*Direct service staff must be age 18 years or older at the time they are hired.

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:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Life Skills Development Level 4 - Prevocational Services

Provider Category:

Agency

Provider Type:

Prevocational Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The provider must meet the following minimum qualifications for staff and staffing ratio:
*The agency manager or director will not have full-time responsibility for providing direct services and will not be included in determining the staffing ratio.
*The program director must possess at a minimum an associate's degree from an accredited college or university and two years, hands-on, related experience.
*Supervisors of direct care staff will have a high school diploma or GED and one year of direct, care-related experience.
*Related experience will substitute on a year-for-year basis for the required college education.
*Direct service staff will work under appropriate supervision.
*The staffing ratio will not exceed 10 recipients per direct service staff for ADT facility-based programs (supervisory and other management staff can be included in determining the direct care staff ratio. Administrative staff and those not providing direct service to the recipient are not considered direct service staff).
*Direct service staff must be age 18 years or older at the time they are hired.

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:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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

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

As a Managed Care Plan, the Pilot Plan negotiates rates for the covered services with their providers. Non-emergency transportation is a covered waiver 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 services must be authorized in the enrollee’s person-centered support plan. Residential habilitation services can be provided in an adult family care home, assisted living facility, foster home, or group home setting, as identified under “Provider Specifications”.

Providers of residential habilitation services must comply with the provider qualification requirements specified in Rule 59G-13.070, Florida Administrative Code (F.A.C.), Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook. Exemptions are specified in Rule 65G-2.008, F.A.C., Staffing Requirements.

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Adult Family Care Home

Provider Qualifications

License *(specify):*

Adult Family Care Homes providing Residential Habilitation must be licensed in accordance with Chapters 408, Part II, and 429, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Providers of standard residential habilitation must hire direct care providers who are age 18 years and older, and have one year experience working in a medical, psychiatric, nursing, or child-care setting, or experience working with recipients with developmental disabilities, or have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Providers of group homes including standard, behavior focus, intensive behavior focus, and enhanced intensive behavior focus residential habilitation must be designated by the APD regional office and must consult with APD for the expressed purpose of ensuring adequate provider capacity before placing an enrollee of the pilot program in a group home licensed by APD. Agencies must hire direct care providers who are age 18 years and older, have at least a high school or GED diploma, have one year of experience working in a medical, psychiatric, nursing, or child-care setting, or experience working with recipients with developmental disabilities. In lieu of the required work experience, the employee may have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Additional qualifications for behavior focus, intensive behavior, and enhanced intensive behavior providers are included in the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, Rule 59G-13.070, F.A.C. For exemptions to this requirement, see Rule 65G-2.008, F.A.C.

All service providers must be in good standing with the Florida Medicaid program and APD. 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 AHCA authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

Assisted Living Facilities providing Residential Habilitation must be licensed in accordance with Chapters 409 and 429, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Providers of standard residential habilitation must hire direct care providers who are age 18 years and older, and have one year experience working in a medical, psychiatric, nursing, or child-care setting, or experience working with recipients with developmental disabilities, or have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Providers of group homes including standard, behavior focus, intensive behavior focus, and enhanced intensive behavior focus residential habilitation must be designated by the APD regional office and must consult with APD for the expressed purpose of ensuring adequate provider capacity before placing an enrollee of the pilot program in a group home licensed by APD. Agencies must hire direct care providers who are age 18 years and older, have at least a high school or GED diploma, have one year of experience working in a medical, psychiatric, nursing, or child-care setting, or experience working with recipients with developmental disabilities. In lieu of the required work experience, the employee may have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Additional qualifications for behavior focus, intensive behavior, and enhanced intensive behavior providers are included in the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, Rule 59G-13.070, F.A.C.

All service providers must be in good standing with the Florida Medicaid program and APD. 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 AHCA authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Foster Home

Provider Qualifications

License *(specify):*

Foster Homes providing Residential Habilitation must be licensed in accordance with Chapter 393, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Providers of standard residential habilitation must hire direct care providers who are age 18 years and older, and have one year experience working in a medical, psychiatric, nursing, or child-care setting, or experience working with recipients with developmental disabilities, or have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Providers of group homes including standard, behavior focus, intensive behavior focus, and enhanced intensive behavior focus residential habilitation must be designated by the APD regional office and must consult with APD for the expressed purpose of ensuring adequate provider capacity before placing an enrollee of the pilot program in a group home licensed by APD. Agencies must hire direct care providers who are age 18 years and older, have at least a high school or GED diploma, have one year of experience working in a medical, psychiatric, nursing, or child-care setting, or experience working with recipients with developmental disabilities. In lieu of the required work experience, the employee may have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Additional qualifications for behavior focus, intensive behavior, and enhanced behavior provider are included in the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, Rule 59G-13.070, F.A.C. For exemptions to this requirement, see Rule 65G-2.008, F.A.C.

All service providers must be in good standing with the Florida Medicaid program and APD. 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 AHCA authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License *(specify):*

Group Homes providing Residential Habilitation must be licensed in accordance with Chapter 393, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Providers of standard residential habilitation must hire direct care providers who are age 18 years and older, and have one year experience working in a medical, psychiatric, nursing, or child-care setting, or experience working with recipients with developmental disabilities, or have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Providers of group homes including standard, behavior focus, intensive behavior focus, and enhanced intensive behavior focus residential habilitation must be designed by the APD regional office and must consult with APD for the expressed purpose of ensuring adequate provider capacity before placing an enrollee of the pilot program in a group home licensed by APD. Agencies must hire direct care providers who are age 18 years and older, have at least a high school or GED diploma, have one year of experience working in a medical, psychiatric, nursing, or child-care setting, or experience working with recipients with developmental disabilities. In lieu of the required work experience, the employee may have 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Additional qualifications for behavior focus, intensive behavior, and enhanced intensive behavior providers are included in the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, Rule 59G-13.070, F.A.C. For exemptions to this requirement, see Rule 65G-2.008, F.A.C.

All service providers must be in good standing with the Florida Medicaid program and APD. 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 AHCA authorizes it to again participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09011 respite, out-of-home
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 family home, foster home, group home, adult day care center, or while involved in activities in the community. The Pilot Plan 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.

Federal financial participation may not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the state that is not a private residence per 42 CFR §441.360(b). Room and board is only paid when respite services are provided within nursing facilities licensed by the state under Section 400, Part II, F.S.

All direct service professionals providing Pilot Plan 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:

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Facility
Agency	Group Home
Agency	Hospice Agency
Agency	Nurse Registry
Agency	Community Care for the Elderly (CCE) Providers
Agency	Nursing Facility
Agency	Homemaker/Companion Agency
Agency	Adult Day Care Center
Agency	Centers for Independent Living
Agency	Home Health Agency
Agency	Housemaker/sitter/companion
Individual	Licensed Practical Nurse
Individual	Independent Vendors
Individual	Registered Nurse

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 Pilot 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 reasons 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License *(specify):*

Group Homes providing respite services to Pilot Waiver recipients must be licensed under Chapter 393, 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:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Hospice Agency

Provider Qualifications

License *(specify):*

Hospice agencies providing respite services to Pilot Waiver recipients must be licensed under Chapter 400, 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:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Nurse Registry

Provider Qualifications

License *(specify):*

Nurse registries must be licensed under Section 400.506, Florida Statutes, to participate in the Pilot Plan as a regular 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 reasons 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

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. Respite service providers employed by CCE Providers must have experience serving 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 reasons 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Nursing Facility

Provider Qualifications

License *(specify):*

Nursing Facilities providing respite services to Pilot Plan 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 reasons 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Homemaker/Companion Agency

Provider Qualifications

License *(specify):*

Homemaker and Companion agencies providing respite care services to Pilot Plan recipients must have registered in accordance with Chapter 400.509, Florida Statutes, and have experience serving 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 reasons 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

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 Pilot Plan.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

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 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Health Agencies must be licensed under Section 400, Part II, 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 reasons 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Housemaker/sitter/companion

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

Licensed Practical Nurses providing respite services to Pilot Waiver recipients must be licensed under Chapter 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 or its designee

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Independent Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Registered Nurses providing respite services to Pilot Waiver recipients must be licensed under Chapter 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 or its designee

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Adult Dental Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

All medically necessary dental services for children under the age of 21 are covered State Plan benefits. As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1915(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. Adult dental services covered by the waiver must not duplicate services provided by Medicaid State Plan dental services. A recipient must not receive more than ten quarter-hour units daily of medically necessary waiver services that exceed the amount, duration, and scope available from the dental plan.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Dental Agencies
Individual	Independent Dentists

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Dental Agencies

Provider Qualifications

License *(specify):*

Dentists providing Adult Dental Services to Pilot Waiver recipients must be licensed under Chapter 466, 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.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Independent Dentists

Provider Qualifications

License *(specify):*

Dentists providing Adult Dental Services to Pilot Waiver recipients must be licensed under Chapter 466, 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.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

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

Service Definition *(Scope):*

Occupational therapy services are services prescribed by a physician, ARNP, or physician assistant that produce specific functional outcomes in self-help, adaptive, and sensory motor skill areas, and assist the recipient to control and maneuver within the environment. The services may also include an occupational therapy assessment, which does not require a physician's prescription. In addition, this service may include training direct care staff and caregivers and monitoring those individuals to ensure they are carrying out therapy goals correctly.

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

These services are provided when Occupational Therapy services furnished under the approved state plan are exhausted. The scope and nature of these services do not differ from services furnished under the state plan. The provider qualifications specified under the state plan apply. The additional amounts of services that may be provided through the waiver are determined by the enrollee's approved plan of care and prior authorizations received.

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Occupational Therapist Assistant
Agency	Occupational Therapist
Agency	Nursing Facility
Agency	Outpatient Hospital Unit
Individual	Occupational Therapist Assistant
Individual	Occupational Therapist
Agency	Center for Independent Living

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 Pilot Plan recipients must be licensed under Section 400, Part III, Florida Statutes. Occupational Therapists employed by home health agencies and assigned to provide occupational therapy services to Pilot Waiver recipients must be licensed under Section 468, Part III, Florida Statutes.

Certificate *(specify):*

Other Standard *(specify):*

Home health agencies providing Occupational Therapy services to Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Occupational Therapist Assistant

Provider Qualifications

License *(specify):*

Occupational Therapist Assistants providing Occupational Therapy services to Pilot Waiver recipients must be licensed under Chapter 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

Occupational Therapists providing services to Pilot Waiver recipients must be licensed under Chapter 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Nursing Facility

Provider Qualifications

License *(specify):*

Nursing facilities who employ occupational therapists who are assigned to provide occupational therapy services to Pilot Plan 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 Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Outpatient Hospital Unit

Provider Qualifications

License *(specify):*

Outpatient hospital units providing occupational therapy services to Pilot Plan 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 Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Occupational Therapist Assistant

Provider Qualifications

License *(specify):*

Occupational Therapist Assistants providing occupational therapy services to Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

Occupational therapists providing occupational therapy services to Pilot Plan recipients must be 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Center for Independent Living

Provider Qualifications

License *(specify):*

Occupational therapists employed by Centers for Independent Living providing occupational therapy services to Pilot Plan recipients must be licensed under Section 468, Part III, Florida Statutes.

Certificate *(specify):*

Other Standard *(specify):*

Centers for Independent Living are defined under Section 413.371, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

These services are provided when Physical Therapy services furnished under the approved state plan are exhausted. The scope and nature of these services do not differ from services furnished under the state plan. The provider qualifications specified under the state plan apply. The additional amounts of services that may be provided through the waiver are determined by the enrollee's approved plan of care and prior authorizations received.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Centers for Independent Living
Individual	Physical Therapy Assistant
Individual	Physical Therapist
Agency	Home Health Agency
Agency	Outpatient Hospital Unit
Agency	Nursing Facility
Agency	Physical Therapy Assistant
Agency	Physical Therapist

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 Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Physical Therapy Assistant

Provider Qualifications

License *(specify):*

Physical therapy assistants providing physical therapy services to Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Physical therapists providing physical therapy services to Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

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

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Outpatient Hospital Unit

Provider Qualifications

License *(specify):*

Outpatient hospital units employing physical therapists and assistants to provide physical therapy services to Pilot Plan 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 Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Nursing Facility

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 Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Physical Therapy Assistant

Provider Qualifications

License *(specify):*

Physical Therapy Assistants providing physical therapy services to Pilot Waiver recipients must be licensed under Chapter 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Physical Therapists providing services to Pilot Waiver recipients must be licensed under Chapter 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Respiratory Therapy

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11110 respitory therapy

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Respiratory therapy is a service prescribed by a physician, ARNP, or physician assistant and relates to impairment of respiratory function and other deficiencies of the cardiopulmonary system. Treatment activities include ventilator support, therapeutic and diagnostic use of medical gases, respiratory rehabilitation, management of life support systems, bronchopulmonary drainage, breathing exercises and chest physiotherapy. The provider determines and monitors the appropriate respiratory regimen and maintains sufficient supplies to implement the regimen. The provider may also provide training to direct care staff to ensure adequate and consistent care is provided. Respiratory therapy services may also include a respiratory assessment.

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

These services are provided when Respiratory Therapy services furnished under the approved state plan are exhausted. The scope and nature of these services do not differ from services furnished under the state plan. The provider qualifications specified under the state plan apply. The additional amounts of services that may be provided through the waiver are determined by the enrollee's approved plan of care and prior authorizations received.

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Respiratory Therapist

Provider Qualifications

License *(specify):*

Respiratory Therapists providing services to Pilot Waiver recipients must be licensed under Chapter 468, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home health agencies employing respiratory therapists who may provide respiratory therapy services to Pilot Plan recipients must be licensed under Section 400, Part III, F.S. Respiratory therapists employed by home health agencies and assigned to provide respiratory therapy services to Pilot Plan 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 member in a safe and healthy manner in the least restrictive setting possible.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Nursing Facility

Provider Qualifications

License *(specify):*

Nursing facilities employing respiratory therapists who may be assigned to provide respiratory therapy services to Pilot Plan recipients in a non-nursing facility 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 therapy services to Pilot Plan 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 member in a safe and healthy manner in the least restrictive setting possible.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Respiratory Therapist

Provider Qualifications

License *(specify):*

Respiratory therapists providing services to Pilot Plan recipients must be licensed under Section 468, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Skilled Nursing

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

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

These services are provided when Skilled Nursing services furnished under the approved state plan are exhausted. The scope and nature of these services do not differ from services furnished under the state plan. The provider qualifications specified under the state plan apply. The additional amounts of services that may be provided through the waiver are determined by the enrollee's approved plan of care and prior authorizations received.

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Registered Nurses providing services to Pilot Waiver recipients must be licensed under Chapter 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 or its designee

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Registered Nurse Agency

Provider Qualifications

License *(specify):*

Registered Nurses providing services to Pilot Waiver recipients must be licensed under Chapter 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 or its designee

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

Licensed Practical Nurses providing services to Pilot Waiver recipients must be licensed under Chapter 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 or its designee

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Nurse Registry

Provider Qualifications

License *(specify):*

Nurse registries providing services to Pilot Plan recipients must be licensed under Section 400, Part III, Florida Statutes. Direct service providers assigned by home health agencies must have experience serving disabled adults and 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 or its designee

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Hospice Agency

Provider Qualifications

License *(specify):*

Hospice agencies providing services to Pilot Plan recipients must be licensed under Section 400, Part III, Florida Statutes. Direct service providers assigned by home health agencies must have experience serving disabled adults and 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 or its designee

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Licensed Practical Nurse Agency

Provider Qualifications

License *(specify):*

Licensed Practical Nurse Agencies providing services to Pilot Plan recipients must be licensed under Section 400, Part III, Florida Statutes. Direct service providers assigned by home health agencies must have experience serving disabled adults and 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 or its designee

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of Medicaid Agency.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home health agencies providing services to Pilot Plan recipients must be licensed under Section 408.810, Florida Statutes. Direct service providers assigned by home health agencies must have experience serving disabled adults and be licensed under Section 464, Florida Statutes.

Certificate *(specify):*

Other Standard *(specify):*

Home health agencies may also meet Federal Certificate 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**

14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations

Service Definition *(Scope):*

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

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

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

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

These services are provided when Specialized Medical Equipment and Supplies (Durable Medical Equipment and Medical Supplies) services furnished under the approved state plan are exhausted. The scope and nature of these services do not differ from services furnished under the state plan. The provider qualifications specified under the state plan apply. The additional amounts of services that may be provided through the waiver are determined by the enrollee's approved plan of care and prior authorizations received.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assistive Technology Supplies and Practitioners
Agency	Retail Stores
Agency	Home Health Agency
Agency	Home Medical Equipment Company
Individual	Pharmacy

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Assistive Technology Supplies and Practitioners

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Retail Stores

Provider Qualifications

License *(specify):*

Retail stores providing Specialized Medical Equipment and Supplies services to Pilot Plan recipients must be licensed under Section 205, Florida Statutes.

Certificate *(specify):*

Other Standard *(specify):*

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

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home health agencies providing Specialized Medical Equipment and Supplies services to Pilot Plan recipients must be licensed under Section 408.810, Florida Statutes.

Certificate *(specify):*

Other Standard *(specify):*

Home health agencies providing Specialized Medical Equipment and Supplies to Pilot Plan recipients may also meet Federal Condition 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 gain participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Medical Equipment Company

Provider Qualifications

License *(specify):*

Home Medical Equipment Companies providing Specialized Medical Equipment and Supplies services to Pilot Plan 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 gain participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Pharmacy

Provider Qualifications

License *(specify):*

Pharmacies providing Specialized Medical Equipment and Supplies services to Pilot Plan 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 gain participate in the Medicaid program.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Specialized Mental Health Counseling

HCBS Taxonomy:

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

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

Service Definition *(Scope):*

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

Specialized mental health counseling for persons with developmental disabilities are services provided to maximize the reduction of a recipient's mental illness and restoration to the best possible functional level. Specialized mental health services focus on the unique treatment of psychiatric disorders and rehabilitation for impairments for persons with developmental disabilities and mental illness. These services include specialized individual, group and family therapy provided to recipients using techniques appropriate to this population.

Specialized Mental Health Counseling services are provided in the provider's office, the recipient's place of residence, or anywhere in the community.

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

These services are provided when Specialized Mental Health (Specialized Therapeutic) services furnished under the approved state plan are exhausted. The scope and nature of these services do not differ from services furnished under the state plan. The provider qualifications specified under the state plan apply. The additional amounts of services that may be provided through the waiver are determined by the enrollee's approved plan of care and prior authorizations received.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Psychologist
Agency	Psychiatrist
Agency	Marriage and Family Therapist
Individual	Marriage and Family Therapist

Provider Category	Provider Type Title
Individual	Clinical Social Worker
Agency	Psychologist
Individual	Mental Health Counselor
Individual	Psychiatrist
Agency	Mental Health Counselor
Agency	Clinical Social Worker

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

Psychologists providing Specialized Mental Health Counseling services to Pilot Waiver recipients must be licensed under Chapter 490, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Two years' experience with individuals who have mental illness and developmental disabilities.

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:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Psychiatrist

Provider Qualifications

License *(specify):*

Psychiatrists providing Specialized Mental Health Counseling services to Pilot Waiver recipients must be licensed under Chapters 458 and 459, F.S.

Certificate *(specify):*

Psychiatrists providing Specialized Mental Health Counseling services to Pilot Waiver recipients must be certified under F.S. rule 59G-1.010, F.A.C.

Other Standard *(specify):*

Two years' experience with individuals who have mental illness and developmental disabilities.

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:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Marriage and Family Therapist

Provider Qualifications

License *(specify):*

Marriage and Family Therapists providing Specialized Mental Health Counseling services to Pilot Waiver recipients must be licensed under Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Two years' experience with individuals who have mental illness and developmental disabilities.

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 desginee

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Marriage and Family Therapist

Provider Qualifications

License *(specify):*

Marriage and Family Therapists providing Specialized Mental Health Counseling services to Pilot Waiver recipients must be licensed under Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Two years' experience with individuals who have mental illness and developmental disabilities.

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:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Clinical Social Worker

Provider Qualifications

License *(specify):*

Clinical Social Workers providing Specialized Mental Health Counseling services to Pilot Waiver recipients must be licensed under Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Two years' experience with individuals who have mental illness and developmental disabilities.

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:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

Psychologists providing Specialized Mental Health Counseling services to Pilot Waiver recipients must be licensed under Chapter 490, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Two years' experience with individuals who have mental illness and developmental disabilities.

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:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Mental Health Counselor

Provider Qualifications

License *(specify):*

Mental Health Counselors providing Specialized Mental Health Counseling services to Pilot Waiver recipients must be licensed under Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Two years' experience with individuals who have mental illness and developmental disabilities.

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:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Psychiatrist

Provider Qualifications

License *(specify):*

Psychiatrists providing Specialized Mental Health Counseling services to Pilot Waiver recipients must be licensed under Chapters 458 and 459, F.S.

Certificate *(specify):*

Psychiatrists providing Specialized Mental Health Counseling services to Pilot Waiver recipients must be certified under rule 59G-1.010, F.A.C.

Other Standard *(specify):*

Two years' experience with individuals who have mental illness and developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Mental Health Counselor

Provider Qualifications

License *(specify):*

Mental Health Counselors providing Specialized Mental Health Counseling services to Pilot Waiver recipients must be licensed under Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Two years' experience with individuals who have mental illness and developmental disabilities.

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:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Clinical Social Worker

Provider Qualifications

License *(specify):*

Clinical Social Workers providing Specialized Mental Health Counseling services to Pilot Waiver recipients must be licensed under Chapter 491, F.S.

Certificate *(specify):*

Other Standard *(specify):*

Two years' experience with individuals who have mental illness and developmental disabilities.

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:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Speech Therapy

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

These services are provided when Speech Therapy services furnished under the approved state plan are exhausted. The scope and nature of these services do not differ from services furnished under the state plan. The provider qualifications specified under the state plan apply. The additional amounts of services that may be provided through the waiver are determined by the enrollee's approved plan of care and prior authorizations received.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Speech-Language Pathologist
Individual	Audiology Assistant
Agency	Audiologist
Agency	Audiology Assistant
Agency	Hospital Outpatient Unit
Agency	Centers for Independent Living
Agency	Home Health Agency
Individual	Speech-Language Pathologist
Individual	Audiologist
Individual	Speech-Language Pathology Assistant
Agency	Speech-Language Pathology Assistant

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Speech Therapy

Provider Category:

Agency

Provider Type:

Speech-Language Pathologist

Provider Qualifications

License *(specify):*

Speech-language pathologists providing services to Pilot Waiver recipients must be licensed under Chapter 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Audiology Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Audiology assistants providing services to Pilot Waiver recipients must be certified under Chapter 468, Part I, F.S.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Audiologist

Provider Qualifications

License *(specify):*

Audiologists providing services to Pilot Waiver recipients must be licensed under Chapter 455, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Audiology Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Audiology assistants providing services to Pilot Waiver recipients must be certified under Chapter 468, Part I, F.S.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

AHCA or its designee

Frequency of Verification:

Upon initial enrollment or upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Hospital Outpatient Unit

Provider Qualifications

License *(specify):*

Hospital outpatient units providing speech therapy services to Pilot Plan 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 speech therapy services to Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License *(specify):*

Speech-language pathologists and assistants employed by Centers for Independent Living providing speech therapy services to Pilot Plan recipients must be licensed under Section 468, Part I, Florida Statutes.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

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

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Speech-Language Pathologist

Provider Qualifications

License *(specify):*

Speech-language pathologists and speech-language pathologist assistants providing speech therapy services to Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Audiologist

Provider Qualifications

License *(specify):*

Audiologists providing services to Pilot Waiver recipients must be licensed under Chapter 455, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Speech-Language Pathology Assistant

Provider Qualifications

License *(specify):*

Speech-language pathology assistants providing services to Pilot Waiver recipients must be licensed under Chapter 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:

Upon initial enrollment and upon reenrollment requirements of Medicaid Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Speech-Language Pathology Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Speech-language pathology assistants providing services to Pilot Waiver recipients must be certified under Chapter 468, Part I, F.S.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Transportation

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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 Pilot Waiver services have the requisite responsibility to encourage enrollee's independence, inclusion, and integration into the community.

Transportation services are provided to Waiver covered services and to Extended State Plan services covered in this waiver and authorized by the plan of care. Providers may not charge a copay under this waiver. The scope and nature of these services do not differ from services furnished under the state plan. The provider qualifications specified under the state plan apply. The additional amounts of services that may be provided through the waiver are determined by the enrollee's approved plan of care and prior authorizations received.

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

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

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

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

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

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

Provider Specifications:

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

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 Pilot 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Transportation

Provider Category:

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assisted Living

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08010 home-based habilitation
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 Pilot 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 Care Coordinator. The Pilot Plan shall be responsible for placing enrollees in the appropriate assisted living facility setting.

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 Care Coordinator 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, Care Coordinators 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.

Respite may be available to persons who receive residential habilitation under the waiver for the relief of a primary caregiver, provided there is no duplication of payment. When respite is furnished for the relief of the primary caregiver, those services may not be billed during the period that respite is furnished. Respite care may not be furnished for the purpose of compensating relief or substitute staff for a waiver residential service. The costs of such staff are met from payments for the waiver residential service.

Each enrollee's person-centered support plan must document personalized modifications from 441.201(c)(4)(VI)(A) through (D) based on a specific assessed need and justifications. Additionally, each enrollee's person-centered

support plan must maintain details required by 441.301(c)(4)(vi)(F)(1 through 8): Identify a specific and individualized assessed need; document the positive interventions and supports used prior to any modifications to the person-centered service plan; document less intrusive methods of meeting the need that have been tried but did not work; include a clear description of the condition that is directly proportionate to the specific assessed need; include regular collection and review of data to measure the ongoing effectiveness of the modification; include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; include the informed consent of the individual; and include an assurance that interventions and supports will cause no harm to the individual.

Payment may not be made for 24-hour skilled care. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

All direct service professionals providing Pilot Plan services have the requisite responsibility to encourage plan members' independence, inclusion, and integration into the community.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	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 Pilot Plan recipients must be licensed under Section 429, 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.

Additional qualifications: As a condition of Medicaid payment, ALFs must offer facility services to Pilot 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Analysis Services

HCBS Taxonomy:

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

Service Definition (Scope):

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

Each enrollee’s person-centered support plan must document personalized modifications from 441.201(c)(4)(VI)(A) through (D) based on a specific assessed need and justifications. Additionally, each enrollee’s person-centered support plan must maintain details required by 441.301(c)(4)(vi)(F)(1 through 8): Identify a specific and individualized assessed need; document the positive interventions and supports used prior to any modifications to the person-centered service plan; document less intrusive methods of meeting the need that have been tried but did not work; include a clear description of the condition that is directly proportionate to the specific assessed need; include regular collection and review of data to measure the ongoing effectiveness of the modification; include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; include the informed consent of the individual; and include an assurance that interventions and supports will cause no harm to the individual.

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

These services are provided when Behavior Analysis services furnished under the approved state plan are exhausted. The scope and nature of these services do not differ from services furnished under the state plan. The provider qualifications specified under the state plan apply. The additional amounts of services that may be provided through the waiver are determined by the enrollee's approved plan of care and prior authorizations received.

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Individual

Provider Type:

Mental Health Counselor

Provider Qualifications

License *(specify):*

Mental Health Counselors providing Behavior Analysis Services to Pilot Waiver recipients must be licensed 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Individual

Provider Type:

Clinical Social Worker

Provider Qualifications

License *(specify):*

Clinical Social Workers providing Behavior Analysis Services to Pilot Waiver recipients must be licensed 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Agency

Provider Type:

Marriage and Family Therapist

Provider Qualifications

License *(specify):*

Marriage and Family Therapists providing Behavior Analysis Services to Pilot Waiver recipients must be licensed 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Agency

Provider Type:

Clinical Social Worker

Provider Qualifications

License *(specify):*

Clinical Social Workers providing Behavior Analysis Services to Pilot Waiver recipients must be licensed 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

Psychologists providing Behavior Analysis Services to Pilot Waiver recipients must be licensed under Chapter 490, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Agency

Provider Type:

Behavior Analyst

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Behavior Analysts providing Behavior Analysis Services to Pilot Waiver recipients must be certified under Chapter 393, F.S.

Other Standard *(specify):*

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

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Agency

Provider Type:

Mental Health Counselor

Provider Qualifications

License *(specify):*

Mental Health Counselors providing Behavior Analysis Services to Pilot Waiver recipients must be licensed 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Agency

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

Psychologists providing Behavior Analysis Services to Pilot Waiver recipients must be licensed under Chapter 490, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Individual

Provider Type:

Marriage and Family Therapist

Provider Qualifications

License *(specify):*

Marriage and Family Therapists providing Behavior Analysis Services to Pilot Waiver recipients must be licensed 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Analysis Services

Provider Category:

Individual

Provider Type:

Behavior Analyst

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Behavior Analysts providing Behavior Analysis Services to Pilot Waiver recipients must be certified under Chapter 393, F.S.

Other Standard *(specify):*

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

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Assistant Services

HCBS Taxonomy:

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

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

Service Definition *(Scope):*

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

These services are one-on-one activities related to the delivery of behavior analysis services and are designated in and required by a behavior analysis service plan. Activities include monitoring of behavior analysis services, the implementation of behavioral procedures, data collection and display as authorized by the consumer's behavior analysis service plan, and training for caregivers. Behavior assistant services are designed for recipients for whom traditional residential habilitation services have been documented as unsuccessful or are considered inappropriate for health or safety reasons. These services may be provided in the provider's office, the recipient's place of residence, or anywhere in the community. However, in all cases, behavior assistant services must also be provided in the setting(s) relevant to the behavior problems being addressed.

Each enrollee’s person-centered support plan must document personalized modifications from 441.201(c)(4)(VI)(A) through (D) based on a specific assessed need and justifications. Additionally, each enrollee’s person-centered support plan must maintain details required by 441.301(c)(4)(vi)(F)(1 through 8): Identify a specific and individualized assessed need; document the positive interventions and supports used prior to any modifications to the person-centered service plan; document less intrusive methods of meeting the need that have been tried but did not work; include a clear description of the condition that is directly proportionate to the specific assessed need; include regular collection and review of data to measure the ongoing effectiveness of the modification; include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; include the informed consent of the individual; and include an assurance that interventions and supports will cause no harm to the individual.

All direct service professionals providing Pilot Plan 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:

Waiver services are limited to individuals over age 21.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Behavior Assistant
Agency	Behavior Assistant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Assistant Services

Provider Category:

Individual

Provider Type:

Behavior Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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

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

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Assistant Services

Provider Category:

Agency

Provider Type:

Behavior Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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

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

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Dietitian Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11040 nutrition consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Dietitian services are those services prescribed by a physician, ARNP, or physician assistant that maintain or improve the overall physical health of a recipient. The services include assessing the nutritional status and needs of a recipient; recommending an appropriate dietary regimen, nutrition support and nutrient intake; and providing counseling and education to the recipient, family, direct service staff and food service staff. The services may also include the development and oversight of nutritional care systems that promote a person's optimal health.

All direct service professionals providing Pilot Plan 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:

This waiver service is only provided to individuals aged 21 and over. All medically necessary services for children under the age of 21 are covered in the Early and Periodic Screening, Diagnostic, and Treatment State Plan benefits, under Section 383.011(1)(e)1, F.S.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Dietitian/Nutritionist or Nutrition Counselor
Agency	Home Health Agency
Individual	Dietitian/Nutritionist or Nutrition Counselor
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: Dietitian Services

Provider Category:

Agency

Provider Type:

Dietitian/Nutritionist or Nutrition Counselor

Provider Qualifications

License *(specify):*

Dietitians, Nutritionists, or Nutrition Counselors providing services to Pilot Plan recipients 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietitian Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home health agencies providing Nutritional Assessment and Risk Reduction services to Pilot Plan 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. 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietitian Services

Provider Category:

Individual

Provider Type:

Dietitian/Nutritionist or Nutrition Counselor

Provider Qualifications

License *(specify):*

Dietitians, Nutritionists, or Nutrition Counselors providing services to Pilot Plan recipients 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietitian Services

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License *(specify):*

Centers for Independent Living are defined in Section 413.371, F.S. Employees of Centers for Independent Living providing services to Pilot Plan recipients must be licensed as either a Dietician or Nutritionist in Nutrition Counselor 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietitian Services

Provider Category:

Agency

Provider Type:

Nurse Registry

Provider Qualifications

License *(specify):*

Nurse registries providing services to Pilot Plan 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. Nutrional Counselors or Dieticians 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietitian Services

Provider Category:

Agency

Provider Type:

Community Care for the Elderly (CCE) Providers

Provider Qualifications

License *(specify):*

Community Care for the Elderly (CCE) providers are defined under Section 410 and 430, F.S. CCE employees providing services to Pilot Plan recipients must be licensed as either a Dietician or Nutritionist in Nutrition Counselor 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Physical adaptations to the home, required by the individual's plan of care, which ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electronic and plumbing systems which are necessary to accommodate the medical equipment and supplies, which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home, which are of general utility, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

All direct service professionals providing Pilot Plan 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:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Architect
Agency	Engineer
Individual	Plumber
Individual	Carpenters/other Independent Vendors
Individual	Engineer
Agency	Architect
Agency	Centers for Independent Living
Individual	General Contractor/Electrician
Agency	Plumbers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Architect

Provider Qualifications

License *(specify):*

Architects providing Environmental Accessibility Adaptations services to Pilot Waiver recipients must be licensed under Chapter 481, F.S.

Certificate *(specify):*

Other Standard *(specify):*

One year experience in Rehabilitation Engineering or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Engineer

Provider Qualifications

License *(specify):*

Engineers providing Environmental Accessibility Adaptations services to Pilot Waiver recipients must be licensed under Chapter 471, F.S.

Certificate *(specify):*

Other Standard *(specify):*

One year experience in Rehabilitation Engineering or Rehabilitation Engineering and Assistive Technology Society of North American (RESNA) certification.

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 desginee

Frequency of Verification:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Plumber

Provider Qualifications

License *(specify):*

Plumbers providing Environmental Accessibility Adaptations services to Pilot Waiver recipients must be licensed under Chapter 552, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Carpenters/other Independent Vendors

Provider Qualifications

License *(specify):*

Carpenters and other Independent Vendors providing Environmental Accessibility Adaptations services to Pilot Waiver recipients must be licensed under Chapter 205, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Engineer

Provider Qualifications

License *(specify):*

Engineers providing Environmental Accessibility Adaptations services to Pilot Waiver recipients must be licensed under Chapter 471, F.S.

Certificate *(specify):*

Other Standard *(specify):*

One year experience in Rehabilitation Engineering or Rehabilitation Engineering and Assistive Technology Society of North American (RESNA) certification.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Architect

Provider Qualifications

License *(specify):*

Architects providing Environmental Accessibility Adaptations services to Pilot Waiver recipients must be licensed under Chapter 481, F.S.

Certificate *(specify):*

Other Standard *(specify):*

One year experience in Rehabilitation Engineering or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

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 Pilot Plan recipients must be licensed by the Department of Business and Professional Regulations (DBPR) under Section 489.131, Florida Statutes, and locally under Section 205, Florida Statutes.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

General Contractor/Electrician

Provider Qualifications

License *(specify):*

General Contractors providing home accessibility adaptations services to Pilot Plan recipients must be licensed by the Department of Business and Professional Regulations (DBPR) under Section 489.131, Florida Statutes, and locally under Section 205, 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:

Upon initial enrollment or upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Plumbers

Provider Qualifications

License *(specify):*

Plumbers providing Environmental Accessibility Adaptations services to Pilot Waiver recipients must be licensed under Chapter 552, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
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.

Meals provided as part of these services may not constitute a "full nutritional regimen" (i.e., up to 2 meals per day and which do not constitute a full nutritional regimen is permitted). This service will pay for up to 2 meals per day.

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

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.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Older American's Act Providers
Agency	Food Establishment
Agency	Community Care for the Elderly (CCE) Providers
Agency	Food Service 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:

Older American's Act Providers

Provider Qualifications

License *(specify):*

Older American Act providers are defined in Rule 58A-1, Florida Administrative Code. All entities providing Home Delivered Meals to Pilot Waiver recipients must be licensed under Section 500.12 or Section 509.241, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Food Establishment

Provider Qualifications

License *(specify):*

Food establishments providing home delivered meal services to Pilot Plan recipients must have a permit issued under Section 500.12, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: 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 Sections 410 and 430, F.S. All entities providing Home Delivered Meals to Pilot Waiver recipients must be licensed under Section 500.12 or Section 509.241, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Food Service Establishment

Provider Qualifications

License *(specify):*

Food Service Establishments providing home delivered meals to Pilot Plan recipients must be licensed under Section 509.241, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Life Skills Development Level 1 - Companion

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Life Skills Development Level 1 – Companion services consist of non-medical care, supervision, and socialization activities provided to recipients age 21 years or older. This service must be provided in direct relation to the achievement of the recipient's goals as specified in the recipient's care plan. The service provides access to community-based activities that cannot be provided by natural or other unpaid supports, and should be defined as activities most likely to result in increased ability to access community resources without paid support. These services can be scheduled on a regular, long-term basis.

Companion providers may support or assist an enrollee with volunteer activities.

Activities can be volunteer activities performed by the recipient as a pre-work activity or activities that connect a recipient to the community.

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

Life Skills Development Level 1 – Companion services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan to foster health, safety, and welfare of the recipient.

The waiver service is limited to individuals over age 21.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Independent Vendors
Agency	Adult Day Training Center
Agency	Agency Vendors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Development Level 1 - Companion

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Health Agencies providing Companion services to Pilot Waiver recipients must be licensed under Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

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

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Development Level 1 - Companion

Provider Category:

Individual

Provider Type:

Independent Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Development Level 1 - Companion

Provider Category:

Agency

Provider Type:

Adult Day Training Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Director: Associate's degree and two years of experience working with individuals with developmental disabilities.
Instructor/supervisor: High school or equivalent diploma and one year of experience in a related field .
Direct service: Age 18 and older.

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

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:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Development Level 1 - Companion

Provider Category:

Agency

Provider Type:

Agency Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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:

Upon initial enrollment and reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Life Skills Development Level 2 - Supported Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
03 Supported Employment	03022 ongoing supported employment, group
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supported employment services provide training and assistance to help support recipients in job development and sustaining paid employment at or above minimum wage unless the recipient is operating a small business. This service can be performed on a full or part-time basis and at a level of benefits paid by the employer for the same or similar work performed by trained non-disabled recipients. The provider assists with the acquisition, retention, or improvement of skills related to accessing and maintaining such employment, or developing and operating a small business. With the assistance of the provider, the recipient receives help in securing employment according to the recipient's knowledge, skills, abilities, supports needed, desired goals, and planned outcomes. This service is conducted in a variety of settings, including work sites in which individuals without disabilities are employed. This service should include assisting a recipient to learn job tasks needed to be employed, and the recipient should be included in all aspects of job development, interviewing, and job seeking activities.

Supported employment services include three models: Individual, Group, and Supported Self-Employment.

Supported Employment is provided to support, obtain and maintain competitive or customized employment in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

The enrollee's person-centered support plan and authorization records must include documentation related to Supported Employment and document if the service is not available through a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.)

Federal financial participation may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

Transportation is not a component of this service. Non-emergency transportation is a covered waiver 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 services must be authorized in the enrollee's person-centered support plan.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Providers
Agency	Agency Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Development Level 2 - Supported Employment

Provider Category:

Individual

Provider Type:

Individual Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Level 2: completion of required pre-service training

Other Standard *(specify):*

Providers of supported employment services must meet one or more of the following requirements:
* Have a bachelor's degree from an accredited college or university with a major in education, rehabilitative science, business or a related degree.
* Have an associate's degree or two years of college from an accredited college or university and have two years of documented direct experience with recipients with developmental disabilities.
* Have one year of college from an accredited college or university and three years of documented direct experience in working with recipients with developmental disabilities.
* Four years of direct professional experience in working with recipients with developmental disabilities may substitute for college on a year for year basis.

The provider must hold a valid high school diploma or GED diploma.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Development Level 2 - Supported Employment

Provider Category:

Agency

Provider Type:

Agency Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Level 2: completion of required pre-service training

Other Standard *(specify):*

Providers of supported employment services must meet one or more of the following requirements:
* Have a bachelor's degree from an accredited college or university with a major in education, rehabilitative science, business or a related degree.
* Have an associate's degree or two years of college from an accredited college or university and have two years of documented direct experience with recipients with developmental disabilities.
* Have one year of college from an accredited college or university and three years of documented direct experience in working with recipients with developmental disabilities.
* Four years of direct professional experience in working with recipients with developmental disabilities may substitute for college on a year for year basis.

The provider must hold a valid high school diploma or GED diploma.

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:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Medication Administration

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11030 medication assessment and/or management
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.

This waiver service is only provided to individuals aged 21 and over. All medically necessary services for children under the age of 21 are covered in the Early and Periodic Screening, Diagnostic, and Treatment State Plan benefits, under Section 383.011(1)(e)1, F.S.

All direct service professionals providing Pilot Plan 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:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Unlicensed Staff Member Trained Per 59A-36.011, F.A.C.
Agency	Home Health Agency

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

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 59A-36.011, F.A.C.

Provider Qualifications

License *(specify):*

Unlicensed staff members trained per Rule 59A-36.011, 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 Pilot Plan recipient who is receiving the medication resides.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medication Administration

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home health agencies providing Medication Administration services to Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: 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 Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medication Administration

Provider Category:

Agency

Provider Type:

Nurse Registry

Provider Qualifications

License *(specify):*

Nurse registries providing Medication Administration services to Pilot Plan recipients must be licensed under Section 400.506, F.S. Nurses assigned by nurse registries to provide Medication Administration services to Pilot Plan recipients 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Medication Management

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11030 medication assessment and/or management
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.

This waiver service is only provided to individuals aged 21 and over. All medically necessary services for children under the age of 21 are covered in the Early and Periodic Screening, Diagnostic, and Treatment State Plan benefits, under Section 383.011(1)(e)1, F.S.

All direct service professionals providing Pilot Plan 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:

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nurse Registries
Agency	Home Health Agencies
Individual	Registered Nurse, Licensed Practical Nurse
Individual	Pharmacist

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):*

Nurse registries providing Medication Management services to Pilot Plan recipients must be licensed under Section 400.506, F.S. Nurses assigned by nurse registries to provide Medication Management services to Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medication Management

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

Home health agencies providing Medication Management services to Pilot Plan recipients must be licensed under Section 400, Part III, F.S. Nurses assigned by home health agencies to provide Medication Management services to Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medication Management

Provider Category:

Individual

Provider Type:

Registered Nurse, Licensed Practical Nurse

Provider Qualifications

License *(specify):*

Registered Nurses and Licensed Practical Nurses providing Medication Management services to Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medication Management

Provider Category:

Individual

Provider Type:

Pharmacist

Provider Qualifications

License *(specify):*

Pharmacists providing Medication Management services to Pilot Plan recipients must be licensed under Section 465, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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. The response center is staffed by trained professionals.

All direct service professionals providing Policy Plan 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.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hospitals
Agency	Contract agencies for Community Care for the Elderly Program
Agency	Electrical or Alarm System Contractors
Agency	Contract agencies for the Community Care for Disabled Adults Program
Individual	Low-Voltage Contractors and Electrical Contractors
Individual	Alarm System Contractor
Individual	Independent vendor (discount or home improvement stores)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Agency

Provider Type:

Hospitals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Hospitals providing PERS monitoring services for Pilot Waiver recipients must be certified under Chapter 395, F.S.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Agency

Provider Type:

Contract agencies for Community Care for the Elderly Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Community Care for the Elderly Programs providing PERS services for Pilot Waiver recipients are authorized under Chapter 430, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Agency

Provider Type:

Electrical or Alarm System Contractors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Contractors providing PERS services for Pilot Waiver recipients must be certified under Chapter 489, F.S.

Other Standard *(specify):*

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

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Agency

Provider Type:

Contract agencies for the Community Care for Disabled Adults Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Community Care for Disabled Adults Programs providing PERS services for Pilot Waiver recipients are authorized under Chapter 410, 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:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (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):*

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Individual

Provider Type:

Alarm System Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Alarm System Contractors providing services to Pilot 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Individual

Provider Type:

Independent vendor (discount or home improvement stores)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Independent vendors providing PERS services for Pilot Waiver recipients must be certified under Chapter 205, F.S.

Other Standard *(specify):*

Freestanding equipment may also be purchased from independent vendors, such as discount or home improvement stores, but these vendors may not provide monitoring.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08020 home health aide
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Personal Supports services for adults age 21 and older, or age 18-20 if the individual lives in their own home, provides assistance and/or training to the recipient in activities of daily living to include the areas of eating, bathing, dressing, personal hygiene, and preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include housekeeping chores such as bed making, dusting and vacuuming and assistance to do laundry, shopping, and cooking which are incidental to the care furnished, or which are essential to the health and welfare of the recipient. Services include non-medical care, supervision and socialization activities provided to an adult on an one-to-one basis or in groups not to exceed three recipients. All direct support professionals have the requisite responsibility to encourage enrollee independence, inclusion, and integration into the community.

These services are provided when Personal Supports (Personal Care) services furnished under the approved state plan are exhausted. The scope and nature of these services do not differ from services furnished under the state plan. The provider qualifications specified under the state plan apply. The additional amounts of services that may be provided through the waiver are determined by the enrollee's approved plan of care and prior authorizations received.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Homemaker/Companion Agency
Agency	Community Care for the Elderly (CCE) Providers
Agency	Center for Independent Living
Agency	Health Care Service Pools
Agency	Home Health Agency
Agency	Registered Nurse Agency
Individual	Independent Vendor
Agency	Foster Home
Individual	Licensed Practical Nurse
Agency	Assisted Living Facility

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Homemaker/Companion Agency

Provider Qualifications

License *(specify):*

Homemaker, companion, and sitter agencies participating in the Pilot Plan must be registered in accordance with Section 400.509, Florida Statutes. Homemakers employed by homemaker, sitter, and companion agenceies who provide homemaker services to Pilot Waiver recipients must have experience serving 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Community Care for the Elderly (CCE) Providers

Provider Qualifications

License *(specify):*

Community Care for the Elderly (CCE) Providers are defined in Chapters 410 and 430, Florida Statutes. Homemakers employed by CCE Providers who provide homemaker services to Pilot Plan recipients must have experience serving 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Center for Independent Living

Provider Qualifications

License *(specify):*

Centers for Independent Living are defined under section 431.371, Florida Statutes, who provide homemaker services to Pilot Plan recipients must have experience serving 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Health Care Service Pools

Provider Qualifications

License *(specify):*

Health service pools providing services to the Pilot Plan recipients must be licensed under Section 400, Part IX, Florida Statutes. Homemakers employed by health service pools must have experience serving 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Health Agencies providing Personal Supports services for Pilot Waiver recipients must be licensed under Chapter 408.810, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Registered Nurse Agency

Provider Qualifications

License *(specify):*

Registered Nurse Agencies providing Personal Supports services to Pilot Waiver recipients must be licensed under Chapter 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:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Independent Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Foster Home

Provider Qualifications

License *(specify):*

Foster Home employees providing Personal Supports services to Pilot Waiver recipients must be licensed under Chapter 393, F.S.

Certificate *(specify):*

Other Standard *(specify):*

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

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

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

Licensed Practical Nurses providing Personal Supports services to Pilot Waiver recipients must be licensed under Chapter 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

Assisted Living Facilities providing Personal Supports services to Pilot Waiver recipients must be licensed under Chapter 464, F.S.

Certificate *(specify):*

Other Standard *(specify):*

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

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

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License *(specify):*

Group Home employees providing Personal Supports services to Pilot Waiver recipients must be licensed under Chapter 393, F.S.

Certificate *(specify):*

Other Standard *(specify):*

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

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

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Nurse Registry

Provider Qualifications

License *(specify):*

Nurse Registries providing Personal Supports services to Pilot Waiver recipients must be licensed under Chapter 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Registered Nurses providing Personal Supports services to Pilot Waiver recipients must be licensed under Chapter 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:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Licensed Practical Nurse Agency

Provider Qualifications

License *(specify):*

Licensed Practical Nurse Agencies providing Personal Supports services to Pilot Waiver recipients must be licensed under Chapter 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Hospice Agency

Provider Qualifications

License *(specify):*

Hospice Agencies providing Personal Supports services to Pilot Waiver recipients must be licensed under Chapter 400, F.S.

Certificate *(specify):*

Other Standard *(specify):*

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

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

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

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

Service Type:

Other Service

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

Service Title:

Private Duty Nursing

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Individual and continuous care (in contrast to part time or intermitted care) provided by licensed nurses within the scope of State law. These services are provided to an individual in their own home or family home or while the individual is in the community.

Private duty nursing services are prescribed by a physician, ARNP, or physician assistant and consist of individual, continuous nursing care provided by registered or licensed practical nurses.

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

These services are provided when Private Duty Nursing services furnished under the approved state plan are exhausted. The scope and nature of these services do not differ from services furnished under the state plan. The provider qualifications specified under the state plan apply. The additional amounts of services that may be provided through the waiver are determined by the enrollee's approved plan of care and prior authorizations received.

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Licensed Practical Nurse Agency
Agency	Registered Nurse Agency
Individual	Licensed Practical Nurse
Agency	Nurse Registry
Individual	Registered Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Health Agencies providing Private Duty Nursing services to Pilot Waiver Recipients must be licensed under Chapter 400, 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:

Upon initial enrollment or upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Licensed Practical Nurse Agency

Provider Qualifications

License *(specify):*

Licensed Practical Nurse Agencies providing Private Duty Nursing services to Pilot Waiver Recipients must be licensed under Chapter 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:

Upon initial enrollment or upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Registered Nurse Agency

Provider Qualifications

License *(specify):*

Registered Nurse Agencies providing Private Duty Nursing services to Pilot Waiver Recipients must be licensed under Chapter 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:

Upon initial enrollment or upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

Licensed Practical Nurses providing Private Duty Nursing services to Pilot Waiver Recipients must be licensed under Chapter 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:

Upon initial enrollment or upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Nurse Registry

Provider Qualifications

License *(specify):*

Nurse Registries providing Private Duty Nursing services to Pilot Waiver Recipients must be licensed under Chapter 400, 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:

Upon initial enrollment or upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Registered Nurses providing Private Duty Nursing services to Pilot Waiver Recipients must be licensed under Chapter 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Residential Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Residential nursing services are services prescribed by a physician, ARNP, or physician assistant and consist of continuous nursing care provided by registered or licensed practical nurses, in accordance with Chapter 464, F.S., and within the scope of Florida Nurse Practice Act, for recipients who require ongoing nursing interventions in a licensed residential facility, group, or foster home.

This waiver service is only provided to individuals aged 21 and over. All medically necessary services for children under the age of 21 are covered in the Early and Periodic Screening, Diagnostic, and Treatment State Plan benefits, under Section 383.011(1)(e)1, F.S.

All direct service professionals providing Pilot Plan 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:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Registered Nurse Agency
Agency	Assisted Living Facility
Agency	Licensed Practical Nurse Agency
Individual	Licensed Practical Nurse
Agency	Group Home
Individual	Registered Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:

Agency

Provider Type:

Registered Nurse Agency

Provider Qualifications

License *(specify):*

Registered Nurse Agencies providing Residential Nursing services to Pilot Waiver Recipients must be licensed under Chapter 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:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

Assisted Living Facilities providing Residential Nursing services to Pilot Waiver Recipients must be licensed under Chapter 400, 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:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:

Agency

Provider Type:

Licensed Practical Nurse Agency

Provider Qualifications

License *(specify):*

Licensed Practical Nurse Agencies providing Residential Nursing services to Pilot Waiver Recipients must be licensed under Chapter 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:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

Licensed Practical Nurses providing Residential Nursing services to Pilot Waiver Recipients must be licensed under Chapter 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:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License *(specify):*

Group Homes providing Residential Nursing services to Pilot Waiver Recipients must be licensed under Chapter 393, 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:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Nursing

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Registered Nurses providing Residential Nursing services to Pilot Waiver Recipients must be licensed under Chapter 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:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Home Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Specialized medical home care services are for a period of up to 24-hours-a-day and include nursing services and medical supervision provided to residents of a licensed foster or group home that serves recipients with complex medical conditions. The group home must maintain a staffing ratio of one nurse to every three recipients in the home who require close nursing supervision.

This waiver service is only provided to individuals aged 21 and over. All medically necessary services for children under the age of 21 are covered in the Early and Periodic Screening, Diagnostic, and Treatment State Plan benefits, under Section 383.011(1)(e)1, F.S.

Specialized Medical Home Care services are provided to enrollees with complex medical conditions requiring an intensive level of nursing care residing in a foster or group home. This can include recipients who are ventilator dependent, require tracheostomy care, or have a need for deep suctioning to maintain optimal health.

The service is provided for up to 24 hours per day and includes nursing services and medical supervision for all individuals residing in the home. The foster or group home must have APD state office authorization and must maintain appropriate and sufficient staffing at all times to meet the intensive needs of all recipients residing in the home. The rate for Specialized Medical Home Care is considered to be an inclusive rate for nursing, medical supervision, and residential habilitation. These services cannot be billed independently when billing for Specialized Medical Home Care. The rate for Specialized Medical Home Care does not include other wellness and therapeutic support services.

All direct service professionals providing Pilot Plan 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:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Nurses Aide
Individual	Registered Nurse
Agency	Registered Nurse Agency
Individual	Licensed Practical Nurse
Agency	Licensed Practical Nurse Agency
Agency	Group Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Home Care

Provider Category:

Agency

Provider Type:

Certified Nurses Aide

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified Nurse Aides providing Specialized Medical Home Care services to Pilot Waiver recipients must be certified under Chapter 464, F.S.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Home Care

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Registered Nurses providing Specialized Medical Home Care services to Pilot Waiver recipients must be licensed under Chapter 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Home Care

Provider Category:

Agency

Provider Type:

Registered Nurse Agency

Provider Qualifications

License *(specify):*

Registered Nurse Agencies providing Specialized Medical Home Care services to Pilot Waiver recipients must be licensed under Chapter 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Home Care

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

Licensed Practical Nurses providing Specialized Medical Home Care services to Pilot Waiver recipients must be licensed under Chapter 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Home Care

Provider Category:

Agency

Provider Type:

Licensed Practical Nurse Agency

Provider Qualifications

License *(specify):*

Licensed Practical Nurse Agencies providing Specialized Medical Home Care services to Pilot Waiver recipients must be licensed under Chapter 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Home Care

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License *(specify):*

Group Homes providing Specialized Medical Home Care services to Pilot Waiver recipients must be licensed under Chapter 393, 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supported Living Coaching

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supported living coaching services provide training and assistance, in a variety of activities, to support recipients who live in their own homes or apartments. These services may include assistance with locating appropriate housing; the acquisition, retention or improvement of skills related to activities of daily living such as personal hygiene and grooming; household chores; meal preparation; shopping; personal finances and the social and adaptive skills necessary to enable recipients to reside on their own.

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

Supported living coaching services, including the housing procurement component, are not to be provided during the same period of time as residential habilitation services or when the recipient is living in the family home, except for the 90 days prior to the recipient moving into the supported living setting.

Transportation is not a component of this service. Non-emergency transportation is a covered waiver 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 services must be authorized in the enrollee’s person-centered support plan.

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Vendors
Individual	Independent Vendors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living Coaching

Provider Category:

Agency

Provider Type:

Agency Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must be age 18 and shall:
• Have a bachelor's degree from an accredited college or university with a major in education, rehabilitative science, business or a related degree.
• Have an associate's degree or two years of college from an accredited college or university and have two years of documented direct experience with recipients with developmental disabilities.
• Have one year of college from an accredited college or university and three years of documented direct experience in working with recipients with developmental disabilities.
• Four years of direct professional experience in working with recipients with developmental disabilities may substitute for college on a year for year basis. The provider must hold a high school or GED diploma.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living Coaching

Provider Category:

Individual

Provider Type:

Independent Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must be age 18 and shall:
• Have a bachelor's degree from an accredited college or university with a major in education, rehabilitative science, business or a related degree.
• Have an associate's degree or two years of college from an accredited college or university and have two years of documented direct experience with recipients with developmental disabilities.
• Have one year of college from an accredited college or university and three years of documented direct experience in working with recipients with developmental disabilities.
• Four years of direct professional experience in working with recipients with developmental disabilities may substitute for college on a year for year basis. The provider must hold a high school or GED diploma.

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Unpaid Caregiver Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

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.

FFP is available for the costs of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the service plan. FFP is not available for the costs of travel, meals and overnight lodging to attend a training event or conference.

All direct service professionals providing Pilot Plan 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:

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Unpaid Caregiver Training

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 and 430, F.S. Unpaid Caregiver Training service providers employed by CCE Providers must have experience serving 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):*

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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Unpaid Caregiver Training

Provider Category:

Individual

Provider Type:

Registered Nurse, Licensed Practical Nurse

Provider Qualifications

License *(specify):*

Registered Nurses and Licensed Practical Nurses providing Unpaid Caregiver Training services to companions, relatives, legal guardians, and families of Pilot Plan 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Unpaid 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 Unpaid Caregiver Training services to Pilot Plan recipients must be licensed under Section 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Unpaid Caregiver Training

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home health agencies providing Unpaid Caregiver Training services 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Unpaid Caregiver Training

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License *(specify):*

Centers for Independent Living providing Unpaid Caregiver Training services to Pilot Plan recipients are defined under Section 413.371, F.S. Direct service providers of Unpaid Caregiver Training services and are employed by Centers for Independent Living must be licensed either as registered or licensed practical nurses under Section 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:

Upon initial enrollment and upon reenrollment requirements of the Medicaid Agency

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

The waiver operates through a managed care service delivery model. Pilot plan employees or other case management providers enrolled in the plan's provider network's assess each member's care needs and develop the care plan to address the identified care needs with the assistance of the member or his/her designated representative.

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): Pilot plans and subcontractors are subject to mandatory criminal history background screenings. For each Pilot 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 all Pilot Plan providers. 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 Pilot Plan will be required to ensure that providers and requisite staff have a current Level 2 Criminal History and/or background investigation. The Pilot Plan shall keep a record of all background checks to be available for AHCA review upon request. Plans are required to keep this information in provider credentialing and re-credentialing files which the State will assess for compliance. 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; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

- [ ] **Self-directed**
- [ ] **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- (●) **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ( ) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The waiver operates in combination with a waiver granted under 1915(a) authority. The Pilot Plans have contractual requirements to maintain a network of provider that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service number. The Pilot Plans will report on their provider network as specified in their contract.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
 # and % of new licensed service providers, by type, within the Pilot Plan provider network that meets provider qualifications prior to delivering services. N: Number of licensed service providers, by type, within the Pilot Plan provider network that meets provider qualifications prior to delivering services. D: Number of licensed service providers, by type, in the Pilot Plan provider network.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Pilot 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of current, licensed service providers, by type, within the Pilot Plan provider network that meets provider qualifications continuously. N: Number of licensed service providers, by type, within the Pilot Plan provider network that meets provider qualifications continuously. D: Number of licensed service providers, by type, in the Pilot Plan provider network.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Pilot 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:

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:
 # and % of non-licensed/non-certified providers by type in Pilot Plan network meeting waiver service provider qualifications prior to service delivery. N: Number of

non-licensed/non-certified providers by type in Pilot Plan network meeting waiver service provider qualifications prior to service delivery. D: Number of non-licensed/non-certified providers by type in Pilot Plan provider network.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Desk Review

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**

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:

Performance Measure:
Number and percentage of non-licensed/non-certified providers by type in Pilot Plan network meeting waiver service provider qualifications continuously. N: Number of non-licensed/non-certified providers by type in Pilot Plan network meeting waiver service provider qualifications continuously. D: Number of non-licensed/non-certified providers by type in Pilot Plan provider network.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Desk Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of providers with staff mandated to report abuse, neglect, and exploitation, verified by Pilot Plan that staff has received appropriate training. N: Number of providers with staff that are mandated reporters, verified by Pilot Plan that staff has received appropriate training. D: Number of providers with staff that are mandated reporters.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Pilot 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 *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of providers whose staff received training in an APD approved curriculum for behavioral emergency procedures consistent w/ requirements of the Reactive Strategies. N: Number of providers whose staff received training in an APD approved curriculum for behavioral emergency procedures consistent with the requirements of the Reactive Strategies. D: Total number of providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Pilot 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 *(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 Statutes provides direction for both AHCA and APD to contract with an independent evaluator to conduct evaluations in a series of areas. These evaluations must include at a minimum, assessments of cost savings, consumer education, choice, and access to services. It also includes evaluations of plans for future capacity and the enrollment of new Medicaid providers, coordination of care, person-centered planning and person-centered well-being outcomes, health and quality of life outcomes and quality of care by each eligibility category and managed care plan in each pilot program site. In addition to case reviews, Florida will also review any complaints received to determine effectiveness in the areas above.

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 AHCA's Florida Health Finder website which lists provider's status and adverse licensure actions. Additionally, the AHCA'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. AHCA notifies plans if a licensure action is taken against a provider, or if a provider is terminated from Medicaid for reasons other than inactivity. AHCA 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 waiver support coordinator. 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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The 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 plans are required to submit at least quarterly provider network lists detailing new service providers. The plans are responsible for enrolling qualified service providers. If the State's review determines a plan's service providers are unqualified, the Pilot Plan must correct the deficiency.

The 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 plans are required to submit at least quarterly provider network lists detailing new service providers. The plans are responsible for enrolling qualified service providers. If the State's review determines a plan's service providers are unqualified, the Pilot Plan must correct the deficiency.

The plans verify service providers with staff mandated to report abuse, neglect and exploitation have received appropriate training. The plan will verify providers with staff that have received training in the APD approved curriculum for behavioral emergency procedures consistent with requirements for Reactive Strategies. During an annual review, the Agency reviews the plan reports for compliance with staff training requirements. The 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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Agency and APD (partner agencies) worked together to review the HCBS Settings Rule (rule) and develop the process, procedures, and tools for determining compliance with the rule's requirements. The partner agencies conducted an assessment of Florida's laws, rules, regulations, standards, and policies to determine whether the State's requirements are consistent with the HCB Settings Rule. The State selected 17 HCB settings Rule criteria to determine whether the statutes and regulations were in compliance.

1. Integration in and supporting full access of the individual receiving Medicaid HCBS to the greater community to the same degree of access as individuals not receiving Medicaid HCBS.
2. Opportunities to seek employment and work in competitive integrated settings.
3. Opportunities to engage in community life.
4. Opportunities to control personal resources.
5. The right to select from among various setting options, including non-disability specific settings.
6. The individual's personal rights of privacy, dignity and respect and freedom from coercion and restraint.
7. The optimization of autonomy and independence in making life choices, including daily activities, physical environment and with whom to interact.
8. Choice regarding services and supports and who provides them.
9. A legally enforceable written agreement between the provider and the consumer that allows the consumer to own, rent or occupy the residence and provides protections that address eviction processes.
10. Privacy in the sleeping or living units that includes the entrance having lockable doors.
11. An option for a private unit and a choice of roommates in semi-private units.
12. Freedom to furnish and decorate sleeping or living units.
13. Freedom and support to control schedules and activities, including access to food at any time.
14. Access to visitors at any time.
15. A physically accessible setting.
16. Locations that have qualities of institutional settings, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution. Additionally, the setting has the effect of isolating individuals receiving Medicaid HCBS from the broader community.
17. Home and community-based settings do not include the following: a nursing facility, institution for mental diseases; an intermediate care facility for individuals with intellectual disabilities; a hospital.

The HCBS settings' tools were designed to allow providers and State assessors to review each setting for the standards set forth by CMS. The tools were made available for public comment prior to implementation. Tools are divided into the following sections; each section contains a number of standards settings must meet:

- Residential
  - Section 1: Setting
  - Section 2: Room/Privacy
  - Section 3: Meals
  - Section 4: Activities/Community Integration
  - Section 5: Respect/Rights/Choices
  - Section 6: Other
- Non-Residential
  - Section 1: Community Integration
  - Section 2: Respect/Rights/Choices
  - Section 3: Employment

The partner agencies have validated the use the HCB setting residential and non-residential tools. The Residential and Non-Residential tools and trainings are posted on the Agency's website. The Agency will use the HCB Characteristic Assessment tools that address each aspect of the HCB settings Rule to ensure ongoing compliance. The tools will be reviewed and amended based on lessons learned and monitoring outcomes to ensure their ongoing efficacy, and applicability to the rule.

- The following providers are residential providers: Assisted Living Facilities, Adult Family Care Homes, and Group Homes/Foster Care Homes.
- The following providers are non-residential providers: Adult Day Care Centers and Adult Day Training Centers.

All settings receiving Florida Medicaid reimbursement for HCBS are required to adhere to the requirements established in the State's HCB settings Rule, Rule 59G-13.075, Florida Administrative Code (F.A.C.) in order to continue to receive reimbursement for HCBS provided after March 17, 2023. The rule became effective on December 25, 2018. The State's HCBS rule is available at https://www.flrules.org/gateway/ruleno.asp?id=59G-13.075

Residential facilities must have residential agreements that comply with section 429 Florida Statutes (F.S.) Attachment B, Section VII.C.5.a., of the SMMC Contract, which specifically requires residential agreements between individuals and facilities. The Pilot Plans are responsible for credentialing all of their providers. As part of the credentialing process, the HCB setting providers must complete the self-assessment and submit the completed self-assessment to the Pilot Plan representative. The Pilot Plan must validate, on-site or virtually, the self-assessment to determine status.

Based on the assessment, HCB settings are categorized as one of the following: fully compliant with the HCB settings Rule; non-compliant with the HCB settings Rule requiring a plan of remediation; or presumptively institutional.
If the HCB setting providers are non-compliant with the rule, the Pilot Plan must impose remediations and track the HCB setting provider' activities until completion. Settings providers must be compliant with the rule before providing services to any Pilot Program enrollee and receiving any Medicaid funding. If the HCB setting provider is determined to be presumptively institutional, the Pilot Plan must visit those settings in-person or virtually to gather additional information to determine whether the setting is compliant with the HCBS Settings rule. The Pilot Plan must submit the evidentiary package, including the full provider compliance assessment package with supporting documentation to the Agency. The Agency reviews the evidentiary packets submitted by the Pilot Plans to determine if the setting is presumptively institutional. The Agency assures that all HCBS settings have been assessed and are compliant with the HCBS settings rules before they serve the waiver recipients. The Pilot Plans assess settings to determine if they have the effect of isolating recipients from the broader community. If the State determines these settings to be presumptively institutional, then the State will submit a request to CMS for a Heightened Scrutiny review.

The State also monitors changes to state laws, rules, regulations, standards, and policy each year. The Agency will update any rules, tools, trainings, and communications based on CMS direction and HCB setting rule updates. The Pilot Plan will continue ongoing monitoring for compliance through the recredentialing process and existing licensing process as the Agency's Division of Health Quality Assurance and APD licensing activities. The Agency ensures that the settings are not being isolated from the community and encourage not only community involvement but also afford access to receive Medicaid services in the community, and access to community activities such as shopping, restaurants, religious institutions, senior centers, etc. Pilot Plan waiver recipients have designated care coordinators to review all services that are requested and approved according to their specific waiver process and documented in each waiver recipient's person-centered service plan. Any modifications of the additional conditions, under 42 C.F.R. 443.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan and will include the requirements outlined at ss 443.301(c)(4)(VI)(F)(1) through (8). The Agency also conducts on-going monitoring through quarterly reviews of Plan enrollee case files, a process to evaluate the recipient's person-centered plan, and to seek feedback from the recipient and the recipient's family or representative. The focus of this review is to ensure the recipient has the continued opportunity to be active in the community, reside in a home-like environment, and make personal choices.

The State has determined the waiver recipients who live in private homes of their own or the home of their family member are in compliance with the HCB setting Final Rule. Per SMD 19-001. Individual, privately-owned homes (privately owned or rented home and apartments in which the individual receiving Medicaid-funded HCBS lives independently or with family member, friends, or roommates) are presumed to be in compliance with the regulatory criteria of the HCB setting Final Rule. Each waiver recipient has a care coordinator to ensure services are being provided and each waiver recipient has access to the community at large. The Pilot Plan is responsible for ongoing monitoring for HCB settings compliance. The Pilot Plan contract requires care coordinators to make face-to-face visits with each enrollee at least once every three months. At these meetings every three months, the care coordinator reviews the person-centered service plan and review for community isolation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Care Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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. Pilot 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 care coordinator, their authorized representative, or any other individuals they would like included. The enrollee may invite anyone of their choosing (family members, authorized representatives, friends, etc.) to participate in their 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 care coordinator 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 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 care coordinator must provide the participant with a written Notice of Adverse Benefit Determination that explains the enrollee's right to file an appeal. The care coordinator assists the enrollee with filing for an appeal.

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. Care coordinators 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. Pilot plans are required to monitor plans of care to ensure they are reflective of an enrollees' needs, preferences, goals, and service authorizations. Additionally, Pilot plans are required to provide extensive training on care plan development and service options.

The plans will be contractually obligated to adhere to the following requirements:

1. The plan shall not contract with the same entity to provide care coordination services/functions and any other covered services for an enrollee unless the plan demonstrates all of the following:

a)The entity is the only willing and qualified entity to provide care coordination services in a geographic area;
b)The entity is a provider of 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 care coordination provider.

2. Prior to implementing a Contract under the above conditions, the Pilot plan shall submit to AHCA procedures that demonstrate the conflict of interest protections that are in place for enrollees receiving care coordination services from a provider of other HCBS services, including separation of care coordination responsibilities from provider functions, and the process that enrollees may use to file a complaint through the plan's alternative dispute resolution process.

The State will assure conflict free care coordination and participant protections by reviewing sampled care plans, participating in Fair Hearings, and reviewing focused managed care plan reviews targeted at the Pilot Plans with significant numbers of care plan related complaints. Pilot plans must be in compliance with program contract standards for care coordination and care planning. Failure to meet those standards subjects the Pilot Plans to enrollment moratoriums and liquidated damages.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The Care Planning process shall be person-centered and place the enrollee at the center of the planning process. Characteristics of the Care Planning process include:

1. The enrollee (and authorized representatives, if applicable) are present at care planning meetings. Care plan meeting times, locations, and attendees are chosen by the enrollee and/or authorized representative.
2. Care Plan goals are developed by conducting a comprehensive assessment and dialogues with the client and their family (if applicable) to determine what is important and the priorities of the recipient and not providers serving them. The Care Plan will also include any barriers that stand in the way of achieving goals and clearly articulate strategies and tangible steps to overcome barriers.
3. The Care Planning process will be conducted based on the client's communication preferences and in a manner that is understandable to the enrollee and how they make choices and decisions.
4. The Care Planning process will include reviewing needs assessed by APD and developing strategies with the enrollee and authorized representative to address assessed needs. The Pilot Plan Care Coordinator will perform additional assessments to determine person-centered outcomes and develop strategies to meet those outcomes during the care planning process.
5. The Care Plan will include at a minimum: goals and barriers to overcome grouped by priority and identified support provided through the pilot provider network as well as other government supports, and community supports including not for profits, faith-based community and private sector. The plan will describe next steps and the frequency of check ins with the enrollee and care coordinator to ensure client desired outcomes and standards are being met.

To support and inform the care plan, prior to the initial care planning meeting, APD will conduct a needs assessment with the recipient and authorized representative to identify functional, behavioral, and physical needs. The Pilot Plan Care Coordinator shall conduct additional assessments described above to begin the care planning process to determine the enrollee's personal goals and barriers to achieve goals.

(a) Services and supports included in the plan of care are determined by the enrollee's goals, barriers and overall plan in conjunction with the initial assessment information provided in consultation with the enrollee and/or his or her family and authorized representative as applicable. The plan of care addresses all health, safety and well-being needs and goals to achieve their God-given potential to thrive identified by the client throughout the assessment. Pilot Plans are responsible for ensuring regular check-ins are established with the enrollee and/or their family and/or legal representative as appropriate at a documented routine cadence that directly supports successful outcomes achieved as a result of the care plan and client feedback. This includes an evaluation of whether services are being delivered in accordance with the care plan and scheduled in accordance with the enrollee's preferences. During a periodic review, the Pilot Plan must specifically involve the enrollee and/or their family and/or their authorized representative in assessing whether the services furnished are consistent with the enrollee's assessed needs, quality standards and personal outcomes. Revisions to the plan of care must be done in consultation with the enrollee, and/or their family, and/or their authorized representative.

(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.

During each care planning meeting, the Care Coordinator 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 care plan, which is then completed with the signatures of those present during the meeting along with the enrollee and /or their authorized representative's signature.

The Care Coordinator shall be available to meet the enrollee's needs and address needs if they change between care plan meetings and contacts. The Care Coordinator shall have a 24/7 on-call system.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing

information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Each enrollee will have a person-centered plan of care. In consultation with the enrollee, and/or family, and/or legal representative, the Pilot Plan is required to develop an individualized written plan of care utilizing an assessment and care plan 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 plan of care shall be updated if the needs and goals of the enrollee and/or family and/or legal representative change.

The Pilot Program will use an Individualized Person-Centered Care Plan development process and services and supports shall be delivered in accordance with the person-centered care plan which incorporates the inclusion of family members or legal representative as appropriate. The person-centered care plan is based on the needs assessment administered by APD as well as a comprehensive assessment that not only identifies an individual's physical, functional, and behavioral status but also their goals, and addresses resources and supports to accomplish the client’s goals. Resources and supports should include both Medicaid provider supports as well as additional supports from community resources like not for profits, faith-based organizations and private sector businesses. The plan should also be developed with additional state offerings in mind that help the client accomplish their full potential to thrive. The development should also include a description of next steps, the plan for navigation of service delivery, supports and resources and the frequency of check ins with the client and care coordinator to ensure client desired outcomes and standards are being met.

Development of the plan must enhance an individual's potential to thrive through empowerment, independence and quality of life through meaningful community involvement.

Examples may include:
-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.
-Working towards employment and educational opportunities.
-Participating in community activities of choice, including participation with faith-based organizations and local community groups.

Enrollee Information
Upon enrollment, the plan will provide its members with an enrollee handbook that includes plan network information and services and a description of the care planning process. Managed care plan network information will also be made available online. In addition, during the development of the enrollee’s plan of care, the plan and/or care coordinator will inform the client of the services available in the plan and work with the client, family and/or the enrollee’s authorized representative as appropriate in developing a plan of care that best meets the enrollee’s service needs and goals to increase well-being.

The Comprehensive Assessment
Prior to developing the person-centered care plan, APD will conduct a needs assessment with the enrollee and authorized representative to identify functional, behavioral, and physical needs. The Care Coordinator shall conduct additional comprehensive assessments to determine the enrollee’s desired outcomes and personal goals. When developing the initial care plan, the Care Coordinator utilizes information from the APD assessment and other assessments to develop strategies to meet the enrollees needs and personal goals. The Pilot Plan will not only be required to complete a waiver-specific assessment but is also expected to use the initial eligibility and level of care assessment conducted by the state via the APD. The comprehensive assessment includes evaluations of the enrollee'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. Care coordinators are also required to assess the immediacy of the enrollee's service needs and personal goals.

APD is responsible for conducting the initial comprehensive assessment and the Care Coordinator shall perform additional assessments which all guide the development of the person-centered care plan. Following an initial orientation, the Care Coordinator is required to contact the enrollee at a routine frequency established by all parties and documented in the care plan. For example: 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 Care Coordinator and the enrollee 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

plan or Care Coordinator. The Care Coordinator is also required to update the enrollee's person-centered care plan following a significant change in their health or functional status. Additionally, the Care Coordinator is responsible for authorizing the enrollee's services and coordinating their care on an ongoing basis.

Enrollee Goals must drive outcomes of health, safety and wellbeing and be measurable to determine effectiveness of strategies and resources established to achieve goals.

Care Plan Implementation
Care Coordinators are tasked with developing and implementing care plans using a person-centered approach. The Care Coordinator is responsible for ensuring it is implemented appropriately. Pilot Plan Care Coordinators are the lead coordinators for enrollees receiving 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 on a routine basis established by all parties and at least monthly contact the enrollee 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 client’s needs, goals, health status, etc.

Monitoring Activities by the State for the Care Planning Process
On an ongoing basis throughout the calendar year, APD, AHCA or a contracted third party as established by the state will conduct monitoring reviews of a random, representative sample of current enrollee files for each plan, organized by region. As part of this review, the monitoring will include a review of the enrollee's care plans to ensure that the Pilot Plan Care Coordinators 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 Care Coordinators.

To better ensure that the Pilot Plan Support Coordinators are conducting and properly documenting community integration goal planning activities, the state also requires the Pilot Plans to audit a random representative sample of current enrollee's case records for the following elements specifically related to community integration goal planning activities:
-Identified goals
-Identified barriers to achieving goals
-Identified services for overcoming barriers
-Identified timeframes for goal attainment

Progress updates
Progress means information regarding whether services 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, Pilot Plans 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 monitoring activities 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 enrollee's goals in conjunction with the initial assessment information provided by APD in consultation with the enrollee, family, and/or authorized 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))

Each Pilot Plan will have the flexibility to design a plan of care form or system that includes these minimum components listed throughout and the template will be reviewed and approved by the State.

If immediate services are needed while the plan of care is being developed, the care coordinator will immediately work with the enrollee to ensure temporary services are provided for stability.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the scheduled care plan meeting and throughout the year, the care coordinator must remain aware of possible risks to the health, safety, and welfare of the recipient. The care coordinator will counsel recipients on the selection of supports and services that best mitigate risks to the recipient. The care coordinator will engage in continuous monitoring, including use of the individual budget and through face-to-face meetings held by the care coordinator with the recipient that will identify possible risk factors to address and thereby reduce or eliminate those factors from the recipient's daily life. The care plan, developed with the participation of the recipient and his or her family and guardian, in accordance with their preferences, identifies critical services that affect the recipient's health, safety, and welfare with backup supports identified, including paid or unpaid supports. With every contact with or on behalf of the recipient, the provision of those identified critical services should be specifically reviewed and addressed if necessary.

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 Pilot Plan 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. Pilot Plans also make trained staff available that can link enrollees to waiver providers in their area. Care coordinators 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 plan's network. Prior to implementation, the network sufficiency of each Pilot 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):

AHCA 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.

AHCA will require remediation of any issues discovered during these monitoring activities and will impose penalties and/or sanctions as appropriate. The Pilot Plans shall ensure that the service plans are developed and updated timely. AHCA 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 Pilot Plans so that the percent of the sample drawn randomly from each Pilot Plan matches the percent of the overall population served by that Pilot Plan. Proportionate random sampling ensures that the Pilot 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 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:

Managed Care Plan(s) contracted with AHCA to provide Pilot waiver services.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

On an ongoing basis throughout the calendar year, APD, AHCA or a contracted third party as established by the state will conduct monitoring reviews of a random, representative sample of current enrollee files for each plan, organized by planning and service area. As part of this review, the evaluation will include a review of the enrollee's healthy, safety and well-being and are used to effectively deliver waiver services that are furnished in accordance with the plan on a quarterly basis.

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. Care coordinators 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.

Enrollee access to services (including non-waiver and healthcare services) identified in the plan:
Pilot Plans are required to maintain a region-wide network of providers in sufficient numbers to meet the access standards for services for all plan enrollees. Provider ratios and provider-specific geographic standards are required for urban and rural counties. 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 Pilot Plan 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, safety and wellbeing:
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 AHCA, APD or any contracted entity conducting performance monitoring for purposes of the Pilot, AHCA personnel will contact the Pilot plan that is non-compliant and provide an opportunity for the plan to remedy the issue. AHCA and APD will monitor the Pilot plan until the noncompliance is corrected or the staff is appropriately trained. AHCA continues to monitor the plan through routine desk reviews. However, if the area of non-compliance is not adequately addressed by the Pilot plan consistently over time, or the Pilot plan continues to have areas of non-compliance identified, AHCA will complete a targeted monitoring project consisting of an intensive desk review. The Pilot plan may be placed on a corrective action plan which is approved by both AHCA and APD for a specified period of time and must report on their compliance more frequently to AHCA and APD until the issue is resolved. AHCA may also apply liquidated damages and sanctions, up to and including termination, for chronic non-compliance.

On a quarterly basis, Pilot Plans 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 monitoring activities to determine if barriers exist across enrollee experience and if trends exist across particular settings and to resolve any issues revealed by the data.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

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.

Pilot Plans must separate responsibility for development and monitoring of care plans. Support coordinators who develop care plans cannot be given the responsibility for monitoring waiver care plans. Pilot Plans failing to separate the development of and monitoring care plans are subject sanctions.

The State's desk review and on-site monitoring review Pilot 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.

Pilot Plans must separate responsibility for care plan development and monitoring. Pilot Plans must audit support coordinator activities, including enrollee plans of care. In accordance with the State's contract with Pilot Plans, as approved by CMS:

The Pilot Plans 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 Pilot Plans shall compile reports of these monitoring activities to include an analysis of the data and a description of the continuous improvement strategies the Pilot Plans have taken to resolve identified issues. This information shall be submitted to AHCA on a quarterly basis, thirty (30) days after the close of each quarter.

AHCA reviews a random sample from the Case File Audit Report quarterly and validates the data that is submitted to AHCA. The EQRO does not validate this report.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
Number and percentage of enrollees whose care plans include supports and services consistent with assessed needs and risks. N: Number of enrollees whose care plans include supports and services consistent with assessed needs and risks. D: Number of care plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Pilot 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% +/- 5%
☐ **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**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and 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 care plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Pilot 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% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of enrollees whose care plans are updated at least annually.
N: Number of enrollees whose care plans are updated at least annually. D: All care plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Pilot Plan enrollee file

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of enrollees whose care plans are updated when needs have changed. 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:
Pilot Plan enrollee file

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative**

		Sample Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Number and percentage of 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 enrollees plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Pilot Plan enrollee file

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **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:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of enrollee plans of care distributed within ten days of development to primary care physician and home and community-based services setting. N: Number enrollee plan of care distributed within ten days of development to primary care physician and community-based services setting. D: Number of enrollee records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Pilot 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**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **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:
Number and percentage of enrollee plans of care where enrollee participation is verified by signatures. N: Number enrollee 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:
Pilot 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% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of 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 plan of care as to the service type, amount, frequency, duration, and scope. D: Total number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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% +/- 5%
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of 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: All care plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Pilot Plan enrollee file

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of new enrollee 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:
Pilot Plan enrollee file

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

By contract, approved care plans must address all assessed needs including risk factors. During quarterly desk reviews, care plans are reviewed to verify needs were assessed and risk factors identified. If the Pilot Plan is out of compliance, documentation will be requested that shows needs and risks were identified. In addition, the Pilot Plan must submit signed training attestation that the care coordinator has been trained on the importance of needs assessment and risk factor identification.

The Pilot 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 Pilot 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 care coordinator 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 Pilot Plan must submit a signed training attestation that the care coordinator has been trained on the importance of personal goal planning during the care planning process.

The Pilot Plans must ensure the care plans are distributed to the primary care physician and HCB setting 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 Pilot Plan is out of compliance, the most recent copy of the care plan must be sent to the primary care physician and HCB setting and the care coordinator must be trained on the importance of forwarding the care plan to the enrollee’s primary care physician and HCB setting within 10 business days of development/update. The Pilot Plan must submit a signed and dated attestation that the care plan was submitted to the primary care physician and HCB setting and 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 Pilot Plan is out of compliance with the annual care plan update and the care plan update has still not occurred, the care coordinator will meet with the enrollee to create an updated care plan. The Pilot Plan must submit evidence of remediation. The care coordinator must be trained on the importance of updating the care plan annually and the Pilot Plan must submit a signed and dated attestation that the training occurred.

By contract, Pilot 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 Pilot 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 Pilot Plan must confirm that the face-to-face meeting occurred. The care coordinator 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 Pilot Plan must submit a signed and dated attestation that the training occurred.

Pilot Plan care coordinator 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 Pilot Plan is out of compliance with the care plan review every three months, and the care plan review has still not occurred, the care coordinator will meet with the enrollee to review the care plan. The Pilot Plan must submit evidence of remediation. The care coordinator must be trained on the importance of reviewing the care plan within every three months. The Pilot Plan must submit a signed and dated attestation that the training occurred.

The Pilot 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 Pilot Plan is out of compliance, the care coordinator must be trained on the importance of obtaining enrollee or enrollee representative’s signature and date on the care plans. The Pilot Plan must submit a signed and dated attestation that the training occurred and a signed and dated copy of the care plan.

The Pilot 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 Pilot Plan care coordinator should assist the enrollee with completing the form and submit a copy of the signed form. The Pilot Plan must submit evidence of remediation. The care coordinator must be trained on the importance of ensuring the enrollee completes a freedom of choice form and the Pilot Plan must submit a signed and dated attestation that the training occurred.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied,

suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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, the Pilot 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 Pilot Plan as well as the enrollee and his or her representative, or the representative of a deceased enrollee's estate. The care coordinator 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**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

AHCA maintains an enrollee and provider complaint hub. Pilot Plan enrollees and providers access the complaint hub through the AHCA web site or a toll free telephone number. Complaints are reviewed and resolved by AHCA staff. Hub metrics are maintained by AHCA and reviewed periodically.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

For the complaint hub, enrollees and providers access AHCA's website, complete an on-line complaint form, and submit the electronic complaint to AHCA. Complaint hub staff contact Agency units responsible for the complaint area and seek direction on the resolution of the complaint or, if necessary, AHCA subject matter specialists are contacted to resolve the complaint. Service provider complaints are usually resolved through contacting the Pilot Plan involved about the complaint.

The Pilot Plan contract has specific language for Complaints, Grievances, Appeals, and Fair Hearings. Participants are informed that neither Complaints nor Grievances are a pre-requisite or substitute for a Fair Hearing. The Pilot Plan contract section outlines the timeframes, processes to follow, enrollee notification requirements, and reporting requirements of the grievance/complaint system. Enrollee information about complaints, grievances, appeals, and fair hearings are included in the Agency drafted member handbook.

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. AHCA will share this information with APD on a monthly basis, or at a different timeline upon request of APD. Pilot Plan contracts and subcontracts specify incident reporting format, requirements, processes and timeframes for responding to critical events or incidents, including conducting investigations. Through the AHCA's ongoing monitoring activities, plans' adherence to these requirements will be monitored and observed for any necessary remediation.

The Pilot Plan providers shall report critical and reportable incidents within the timelines specified in Rule 65G-2.010(5). A Critical/Reportable Incident Report shall be reported in written form via email. A Critical/Reportable 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 Pilot Plan.

Critical incidents include:
1. Unexpected Client Death
2. Life Threatening Injury or Illness
3. Sexual Misconduct
4. Missing Child or Adult Who Has Been Adjudicated Incompetent
5. Media attention
6. Client Arrest for Violent Crime
7. Verified Abuse, Neglect or Exploitation Investigations
8. Staff Arrest for Disqualifying Offense

Reportable incidents include:
1. Client Deaths
2. Altercations
3. Client Injury
4. Client Arrest
5. Missing Competent Adult
6. Suicide Attempted
7. Baker Act
8. Hospitalization for illness or injury
9. Client Arrest from Non-Violent Crime

This does not replace the abuse, neglect, and exploitation reporting required by state law and rule. Allegations of abuse, neglect, or exploitation must always be reported immediately to the Florida Abuse Hotline.

Allegations of abuse, neglect, or exploitation must always be reported immediately to the Florida Abuse Hotline.

Pilot Plans are required to submit reports to AHCA regarding critical and reportable incidents affecting enrollees, including allegations of abuse, neglect, or exploitation. AHCA will share this information with APD on a monthly basis, or at a different timeline upon request of APD.

Timeframes are set in Rule 65G-2.010(5), F.A.C. Critical Incidents must be reported within 1 hour of the incident or from becoming aware of the incident. Reportable Incidents must be reported within 1 day of the incident or from becoming aware of the incident.

Unauthorized use of restraint, seclusion, and restrictive interventions must be documented and reported to AHCA and to the APD Local Review Committee for behavioral review and intervention. If the use of restraint, seclusion, or restrictive intervention reaches a level of one of the incident categories, the provider will need to report the incident to the Pilot Plan in accordance with the required timeframes. If the use of restraint, seclusion, and restrictive intervention is suspected to be abuse, neglect, or exploitation, a report to the DCF Abuse Hotline is required.

Serious injuries requiring medical intervention are captured in the critical incident category "Life-threatening Injury or Illness" and the reportable categories of "Client Injury" or "Hospitalization for Injury or Illness," dependent on the nature of the injury.

Financial exploitation is reported to the DCF Abuse Hotline for investigation. If the investigation is verified for exploitation, this incident will be captured in the Critical category of Verified Abuse, Neglect, or Exploitation Investigation.

Medication Errors must be documented and reported to APD/AHCA in accordance with the requirements set in Rule 65G-7.006, F.A.C. If the medication error reaches a level of one of the incident categories, the provider will need to report the incident to the Pilot Plan in accordance with the required timeframes. If the medication error is suspected to be abuse, neglect, or exploitation, a report to the DCF Abuse Hotline is required.

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.

Pilot Plans are required to submit reports to AHCA regarding critical and reportable incidents affecting enrollees, including allegations of abuse, neglect, or exploitation. AHCA will share this information with APD on a monthly basis, or at a different timeline upon request of APD. 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 DCF. (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 recipient's 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.

Pilot Plan providers are required to report critical and reportable incidents related to enrollees to AHCA. AHCA will share this information with APD on a monthly basis, or at a different timeline upon request of APD. 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/Reportable Incident reports are evaluated as follows:
•The Pilot Plan shall identify and track critical and reportable incidents and review and analyze incidents to identify and address/eliminate potential and actual quality of care and/or health and safety issues. If the Pilot Plan fails to comply with this requirement, AHCA will require corrective action within time frames that are based upon the severity of the deficiency. If the Pilot 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 Pilot Plan must assist as necessary to address health and safety issues. If the Pilot Plan fails to comply, sanctions ranging from enrollment suspension to contract termination may be assessed.

•If APS reports are not investigated within 24 hours, AHCA 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.

Incidents that relate to persons licensed under Chapter 456, Chapter 458, Chapter 459, or Chapter 461 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 and APD may investigate, as deemed 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 and reportable incidents or events that affect enrollees. AHCA will share this information with APD on a monthly basis, or at a different timeline upon request of APD.

Quality and Program staff from AHCA and APD will meet to discuss the individual critical incident report that includes the name and type of facility, critical incident type, details of the incident, planned or required follow-up, and relevant dates. Then the group will identify trends in reports by regions, identify provider types where incidents occur, and discuss best practices or ways to reduce incidents and share findings with the Pilot Plans. These meetings will occur at least quarterly. During these meetings, staff will determine if there are trends in the individual home and community-based services (HCBS) providers (ALF, AFCH, ADC, residential habilitation, prevocational services, and adult day training) being reported. If providers are identified, AHCA and APD staff will work with the Pilot Program through their contract manager to ensure the providers are compliant with the HCBS Final Setting Rule.

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.

AHCA will collaborate with the Department of Children and Families – Adult Protective Services and other State agencies. AHCA will foster increased oversight of the Pilot Plans and providers regarding critical incidents and other health, safety and welfare sub-assurances required for the successful operation of the Pilot Plan. 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 Plan contract requires health, safety, and welfare issues, be reported to AHCA by the plan. If the Pilot 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 Pilot Plan fails to implement the corrective action timely, the Pilot 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. Pilot Plans must assist as necessary with services to address the health, safety and welfare issues. If the Pilot 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, AHCA 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, AHCA will report the unexplained delays to the Department of Children and Families Division management responsible for the APS program. For APS reports that are not investigated, AHCA 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).

Chapter 393, Florida Statutes, requires emergency procedures to be used only for imminent danger. APD has promulgated Rule 65G-8, F.A.C., “Reactive Strategies" to establish emergency procedure curricula, for staff training to assure competent implementation of these procedures when preventative or less restrictive procedures have failed. Providers must maintain a reactive strategy policy and procedure, conduct assessments to determine history of trauma and pre-existing medical conditions that may preclude specific techniques or procedures, and specify who can authorize the use of these procedures. This rule also identifies limits for use of reactive strategies, prohibits selected procedures, and requires documentation and reporting of these procedures when used.

Rule 65G-4, F.A.C., “Behavioral Practice and Procedure,” includes the monitoring and oversight of these procedures by the Local Review Committee, as well as a requirement to develop a behavior program when criteria for frequent use of seclusion and restraints are met.

Types of permitted restraint or containment include:
a. Manual restraint
b. Mechanical restraint
c. Chemical restraint
d. Behavioral protective devices
e. Medical protective devices
f. Time-out (< 20 minutes)
g. Time-out (> 20 minutes), reported as Seclusion (door cannot be locked).

Alternative methods to avoid the use of restraint and seclusion are a required component within the emergency procedure curricula reviewed and approved by the APD. Provider agencies that use emergency procedures are required to ensure staff are trained in one of these curricula. These curricula are required to include common preventative or diffusionary approaches such as:
a. Prompting and redirection
b. Varied verbal and nonverbal methods of defusing behavior problems, such as
1. Environmental modifications;
2. Body posture and movement;
3. Facial expression;
4. Empathic listening;
5. Increasing space between the individual and staff;
6. Things to say and how to say them/tone of voice;
7. Taking a walk.
c. Preventative measures, such as
1. Behavioral programs, including a required component for training and reinforcing replacement or alternative behavior;
2. Environmental modifications;
3. Rich, meaningful and diversionary activities;
4. Reinforcement procedures for demonstrating appropriate behavior;
5. Skill training, such as: social skills, problem solving, relaxation training, anger management training;
6. Medication for diagnosed mental health conditions;
7. Medical and dental exams to rule out any underlying physical conditions;
8. Other traditional therapies.

All emergency procedures (including seclusion and restraint) must be documented and reported monthly to the local APD Field Office and the AHCA Contract Manager. Submitted reports are reviewed by the Area Behavior Analyst and/or their designee. Reporting is reviewed monthly at the Local Review Committee and feedback is provided to individual providers and the Pilot Plans. Excessive frequency and duration of use as well as cases with injury will result in provider-specific feedback for correction or additional review of the person’s behavioral data and behavior program. Individuals who have received an emergency procedure at a frequency of more than two times in any thirty-day period, or six times in any twelve-month period, will result in a request for behavioral services and typically a behavioral assessment and behavior program development.

In an emergency, when continuous and ongoing behavior poses a threat to self, others or property, and all

other interventions to diffuse the problem behavior have failed, then with the proper number of direct care staff, they may implement reactive strategies that they have been trained and certified to implement. At the onset of seclusion or restraint implementation, staff will notify the appropriate authorizing agent of the conditions leading up to the use of the emergency procedure. The authorizing agent is then responsible for assuring that the procedure is in compliance with policy and rule or terminate the procedure. These procedures are monitored continuously during their application. When the emergency has ended the procedures are to be terminated. As soon as possible after the procedures have been terminated staff must document the use of the reactive strategy.

All personnel that use reactive strategies must be trained in an emergency procedure protocol. The emergency procedure training curriculum includes the following:
- non-physical crisis (preventative) intervention techniques;
- history of applied use to persons with developmental disabilities;
- criteria for use of reactive strategies, and methods for reducing physical interventions
- instruction in reactive strategy precautions and potential hazards; and
- it also includes a “release” criterion (e.g., a stated period of calm behavior) that is of short duration and that is client-driven or initiated.

The state employs the following practices to ensure the health and safety of individuals. Annually, the person’s medical condition must be assessed to determine whether or not he or she might be placed at risk of physical injury during restraint or seclusion, or otherwise precludes the use of one or more emergency procedures. An emergency procedure must provide for the least possible restriction consistent with its purpose. The requirements of rule require reactive strategies to be implemented in a manner that permits the greatest possible amount of comfort and protection from injury to the individual. Staff must continuously observe the client during restraint procedures, monitor respiration rate, and determine when release criteria have been met. Before initiating a seclusion or restraint procedure, staff must inspect the environment and the individual in order to ensure that any foreign objects that might present a hazard to the individual’s safety are removed. Any room in which the individual is held must have sufficient lighting and ventilation to permit the individual to be seen, to maintain a comfortable temperature, and must have enough space to permit him or her to lie down comfortably. The door to any room in which an individual is secluded without an attending staff person must not be locked; however, the door can be held shut by a staff person using a spring bolt, magnetic hold, or other mechanism that permits the individual in seclusion to leave the room if the caregiver leaves the vicinity.

Monthly reactive strategy reporting is monitored by the ABAs and ASBA for unusual patterns of use and procedures with adverse outcomes. Providers who have exhibited a pattern in reporting the use of reactive strategies are noted by ABAs and required to report monthly even if no procedures were implemented during the month. In addition, ABAs are also required to note gaps in reporting when they occur, prompting formal action against the provider. Additionally, ABAs are required to complete an investigative follow-up for every reported incident involving the use of restraint, seclusion, restrictive intervention or a significant behavioral episode. Results from the investigation are documented and may require the provider to develop a corrective action plan by the Region’s Quality Assurance unit. More severe action may be taken depending on the history of deficiencies. The Local Review Committee must review behavior analysis providers’ behavior programs before they are implemented. The review ensures technical integrity, appropriateness of interventions, use of the least restrictive methods, and that an individual’s rights are protected.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Chapter 393, Florida Statutes, requires emergency procedures to be used only for imminent danger and APD has promulgated Rule 65G-8, F.A.C., "Reactive Strategies," and amended Rule 65G-4, F.A.C., "Behavioral Practice and Procedure," to establish limitations and requirements when these procedures are used on waiver enrolled recipients.

These rules call for use of restraints or seclusion as a last resort, with efforts implemented to use preventative or less restrictive interventions first. All use of restraints and seclusion must be logged by providers, with reports submitted to APD and the AHCA Contract Manager monthly. In addition, behavioral services are monitored by the behavior analyst assigned to provide services either as an independent provider or as part of a residential program. This level of monitoring, as well as monitoring of incident reports provides additional opportunities to assure that reactive strategies are documented and used appropriately.

All waiver providers serving individuals with significant inappropriate behavior that may require use of physical management techniques are required to train their staff in an APD approved curriculum for emergency procedures. Minimum standards for curriculum content are outlined in Rule 65G-8, F.A.C., "Reactive Strategies." The providers are obligated to notify the APD and the Pilot Plan of the curriculum they have elected to use and maintain records of certification of all staff for review by APD.

Reports of Reactive Strategy use will be reviewed at least monthly during the regular meeting of the APD Local Review Committee (LRC) to assure that individuals meeting limiting criteria for emergency procedure use have a behavior analysis support plan developed and reviewed to monitor the effectiveness of programs when they are in place. Behavior programs for individuals receiving use of reactive strategies will be reviewed at a frequency determined by the LRC chairperson, or at least annually.

Data related to reactive strategies is monitored for trends and patterns at three levels:

Clinician Level: For those individuals with behavior programs, the behavior analyst providing services is watching the reactive strategy data in conjunction with data for targeted behavior that are the focus of the behavior program. This data is used to evaluate the effectiveness of the program written, along with fidelity data to show how well staff are implementing the plan. These data help to guide the need for revisions to the plan or additional training and monitoring of staff.

Local Field Office Level: The second level of review is conducted by the Area Behavior Analyst who sees data from all providers reporting use of reactive strategies locally. Providers appearing to use higher frequency and duration of procedures are given feedback by the Area Behavior Analyst to make corrections, or closer scrutiny of individualized behavior programs for their residents may be undertaken at the Local Review Committee conducted by the Area Behavior Analyst. This allows peers to offer suggestions for improvements to behavior programs. Information is also submitted to the Pilot Plans.

State Office Level: The third level of review occurs at the State Office level where all Field Office reports are submitted monthly. Data is reviewed by APD and AHCS and trended to determine the average frequency, average duration, and numbers of procedures used on average across the state and within each area served by a Field Office. These trends are generated for each local area to allow feedback to be provided to the Area Behavior Analysts for follow-up with providers and/or the individuals they serve, as well as the Pilot Plans.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Chapter 393.13, Florida Statutes, outlines the rights of enrollees receiving treatment from Pilot Plan providers, within the least restrictive conditions necessary to achieve the purpose of treatment. Treatment programs involving use of noxious or painful stimuli are prohibited. As set forth in Ch. 393 the rights of enrollees include, unrestricted right to communication, the possession and use of one's own clothing and personal effects, prompt and appropriate medical treatment, space for storage of possessions, opportunities for physical exercise, humane discipline, medical examination prior to behavioral treatment, be free from unnecessary use of restraint and seclusion, have a central record, and have the ability to vote. Unless there is reason to believe that unrestricted exercise of these provisions may be harmful to the client or others, then the enrollee's support plan must identify those circumstances and a plan of treatment must be developed to provide temporary limitation and active remediation that will lead to full restoration.

Initially, the Care Coordinator takes lead on identifying service needs and discussing proposed treatment options with the enrollee, their legal guardian and the enrollee's circle of supports. The care plan identifies services, level of supervision or supports, as well as formalized services found in a behavior analysis support plan, in a safety plan or a combination of the two. When behavioral interventions are appropriate, standards of practice outlined in Rule Chapter 65G-4, F.A.C. Behavioral Service Practice and Procedure call for the "least restrictive most effective intervention."

The procedures to be used in the behavior plan are determined on a case-by-case basis depending on the results of a comprehensive functional assessment to identify the behaviors to be addressed, as well as the causes or functions of the behavior and to rule out other appropriate alternative treatments, including medical, physical or occupational interventions. Also evaluated are the risks presented to self, others and property. It is often the case that there are multiple known treatments found in the behavioral literature for a particular problem behavior. However, individual circumstances and the environment within which the treatment will be implemented will dictate the choice of procedures in an intervention package. In all cases a reinforcement component is required, at least to reinforce appropriate alternative replacement behavior for the targeted inappropriate or undesirable behavior.

Behavior plans addressing behaviors dangerous to self and others or those containing restrictive procedures must be submitted to the Local Review Committee (LRC), a peer review committee. The behavior plan is reviewed to ensure protection of enrollee's rights, clinical integrity and compliance with the requirements of Rule Chapter 65G-4, F.A.C. In addition, the LRC renders a decision to approve the program or not, and establishes the frequency of periodic review of the program, and submits information to the Pilot Plans. Reviews are intended to evaluate the continued appropriateness of the procedures and their effectiveness. Behavior programs are updated and reviewed as needed, and reviewed at least annually by the LRC. When the data does not show the anticipated change or progress, then the behavior analyst needs to determine whether there is a problem with the procedures written or a problem with implementation. If there is a problem within the program, then modification will be made and resubmitted to the LRC.

Use of unauthorized restrictive interventions (abridgement of rights) may be detected when facilities are monitored monthly for compliance with enrollee behavior management rules, Rule 65G-8, F.A.C., and by the ABA and ASBA for unusual patterns of use and procedures with adverse outcomes, such as a enrollee death, enrollee injury or procedures lasting over 60 minutes. More specifically, every use of a reactive strategy (seclusion and restraint) is reviewed at the Local Review Committees of Behavior Analysts and may be reported to protective services.

Monthly reactive strategy reporting is monitored by the ABAs and ASBA for unusual patterns of use and procedures with adverse outcomes. Providers who have exhibited a pattern in reporting the use of reactive strategies are noted by ABAs and required to report monthly even if no procedures were implemented during the month; the Pilot Plans also receive copies of these reports. In addition, ABAs are also required to note gaps in reporting when they occur, prompting formal action against the provider, and submit this information to the Pilot Plans.

Additionally, ABAs are required to complete an investigative follow-up for every reported incident involving the use of restraint, seclusion, restrictive intervention or a significant behavioral episode. Results from the investigation are documented and may require the provider to develop a corrective action plan by the Region's Quality Assurance unit and submit this information to the Pilot Plans. More severe action may be

taken depending on the history of deficiencies. The Local Review Committee must review behavior analysis providers' behavior programs before they are implemented. The review ensures technical integrity, appropriateness of interventions, use of the least restrictive methods, and that an enrollee's rights are protected.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The APD is primarily responsible for monitoring and providing oversight for the use of restrictive procedures implemented with the enrollees, as outlined in Chapter 393, Florida Statutes, and specified in Rule 65G-4, F.A.C. (Behavioral) Service Delivery Practice and Procedure.

Chapter 393.13, F.S., calls for the adoption of a system for the oversight of the plans or behavioral programs. The system was intended to establish guidelines and procedures governing the design, approval, implementation, and monitoring of all behavior programs involving enrollees. This establishing language authorized the development of rule chapter 65G-4, F.A.C., Behavioral Service Practice and Procedure. This rule identifies the qualifications and credentials required for individuals who provide behavioral services. Furthermore, it identifies a senior clinician to oversee, maintain and give direction to standards of behavioral practice statewide. Under this rule Area Behavior Analysts are established and out-posted throughout the state to reinforce standards of practice through the Local Review Committees (LRC) that provide peer review for new and ongoing behavior programs developed and implemented by behavioral service providers. The LRC reviews and approves behavior programs to assure that they comply with Ch. 393, F.S., Rule 65G-4 and 65G-8, F.A.C., Reactive Strategies, and is consistent with contemporary behavior analysis practices. Behavior programs are reviewed regularly based on a schedule of review determined by the LRC, as often as monthly depending on the severity of behaviors or restrictiveness of procedures, but at least on an annual basis. This information is submitted to the Pilot Plans.

Monthly, the licensing staff within each local APD Field Office, across the state, monitor residential providers. During these visits they view the home and the individuals residing there and the direct care staff. While conversing with the residents or staff, reviewing consumer records, logbooks for cross-shift communication or behavioral data collection sheets, evidence may emerge that leads to the discovery of inappropriate use of "restrictive interventions" that abridge the rights of individuals.

If any of these events rise to the level of an "incident" or a call to the Abuse Hotline, operated by the Department of Children and Families, the use or misuse of "restrictive interventions" may be identified. Those events that result in investigations of abuse, neglect or exploitation, incident reporting or use of reactive strategies are reported in the Evidentiary (372) Reports submitted annually, with monthly assurance indicators reviewed and reported to AHCA, the state Medicaid agency on a quarterly basis.

Use of unauthorized restrictive interventions (abridgement of rights) may be detected when facilities are monitored monthly for compliance with enrollee behavior management rules, Rule 65G-8, F.A.C., and by the ABA and ASBA for unusual patterns of use and procedures with adverse outcomes, such as an enrollee death, enrollee injury or procedures lasting over 60 minutes. More specifically, every use of a reactive strategy (seclusion and restraint) is reviewed at the Local Review Committees of Behavior Analysts and may be reported to protective services.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- ○ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Chapter 393, Florida Statutes, requires restrictive procedures to be used only for imminent danger. The APD has promulgated Rule 65G-8, F.A.C., “Reactive Strategies" to establish Agency-approved emergency procedure curricula, for staff training to assure competent implementation of these procedures when preventative or less restrictive procedures have failed. Providers must maintain a reactive strategy policy and procedure, conduct assessments annually to determine history of trauma and pre-existing medical conditions that may preclude use of specific techniques or procedures, and specify who can authorize the use of these procedures. This rule also identifies limits for use of reactive strategies, prohibits selected procedures, and requires documentation and reporting of these procedures when used.

Under this rule, “seclusion” is defined as, enforced confinement to a room or area, and is not a “time out”. However, if a time-out procedure exceeds 20 minutes in duration it must be reported as “seclusion”. Any room or space that is used for seclusion must have sufficient lighting and ventilation in accordance with normal standards of comfort, and allow for sufficient dimensions for the enrollee to stand or to lie down comfortably. The door to the room may be held by staff, or by means of a mechanical device requiring constant staff pressure, but cannot be locked. Staff must monitor the individual in seclusion continuously.

All reactive strategies require an “authorizing agent” to approve the use of the procedure. A procedure is limited to one hour. If additional time in the procedure is necessary, then reauthorization is required. As soon as the procedure is terminated staff must document its use. A monthly summary of all reactive strategies must be submitted to the local APD Field Office, with copies to the Pilot Plans, with all provider reports compiled and submitted to the APD State Office and AHCA for review.

Rule 65G-8, F.A.C., Reactive Strategies and rule 65G-4, F.A.C., Behavioral Practice and Procedure, requires the monitoring and oversight of these procedures by the assigned behavioral services provider, the Area Behavior Analyst, the Local Review Committee, and the Agency Senior Behavior Analyst. If an enrollee receives a reactive strategy as an emergency procedure more than two times in a 30 day period or more than six times in any twelve-month period then the provider or facility must request behavior analysis services for the enrollee. In most cases this leads to completion of a behavioral assessment and development of a behavior plan in the interest of devising less restrictive procedures to intervene leading to the development of more adaptive alternative behaviors and reduction of the challenging behaviors for which reactive strategies have been necessary.

The use of seclusion is identified through self-report by providers. There are varied requirements established in statute and rule, including that staff using reactive strategies must be trained in an approved curriculum, that there must be designated “authorizing agents” within a providing agency, as well as prohibitions and limitations on the use of selected procedures, and requirements for documentation and monthly reporting. Facilities are monitored monthly for compliance with enrollee behavior management rules, Rule 65G-8, F.A.C., and by the ABA and ASBA for unusual patterns of use and procedures with adverse outcomes, such as an enrollee death, enrollee injury or procedures lasting over 60 minutes. More specifically, every use of a reactive strategy (seclusion and restraint) is reviewed at the Local Review Committees of Behavior Analysts and may be reported to protective services.

Monthly reactive strategy reporting is monitored by the ABAs and ASBA for unusual patterns of use and procedures with adverse outcomes. Providers who have exhibited a pattern in reporting the use of reactive strategies are noted by ABAs and required to report monthly even if no procedures were implemented during the month. In addition, ABAs are also required to note gaps in reporting when they occur, prompting formal action against the provider.

Additionally, ABAs are required to complete an investigative follow-up for every reported incident involving the use of restraint, seclusion, restrictive intervention or a significant behavioral episode. Results from the investigation are documented and may require the provider to develop a corrective action plan by the Region’s Quality Assurance unit; copies are also submitted to the Pilot Plans. More severe action may be taken depending on the history of deficiencies. The Local Review Committee must review behavior analysis providers’ behavior programs before they are implemented. The review ensures technical integrity, appropriateness of interventions, use of the least restrictive methods, and that an enrollee’s rights are protected.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Chapter 393, Florida Statutes, requires restrictive procedures to be used only for imminent danger and APD has promulgated Rule 65G-8, F.A.C., “Reactive Strategies,” and amended Rule 65G-4, F.A.C., “Behavioral Practice and Procedure,” to establish limitations and requirements when these procedures are used with waiver enrollees.

These rules call for use of restraints or seclusion as a last resort, with efforts implemented to use preventative or less restrictive interventions first. All use of restraints and seclusion must be logged by providers, with reports submitted to APD and the AHCA Contract Manager monthly. In addition, behavioral services are monitored by the behavior analyst assigned to provide services either as an independent provider or as part of a residential program. This level of monitoring, as well as monitoring of incident reports provides additional opportunities to assure that reactive strategies are documented and used appropriately.

By rule, all waiver providers serving individuals with significant inappropriate behavior that may require use of physical management techniques are required to train their staff in an APD approved curriculum for emergency procedures. Minimum standards for curriculum content are outlined in Rule 65G-8, F.A.C., “Reactive Strategies.” The providers are obligated to notify APD and the Pilot Plans of the curriculum they have elected to use and maintain records of certification of all staff for review by APD.

Reports of Reactive Strategy use will be reviewed at least monthly during the regular meeting of the APD Local Review Committee (LRC) and Pilot Plans to assure that enrollees meeting limiting criteria for emergency procedure use have a behavior analysis support plan developed and reviewed to monitor the effectiveness of programs when they are in place. Behavior programs for enrollees receiving use of reactive strategies will be reviewed at a frequency determined by the LRC chairperson, or at least annually.

Data related to reactive strategies, including seclusion, is monitored for trends and patterns at three levels:

Clinician Level: For those enrollees with behavior programs, the behavior analyst providing services is watching the reactive strategy data in conjunction with data for targeted behavior that are the focus of the behavior program. This data is used to evaluate the effectiveness of the program written, along with fidelity data to show how well staff are implementing the plan. These data help to guide the need for revisions to the plan or additional training and monitoring of staff.

Local Field Office Level: The second level of review is conducted by the Area Behavior Analyst who sees data from all providers reporting use of reactive strategies locally. Providers appearing to use higher frequency and duration of procedures are given feedback by the Area Behavior Analyst to make corrections, or closer scrutiny of individualized behavior programs for their enrollees may be undertaken at the Local Review Committee conducted by the Area Behavior Analyst. This allows peers to offer suggestions for improvements to behavior programs. Information is also submitted to the Pilot Plans.

State Office Level: The third level of review occurs at the State Office level where all Field Office reports are submitted monthly. Data is reviewed by APD and AHCA and trended to determine the average frequency, average duration, and numbers of procedures used on average across the state and within each area served by a Field Office. These trends are generated for each local area to allow feedback to be provided to the Area Behavior Analysts for follow-up with providers and/or the enrollees they serve.

Rule 65G-4, F.A.C., “(Behavioral) Service Delivery Practice and Procedure,” includes the monitoring and oversight of these procedures by the Local Review Committee, as well as the requirement to develop a behavior program when criteria for frequent use of “reactive strategies” has been met.

Seclusion within a locked room is not permitted. However, time-out, used either as a planned intervention within a behavior program or used on an emergency basis, whether used within a separate room or not, exceeding 20 minutes in duration is reported as “seclusion.”

Alternative methods to avoid the use of “seclusion” are a required component within the emergency procedure curricula reviewed and approved by the Agency required under Rule 65G-8, F.A.C., “Reactive Strategies.” Provider agencies that use emergency procedures are required to ensure staff are trained in one of these approved curricula. The curricula are required to include common preventative or diversionary

approaches such as:
a. Prompting and redirection
b. Varied verbal and nonverbal methods of defusing behavior problems, such as
1. Environmental modifications;
2. Body posture and movement;
3. Facial expression;
4. Empathic listening;
5. Increasing space between the individual and staff;
6. Things to say and how to say them/tone of voice;
7. Taking a walk.
c. Preventative measures, such as
1. Behavioral programs, including a required component for training and reinforcing replacement or alternative behavior;
2. Environmental modifications;
3. Rich, meaningful and diversionary activities;
4. Reinforcement procedures for demonstrating appropriate behavior;
5. Skill training, such as: social skills, problem solving, relaxation training, anger management training;
6. Medication for diagnosed mental health conditions;
7. Medical and dental exams to rule out any underlying physical conditions;
8. Other traditional therapies.

The State utilizes multiple levels of detection for the unauthorized use or misuse of seclusion. Monthly, the licensing staff within each local APD Field Office across the state monitor all residential providers. During these visits they view the home and the enrollees residing there and the direct care staff. While conversing with the residents or staff, reviewing enrollee records, log books for cross-shift communication or behavioral data collection sheets, evidence may emerge that leads to the discovery of either appropriate or inappropriate practices. Each of these methods enable reviewers to determine whether these events were addressed appropriately or not.

Similarly, if an event rises to the level of an “incident” or a call to the Abuse Hotline, operated by the Department of Children and Families, the unauthorized use or misuse of seclusion may be identified. In addition, providers are required under Rule 65G-8, F.A.C., “Reactive Strategies” to report all applications of seclusion and restraint. The report indicates whether seclusion was used or not, the duration and whether any injuries occurred. If reported, and reported accurately, this allows the review, analysis and follow-up by the Regional Behavior Analyst, as well as the Agency Senior Behavior Analyst at the State Office level.

The use of seclusion is identified through self-report by providers. There are varied requirements established in statute and rule, including that staff using reactive strategies must be trained in an Agency approved curriculum, that there must be designated “authorizing agents” within a providing agency, as well as prohibitions and limitations on the use of selected procedures, and requirements for documentation and monthly reporting to the Agency. Facilities are monitored monthly for compliance with client behavior management rules, Rule 65G-8, F.A.C., and by the ABA and ASBA for unusual patterns of use and procedures with adverse outcomes, such as an enrollee death, enrollee injury or procedures lasting over 60 minutes. More specifically, every use of a reactive strategy (seclusion and restraint) is reviewed at the Local Review Committees of Behavior Analysts and may be reported to protective services.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The service providers have rules, policies, and procedures to follow to ensure the safe administration or supervision of medication administration. Medication administration, supervision, and assistance may be provided to enrollees as long as qualified staff are available to render the service.

The enrollee's care coordinator is also involved in reviewing the enrollee's medical records and Medication Administration Record (MAR) if the enrollee resides in an APD group home. Those residing in a supported living residence, could have a supported living coach who assists, or provides oversight for medication administration.

APD staff monitor APD group homes on a monthly basis. APD staff, service providers, and support coordinators all work with the APD Medical Case Managers to address areas of concern regarding medication regimens on an ongoing basis.

Medical Case Managers will review medications, physician orders, and MARs, as requested by licensing staff, service providers, and support coordinators. The contracted vendor also monitors provider compliance (if applicable) with medication administration on an ongoing basis, and issues alerts or reports to both the provider and APD for remediation of identified issues.

APD Medical Case Managers provide training to APD staff on Chapter 393.506, Florida Statutes, and Rule 65G-7, F.A.C., Medication Administration. Any medication error discovered by the APD in APD licensed homes results in a "notice of non-compliance" and a corrective action plan. This encourages providers to self-report medication errors, and suggest what remediation they will put in place to prevent future occurrences. All medication errors are reviewed by APD Medical Case Managers, with follow-up if necessary. If the Medical Case Manager determines that the error justifies corrective action (additional training, new policy/procedure for the provider, etc.), APD notifies the provider of the corrective action and includes a specific timeframe for completion. APD nursing staff reviews medication error spreadsheets with each office a minimum of twice yearly. All providers who are responsible for medication administration are required to both record and report all medication errors to the APD.

In addition, unlicensed direct care staff are trained to compare the prescription to both the medication label and the entry in the MAR with each administration of medication, and to report discrepancies to their supervisors immediately.

Controlled substances in APD licensed group homes must be counted as specified in Rule 65G-7.007(5), F.A.C. These medications must be counted each shift by oncoming and offgoing staff. In cases where there are no shifts there are alternatives provided, all of which require a count at least once in each 24-hour period. Controlled substances must be stored separately from other medications and double locked. While the first line of controlled substance monitoring is performed by group home staff, the second line monitoring for controlled substances in APD-licensed group homes are performed by APD staff during monthly and annual licensure monitoring visits.

APD will share findings with the Pilot Plans and AHCA.

For enrollees living in 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 59A-36.011, 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 enrollee'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.

AHCA monitors providers on an annual basis to assess whether Pilot Plans are in compliance with State and Federal medical management and administration regulations. This may include reviewing medication reports, enrollee case files for prescriptions, the provider's critical incident reports and APD findings as necessary. AHCA will cross reference its information with the Pilot 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 guidelines.

The APD Medical Case Managers review and follow-up on issues cited by licensing, providers, APD staff, support coordinators, and the Pilot Plans on an ongoing basis.

Medication errors are reported to the APD on the Medication Error Report Form. The APD Medical Case Managers will review and follow up as necessary. If the APD Medical Case Manager determines that a medication error justifies corrective action, including additional training, the APD will notify the provider and include a specific and reasonable timeframe for completion.

The APD staff, Medical Case Managers, and contracted vendor monitor and review MARs, recipient Authorization for Medication Administration and Informed Consent, and the direct service provider’s Validation Certificate and Medication Administration Training Certificate.

Any medication error discovered in an APD licensed home that was not self-reported, results in a "notice of non-compliance" and a corrective action plan. This encourages group home providers to self-report medication errors, and suggest what remediation they will do to prevent future occurrences. All providers who are responsible for medication administration (anywhere that medication administration occurs, including ADT, supported living, and any other environments where services are provided) are required to both record and report medication errors to APD staff. All medication errors are reviewed by APD Medical Case Managers, with follow-up if necessary.

If the Medical Case Manager determines that the error justifies corrective action (additional training, new policy/procedure for the provider, etc.), the APD notifies the provider of the corrective action and includes a specific timeframe for completion. The APD State Office reviews medication error spreadsheets with each Regional/Field Office at least twice yearly. Information on Pilot Plan enrollees will be sent to the Pilot Plans.

AHCA's Division of Health Quality Assurance surveys licensed assisted living facilities at least biennually. 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 Pilot Plan Quality Management Strategy or more frequently as needed.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of**

medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver providers are responsible for the administration of medications to waiver enrollees who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.

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 59A-36.011, 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.

Chapter 393.506, Florida Statutes and Rule 65G-7, F.A.C., Medication Administration govern the administration of medications or the supervision of medication administration for unlicensed staff. This outlines:

a. Who can administer or supervise;
b. Training required;
c. Validation of skills;
d. Informed consent;
e. Medication administration procedures;
f. Medication errors;
g. Storage requirements;
h. Documentation and record keeping; and
i. Off-site medication administration.

Direct service providers who administer medication must first take a Medication Administration Training course that has been approved by the APD and which is taught by a Registered Nurse. They must pass this course with a score of 80% or greater on the final exam. Before administering medications, they must be ‘validated’ to administer medications by a RN, ARNP, MD, or PA, in an actual client setting, with an actual client, and using medication that is ordered for that client. No simulation is allowed. Each route of medication administration must be validated separately. The routes direct service providers are allowed to administer are: oral, enteral, topical, otic, inhaled, ophthalmic, rectal, and transdermal. There is no requirement that each direct service provider be validated on all routes, but no direct service provider may administer medication via a route on which they have not received validation. All validations must be renewed annually. If validation of the primary route (usually oral or enteral) is allowed to lapse, the direct service provider must re-take the Medication Administration Training course, and then attempt validation. Before revalidating, all direct service providers must take and pass an Annual Update on Medication Administration and Medication Error Prevention, provided online on TRAIN Florida or from their APD Regional Medical Case Manager. If validation of the primary route (usually oral or enteral) is allowed to lapse, the direct service provider must re-take the Medication Administration Training course, and then attempt validation.

Direct service providers who are trained and validated on their primary routes may receive further training from an authorized Trainer to provide Prescribed Enteral Formula Administration to clients. They must be trained and receive validation with an actual client using that client’s actual Prescribed Enteral Formula. Direct service providers who provide this service must take and pass an Annual Update on Prescribed Enteral Formula Administration annually with their APD Regional Medical Case Manager.

Licensed Practical Nurses, Registered Nurses, and Advanced Practice Registered Nurses must take and pass a Medication Administration Trainer Training course before being approved to train direct service providers on Medication Administration. When they are approved as Medication Trainers, they receive the approved course materials from their APD Regional Medical Case Manager. Medication Trainers are required to attend and pass

an Annual Update course provided by APD Medical Case Managers annually in order to continue to train.

Licensed Practical Nurses, Registered Nurses, Advanced Practice Nurses, Medical Doctors, Doctors of Osteopathy, and Physician Assistants who wish to provide Validation Training to direct service providers must take a training course with their Regional Medical Case Manager before being approved, with the exception of Nurses who are approved as Medication Trainers. Validation Training providers do not have an Annual Update requirement, but may be required to attend further trainings or updates from time to time.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

APD Medical Case Managers/Regional/Field Offices review all medication errors submitted for providers under Chapter 393.506, F.S.

AHCA reviews all medication errors submitted for providers under Chapter 429.256, F.S.

(b) 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 reaction for an enrollee, the Pilot Plan must submit an incident report to AHCA within 24 hours.

-Medications given to the wrong person
-Wrong dose of medication given
-Newly prescribed order not initiated within 24 hours
-Medication refill not ordered timely
-Controlled Medication Sheet not accurate
-MAR not accurately documented
-Wrong medication given
-Medication not given
-Medication not given at the right time
-Refused medication

(c) Specify the types of medication errors that providers must *report* to the state:

-Medications given to the wrong person
-Wrong dose of medication given
-Newly prescribed order not initiated within 24 hours
-Medication refill not ordered timely
-Controlled Medication Sheet not accurate
-MAR not accurately documented
-Wrong medication given
-Medication not given
-Medication not given at the right time
-Refused medication

Medication errors that occur in other service environments are also reported.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

APD staff monitor group homes on a monthly basis.

Medication errors are reported to APD on the Medication Error Report Form. The APD Medical Case Managers review and follow up as necessary. If the APD Medical Case Manager determines that a medication error justifies corrective action, including additional training, the APD will notify the provider and include a specific and reasonable timeframe for completion.

The APD Medical Case Managers provide training to the APD Field Office staff on Chapter 393.506, Florida Statutes, and Rule 65G-7, F.A.C., Medication Administration. Any medication error discovered by the agency in APD licensed homes results in a “notice of non-compliance” and a corrective action plan. This encourages providers to self-report medication errors, and suggest what remediation they will put in place to prevent future occurrences. All medication errors are reviewed by the APD Medical Case Managers, with follow-up if necessary. If the Medical Case Manager determines that the error justifies corrective action (additional training, new policy/procedure for the provider, etc.), the APD notifies the provider of the corrective action and includes a specific timeframe for completion. The APD reviews Medication Error Spreadsheets with each Regional/Field office at least twice yearly. All providers who are responsible for medication administration are required to both record and report all medication errors to the APD staff. APD will share findings with the Pilot Plans and AHCA.

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 Pilot Plans. Pilot 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 Pilot Plan 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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of critical incidents reported to AHCA within required time frames. N: Number of critical incidents reported to AHCA within required time frames. D: Number of critical incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of health, safety and welfare issues reported in critical incidents 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):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of Adult Protective Services (APS) cases of enrollees with substantiated reports of abuse, neglect or exploitation (ANE) reported by the Plan as critical incidents. N: Number of APS cases of enrollees with substantiated reports of ANE reported by the Plan as critical incidents. D: Number of enrollees with substantiated APS reports of ANE.

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:

Number and percentage of enrollees with reports of use of prohibited restraints, reported by the Plan to Adult Protective Services (APS) within 24 hours of the incident. N: Number of enrollees with reports of use of prohibited restraints, reported by the Plan to APS within 24 hours of the incident. D: Number of enrollees with reports of use of prohibited restraints.

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:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of recipients who received a telephone contact from their care coordinator at least monthly to assess health status, satisfaction with services and any additional needs. N:Number of enrollees who received a telephone contact from their care coordinator at least monthly to assess health status, satisfaction with services and any additional needs. D:Number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Pilot Plan enrollee record

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

By contract, health safety and welfare issues must be reported in critical incident reports by the Pilot Plan to AHCA within 24 hours. AHCA may elect to assess and collect liquidated damages for each occurrence in which the Plan failed to timely file the critical incident report. If the Plan continues untimely submission of the required reports, the 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 Plan and necessary services are provided. The 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 Plan coordinates with the investigator to find a safe living environment or another participating provider of the enrollee's choice.

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 care coordinator must document the concern in the enrollee's case file along with how the concern was addressed. If a health status concern is not addressed, the care coordinator must address the concern and the Plan must provide additional training to the care coordinator on the importance of addressing health status concerns. The Plan must submit a signed and dated attestation that the training occurred.

Enrollees who are the subject of substantiated reports of abuse, neglect or exploitation must have appropriate follow-up from their Plan. During quarterly reviews, a list of substantiated Adult Protective Services (APS) cases are received from APS. If the Plan did not submit a critical incident report for the incident, a request for contact is sent to the 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 AHCA. The 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*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

AHCA and APD will establish a Quality Improvement Team for the Pilot Plans. 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 will meet 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); large number of well-being outcomes not being achieved; 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 the threshold set by AHCA and APD, 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 and APD 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.

It is the State’s intention that the Pilot 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 these processes to ensure the Pilot Plans are in compliance with waiver and contract requirements. 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 the Pilot Plans a capitated monthly fee for each recipient, 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.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

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 Pilot Plan rate for performance measures.

Quality measures involving 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 Pilot Plan providers through program memorandums and the contract amendment process. All revisions, additions or deletions of performance measures listed in 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 Pilot Plans, so the percent of the sample drawn randomly from each Pilot Plan matched the percent of the overall population served by the Pilot Plan. Proportionate random sampling ensures that all 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. AHCA staff will attend these meetings. All evaluation meetings will keep meeting minutes. Approved meeting minutes will be maintained by AHCA.

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 Pilot 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 Florida Office of Insurance Regulation determines whether Pilot 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 Pilot Plans (non-HMOs), AHCA reviews their annual financial statements and also verifies compliance with Pilot Plans' required insolvency protection and surplus accounts.

This waiver is being operated with a concurrent 1915a Managed Care waiver. AHCA's Bureau of Medicaid Program Integrity (MPI) performs audits and investigations of all post-payment activities. The Managed Care Plan is required by contract to have a Compliance Officer and Fraud Investigative Unit Manager. The plan is required to establish functions and activities governing program integrity to reduce the incidence of fraud and abuse and maintain a Fraud Investigative Unit. The required Compliance Plan and Anti-Fraud Plan include review of post-payment activities. The plan submits its Anti-Fraud Plan to MPI annually.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of approved monthly capitation payment made in a quarter to the capitated Pilot Plans for qualified recipients. N: Number of approved monthly capitation payments made in the quarter to capitated Pilot 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:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of monthly capitation payments made in the quarter to the Pilot Plans for services rendered. N: Number of monthly capitation payments made in the quarter for the 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 Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

Florida's certified Medicaid Management Information System is programmed to verify all Pilot Plan and recipient enrollment eligiblity criteria before approving a recipient's enrollment and generating a capitation payment. The Medicaid program has established edits to check Pilot Plan and recipient eligiblity criteria before each payment is made. No capitation payments are made to ineligible Pilot Plans for ineligible enrollees.

Each Pilot 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 AHCA on an annual basis. Each Pilot Plan must also submit financial reports to AHCA on a quarterly basis. These are reviewed by AHCA to ensure continued provider solvency, and congruence with payment information contained in the State provider payment system.

AHCA 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. AHCA investigates 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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

AHCA operates the State's Medicaid Management Information System. This system contains the system programming for the Pilot Plans and recipient eligibility as well as payment rates. If monthly payments are made to a Pilot plan for non-qualified enrollees, the system error is researched and necessary programming changes are implemented. Pilot Plans receiving the improper payments are notified that the payment will be recouped.

If incorrect payments are made to a Pilot Plan, the payment will be researched. Based upon the research findings related to the payment error, the Pilot 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***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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).*

The State of Florida's Agency for Health Care Administration (AHCA) contracted with Milliman to develop actuarially sound capitation rate ranges for the Comprehensive Intellectual and Developmental Disabilities Managed Care Pilot (Pilot) Plan for the implementation year (January 1, 2023 – December 31, 2023). AHCA is directed to develop a risk-adjusted capitation rate that blends funding for comprehensive services including iBudget, long-term care, and Managed Medical Assistance services.

This waiver is being operated with a concurrent 1915a Managed Care waiver.

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 Pilot Plan, this will be reflected on his/her eligibility file. Provider information is established upon enrollment of the Pilot Plans. Capitated payments flow directly to capitated Pilot Plans from FMMIS. For each recipient enrolled with a Pilot Plan, a monthly payment is generated. Capitated Pilot 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 Pilot 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.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Florida's Medicaid Management Information System (FMMIS) has edits to ensure that, prior to generating a payment to a Pilot Plan, the enrollee is eligible for the Pilot Plan program and is enrolled with the Pilot Plan.

Pilot Plans are required to monitor service delivery to ensure services are rendered in accordance with the plan of care.

The 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 support coordinator shall verify the 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 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 Plan shall provide reports demonstrating support coordination monitoring and evaluation as specified in the Contract, and the Managed Care Plan Report Guide. These reports shall include (but are not limited to) results for the following performance measures: "Number and percentage of plan of care services delivered according to the plan of care as to service type, scope, amount and frequency."

The 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 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 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:

Pilot Plans receive monthly capitation payments for caring for their enrollees from AHCA'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 Pilot 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 Pilot 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 §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

The State will utilize the invitation to negotiate as the procurement process with which to contract with managed care plans. The state statute for this waiver directs AHCA to consider current contracted long-term care plans as qualified providers. The Pilot Plan contract will include all state plan, long-term care, and iBudget benefits. This will be a voluntary plan for Medicaid recipients to join. The two geographic areas consist of Hardee, Highlands, Hillsborough, Manatee, and Polk counties as well as Miami-Dade and Monroe counties. AHCA will pay the Pilot Plans a monthly capitated rates for all covered benefits.

○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §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 §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 Pilot Plans, and the Pilot Plans only receive the monthly capitation payments. Any payment from a capitated Pilot 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 Pilot 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.

Payments to providers of residential habilitation services are not made for the recipient’s room and board, the cost of facility maintenance, upkeep, and improvement, other than such costs for modifications or adaptations to a facility required to ensure the health and safety of residents, or to meet the requirement of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the recipient’s immediate family. Payments will not be made for activities or supervision for which payment is made by a source other than Medicaid.

The amount of room and board payment that participants will make is determined by the Florida Department of Children and Families Adult Services Program. The determination is based upon the participant's income from third party benefits and other income. If income is not sufficient to meet the room and board charges of the facility, the participant's circumstances can be reviewed to determine whether they will be eligible for an Optional State Supplement (OSS). The OSS payments are applied toward the cost of room and board.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	*Col. 2*	*Col. 3*	*Col. 4*	*Col. 5*	*Col. 6*	*Col. 7*	*Col. 8*
Year	*Factor D*	*Factor D'*	*Total: D+D'*	*Factor G*	*Factor G'*	*Total: G+G'*	*Difference (Col 7 less Column4)*
1	*51706.08*	*8436.53*	*60142.61*	*232539.90*	*4902.34*	*237442.24*	*177299.63*
2	*53779.62*	*8774.00*	*62553.62*	*241841.50*	*5098.43*	*246939.93*	*184386.31*

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)
3	56791.26	9265.34	66056.60	255384.62	5383.94	260768.56	194711.96

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 7)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	600	600
Year 2	600	600
Year 3	600	600

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 7)

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.*

Estimates are based upon Florida's Developmental Disabilities Individual Budget (iBudget) Waiver for the last 12 months of statistics available (4/1/2022 - 3/31/2023), with an average stay of 344 days.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 7)

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:*

The reference period for service estimates is 4/1/2022 to 3/31/2023 using claims data available as of 6/27/2023. Estimates are based upon Florida's, Developmental Disabilities Individual Budget (iBudget waiver). For Long Term Care (LTC) services not available in iBudget, service utilization is based upon recipients identified as having been in iBudget and now participating in Statewide Medicaid Managed Care, Long Term Care (SMMC-LTC). For the LTC services Behavior Management, Caregiver Training, Medication Administration, and Medication Management, waiver year 4 data were insufficient to create an estimate of utilization. For these services the recipient count was estimated as one (1) and unit and cost estimates are from waiver year 1 of the current SMMC-LTC waiver authority. The reference period 4/1/2022 to 3/31/2023 reflects costs resulting from new reimbursement rates effective 7/1/2022 due to Florida's $15 minimum wage, and is likely to be more representative of service utilization after the end of the COVID19 Public Health Emergency. Units and recipient counts reflect the entire period 4/1/2022 to 3/31/2023. Costs reflect reimbursements from 7/1/2022 to 3/31/2023.

For the Life Skills Development Level IV Prevocational Training service, waiver year 4 claims data were insufficient to create an estimate of utilization. Estimates from waiver year 5 of the existing iBudget authority were used.

Price inflation rates for waiver year services are from the National Health Expenditure Projections 2021-2030 Forecast Summary published by the Centers for Medicare and Medicaid Services (CMS). For Medicaid, spending growth during the period covered by waiver year 1 is forecasted to be approximately 4.0%. The period covered by waiver years 2 and 3 are expected to increase 5.6% on average. Prices from the reference year (4/1/2022 to 3/31/2023) to waiver year 1 of the renewal were increased approximately 2.7% per year.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D’ estimates are derived from the actual Medicaid cost for State Plan services for waiver recipients. Medicaid/Medicare dual eligible individuals receive prescription drugs through Medicare Part D and enrollment in Medicare approved prescription drug plans. Edits in the Florida Medicaid Management Informational System (FMMIS) prevent Medicaid payment of prescription drug costs for Medicaid/Medicare dual eligible recipients.

Price inflation rates for waiver year services are from the National Health Expenditure Projections 2021-2030 Forecast Summary published by CMS. For Medicaid, spending growth during the period covered by waiver year 1 is forecasted to be approximately 4.0%. The period covered by waiver years 2 and 3 are expected to increase 5.6% on average. Prices from the reference year (4/1/2022 to 3/31/2023) to waiver year 1 of the renewal were increased approximately 2.7% per year.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G estimates are based on Intermediate Care Facilities for individuals with Developmental Disabilities from 4/1/2022 to 3/31/2023 using claims from FMMIS that were submitted and adjudicated as of June 2023.

Price inflation rates for waiver year services are from the National Health Expenditure Projections 2021-2030 Forecast Summary published by CMS. For Medicaid, spending growth during the period covered by waiver year 1 is forecasted to be approximately 4.0%. The period covered by waiver years 2 and 3 are expected to increase 5.6% on average. Prices from the reference year (4/1/2022 to 3/31/2023) to waiver year 1 of the renewal were increased approximately 2.7% per year.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' estimates are derived from the actual Medicaid cost for state plan services for ICF/IDD residents. Medicaid/Medicare dual eligible individuals receive prescription drugs through Medicare Part D and enrollment in Medicare approved prescription drug plans. Edits in FMMIS prevent Medicaid payment of prescription drug costs for Medicaid/Medicare dual eligible recipients

Price inflation rates for waiver year services are from the National Health Expenditure Projections 2021-2030 Forecast Summary published by CMS. For Medicaid, spending growth during the period covered by waiver year 1 is forecasted to be approximately 4.0%. The period covered by waiver years 2 and 3 are expected to increase 5.6% on average. Prices from the reference year (4/1/2022 to 3/31/2023) to waiver year 1 of the renewal were increased approximately 2.7% per year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 7)

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	
Care Coordination	
Life Skills Development Level 3 - Adult Day Training	
Life Skills Development Level 4 - Prevocational Services	
Residential Habilitation	
Respite	
Adult Dental Services	
Occupational Therapy	
Physical Therapy	
Respiratory Therapy	
Skilled Nursing	
Specialized Medical Equipment and Supplies	
Specialized Mental Health Counseling	
Speech Therapy	
Transportation	
Assisted Living	
Behavior Analysis Services	
Behavior Assistant Services	
Dietitian Services	
Environmental Accessibility Adaptations	
Home Delivered Meals	
Life Skills Development Level 1 - Companion	
Life Skills Development Level 2 - Supported Employment	
Medication Administration	
Medication Management	
Personal Emergency Response System (PERS)	
Personal Supports	
Private Duty Nursing	
Residential Nursing	
Specialized Medical Home Care	
Supported Living Coaching	
Unpaid Caregiver Training	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 7)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Adult Day Health Care Total:							***478365.89***
Adult Day Health Care	☒	*Quarter hour*	*32*	*1630.20*	*9.17*	***478365.89***	
Care Coordination Total:							***977909.76***
Care Coordination	☒	*Month*	*597*	*10.82*	*151.39*	***977909.76***	
Life Skills Development Level 3 - Adult Day Training Total:							***1930728.15***
Life Skills Development Level 3 - Adult Day Training	☒	*Quarter hour*	*231*	*1064.73*	*7.85*	***1930728.15***	
Life Skills Development Level 4 - Prevocational Services Total:							***314084.49***
Life Skills Development Level 4 - Prevocational Services	☒	*Hour*	*38*	*1040.98*	*7.94*	***314084.49***	
Residential Habilitation Total:							***13579401.91***
Residential Habilitation	☒	*Month*	*207*	*41.18*	*1593.03*	***13579401.91***	
Respite Total:							***211142.19***
Respite	☒	*Quarter hour*	*19*	*1919.30*	*5.79*	***211142.19***	
Adult Dental Services Total:							***1497.97***

GRAND TOTAL:		***31023648.63***
Total: Services included in capitation:		*31023648.63*
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		***600***
Factor D (Divide total by number of participants):		***51706.08***
Services included in capitation:		*51706.08*
Services not included in capitation:		
Average Length of Stay on the Waiver:	*344*	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Dental Services	☒	Occurrence	1	4.52	331.41	1497.97	
Occupational Therapy Total:							50215.43
Occupational Therapy	☒	Quarter hour	11	277.51	16.45	50215.43	
Physical Therapy Total:							58587.86
Physical Therapy	☒	Quarter hour	13	266.83	16.89	58587.86	
Respiratory Therapy Total:							19818.39
Respiratory Therapy	☒	Quarter hour	2	586.69	16.89	19818.39	
Skilled Nursing Total:							17218.72
Skilled Nursing	☒	Occurrence	1	581.91	29.59	17218.72	
Specialized Medical Equipment and Supplies Total:							309212.12
Specialized Medical Equipment and Supplies	☒	Item	148	1755.69	1.19	309212.12	
Specialized Mental Health Counseling Total:							7671.76
Specialized Mental Health Counseling	☒	Quarter hour	3	178.33	14.34	7671.76	
Speech Therapy Total:							28134.79
Speech Therapy	☒	Quarter hour	7	238.39	16.86	28134.79	
Transportation Total:							659946.64
Transportation	☒	Trip	174	303.91	12.48	659946.64	
Assisted Living Total:							1547940.70
Assisted Living	☒	Day	70	31.45	703.13	1547940.70	
Behavior Analysis Services Total:							398558.53
Behavior Analysis Services	☒	Quarter hour	88	230.37	19.66	398558.53	
Behavior							50649.80

GRAND TOTAL:		31023648.63
Total: Services included in capitation:		31023648.63
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		600
Factor D (Divide total by number of participants):		51706.08
Services included in capitation:		51706.08
Services not included in capitation:		
Average Length of Stay on the Waiver:	344	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistant Services Total:							
Behavior Assistant Services	☒	Quarter hour	2	1984.71	12.76	**50649.80**	
Dietitian Services Total:							**880.32**
Dietitian Services	☒	Quarter hour	1	60.67	14.51	**880.32**	
Environmental Accessibility Adaptations Total:							**15115.08**
Environmental Accessibility Adaptations	☒	Occurrence	3	7.11	708.63	**15115.08**	
Home Delivered Meals Total:							**46011.65**
Home Delivered Meals	☒	Meal	64	108.60	6.62	**46011.65**	
Life Skills Development Level 1 - Companion Total:							**2164297.43**
Life Skills Development Level 1 - Companion	☒	Quarter hour	147	2927.06	5.03	**2164297.43**	
Life Skills Development Level 2 - Supported Employment Total:							**72274.78**
Life Skills Development Level 2 - Supported Employment	☒	Quarter hour	24	321.05	9.38	**72274.78**	
Medication Administration Total:							**4354.10**
Medication Administration	☒	Administration	1	138.05	31.54	**4354.10**	
Medication Management Total:							**1558.21**
Medication Management	☒	Evaluation	1	74.13	21.02	**1558.21**	
Personal Emergency Response System (PERS) Total:							**738.89**

GRAND TOTAL:	**31023648.63**
Total: Services included in capitation:	31023648.63
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**600**
Factor D (Divide total by number of participants):	**51706.08**
Services included in capitation:	51706.08
Services not included in capitation:	
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System (PERS)	☒	Daily Maintenance	2	9.91	37.28	738.89	
Personal Supports Total:							6946657.39
Personal Supports	☒	Quarter hour	220	5117.62	6.17	6946657.39	
Private Duty Nursing Total:							417231.75
Private Duty Nursing	☒	Quarter hour	4	15591.62	6.69	417231.75	
Residential Nursing Total:							198906.44
Residential Nursing	☒	Quarter hour	2	15068.67	6.60	198906.44	
Specialized Medical Home Care Total:							136721.65
Specialized Medical Home Care	☒	Day	1	270.42	505.59	136721.65	
Supported Living Coaching Total:							377603.94
Supported Living Coaching	☒	Quarter hour	69	686.64	7.97	377603.94	
Unpaid Caregiver Training Total:							211.92
Unpaid Caregiver Training	☒	Quarter hour	1	7.42	28.56	211.92	

GRAND TOTAL:	**31023648.63**
Total: Services included in capitation:	31023648.63
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**600**
Factor D (Divide total by number of participants):	**51706.08**
Services included in capitation:	51706.08
Services not included in capitation:	
Average Length of Stay on the Waiver:	344

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 7)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**497667.46**
Adult Day Health Care	☒	Quarter hour	32	1630.20	9.54	**497667.46**	
Care Coordination Total:							**1017054.57**
Care Coordination	☒	Month	597	10.82	157.45	**1017054.57**	
Life Skills Development Level 3 - Adult Day Training Total:							**2006973.46**
Life Skills Development Level 3 - Adult Day Training	☒	Quarter hour	231	1064.73	8.16	**2006973.46**	
Life Skills Development Level 4 - Prevocational Services Total:							**326742.80**
Life Skills Development Level 4 - Prevocational Services	☒	Hour	38	1040.98	8.26	**326742.80**	
Residential Habilitation Total:							**14122567.76**
Residential Habilitation	☒	Month	207	41.18	1656.75	**14122567.76**	
Respite Total:							**219529.53**
Respite	☒	Quarter hour	19	1919.30	6.02	**219529.53**	
Adult Dental Services Total:							**1557.91**
Adult Dental Services	☒	Occurrence	1	4.52	344.67	**1557.91**	
Occupational Therapy Total:							**52230.16**
Occupational Therapy	☒	Quarter hour	11	277.51	17.11	**52230.16**	
Physical Therapy Total:							**60946.64**
Physical Therapy	☒	Quarter hour	13	266.83	17.57	**60946.64**	
Respiratory Therapy Total:							**20616.29**

GRAND TOTAL:	**32267770.41**
Total: Services included in capitation:	32267770.41
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**600**
Factor D (Divide total by number of participants):	**53779.62**
Services included in capitation:	53779.62
Services not included in capitation:	
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respiratory Therapy	☒	Quarter hour	2	586.69	17.57	20616.29	
Skilled Nursing Total:							17905.37
Skilled Nursing	☒	Occurrence	1	581.91	30.77	17905.37	
Specialized Medical Equipment and Supplies Total:							322204.23
Specialized Medical Equipment and Supplies	☒	Item	148	1755.69	1.24	322204.23	
Specialized Mental Health Counseling Total:							7976.70
Specialized Mental Health Counseling	☒	Quarter hour	3	178.33	14.91	7976.70	
Speech Therapy Total:							29252.84
Speech Therapy	☒	Quarter hour	7	238.39	17.53	29252.84	
Transportation Total:							686386.81
Transportation	☒	Trip	174	303.91	12.98	686386.81	
Assisted Living Total:							1609868.89
Assisted Living	☒	Day	70	31.45	731.26	1609868.89	
Behavior Analysis Services Total:							414573.85
Behavior Analysis Services	☒	Quarter hour	88	230.37	20.45	414573.85	
Behavior Assistant Services Total:							52674.20
Behavior Assistant Services	☒	Quarter hour	2	1984.71	13.27	52674.20	
Dietitian Services Total:							915.51
Dietitian Services	☒	Quarter hour	1	60.67	15.09	915.51	
Environmental Accessibility Adaptations Total:							15719.78

GRAND TOTAL:	32267770.41
Total: Services included in capitation:	32267770.41
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	600
Factor D (Divide total by number of participants):	53779.62
Services included in capitation:	53779.62
Services not included in capitation:	
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations	☒	Occurrence	3	7.11	736.98	15719.78	
Home Delivered Meals Total:							47818.75
Home Delivered Meals	☒	Meal	64	108.60	6.88	47818.75	
Life Skills Development Level 1 - Companion Total:							2250353.00
Life Skills Development Level 1 - Companion	☒	Quarter hour	147	2927.06	5.23	2250353.00	
Life Skills Development Level 2 - Supported Employment Total:							75202.75
Life Skills Development Level 2 - Supported Employment	☒	Quarter hour	24	321.05	9.76	75202.75	
Medication Administration Total:							4528.04
Medication Administration	☒	Administration	1	138.05	32.80	4528.04	
Medication Management Total:							1620.48
Medication Management	☒	Evaluation	1	74.13	21.86	1620.48	
Personal Emergency Response System (PERS) Total:							768.42
Personal Emergency Response System (PERS)	☒	Daily Maintenance	2	9.91	38.77	768.42	
Personal Supports Total:							7228126.49
Personal Supports	☒	Quarter hour	220	5117.62	6.42	7228126.49	
Private Duty Nursing Total:							434070.70
Private Duty Nursing	☒	Quarter hour	4	15591.62	6.96	434070.70	

GRAND TOTAL:	**32267770.41**
Total: Services included in capitation:	32267770.41
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**600**
Factor D (Divide total by number of participants):	**53779.62**
Services included in capitation:	53779.62
Services not included in capitation:	
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Nursing Total:							**206742.15**
Residential Nursing	☒	Quarter hour	2	15068.67	6.86	**206742.15**	
Specialized Medical Home Care Total:							**142189.54**
Specialized Medical Home Care	☒	Day	1	270.42	525.81	**142189.54**	
Supported Living Coaching Total:							**392764.95**
Supported Living Coaching	☒	Quarter hour	69	686.64	8.29	**392764.95**	
Unpaid Caregiver Training Total:							**220.37**
Unpaid Caregiver Training	☒	Quarter hour	1	7.42	29.70	**220.37**	

GRAND TOTAL:	**32267770.41**
Total: Services included in capitation:	32267770.41
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**600**
Factor D (Divide total by number of participants):	**53779.62**
Services included in capitation:	53779.62
Services not included in capitation:	
Average Length of Stay on the Waiver:	344

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 7)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**525315.65**
Adult Day Health Care	☒	Quarter hour	32	1630.20	10.07	**525315.65**	
Care Coordination							**1074027.72**

GRAND TOTAL:	**34074756.16**
Total: Services included in capitation:	34074756.16
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**600**
Factor D (Divide total by number of participants):	**56791.26**
Services included in capitation:	56791.26
Services not included in capitation:	
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Care Coordination	☒	Month	597	10.82	166.27	**1074027.72**	
Life Skills Development Level 3 - Adult Day Training Total:							**2120111.67**
Life Skills Development Level 3 - Adult Day Training	☒	Quarter hour	231	1064.73	8.62	**2120111.67**	
Life Skills Development Level 4 - Prevocational Services Total:							**344939.13**
Life Skills Development Level 4 - Prevocational Services	☒	Hour	38	1040.98	8.72	**344939.13**	
Residential Habilitation Total:							**14913448.60**
Residential Habilitation	☒	Month	207	41.18	1749.53	**14913448.60**	
Respite Total:							**231928.21**
Respite	☒	Quarter hour	19	1919.30	6.36	**231928.21**	
Adult Dental Services Total:							**1645.14**
Adult Dental Services	☒	Occurrence	1	4.52	363.97	**1645.14**	
Occupational Therapy Total:							**55160.66**
Occupational Therapy	☒	Quarter hour	11	277.51	18.07	**55160.66**	
Physical Therapy Total:							**64346.05**
Physical Therapy	☒	Quarter hour	13	266.83	18.55	**64346.05**	
Respiratory Therapy Total:							**21766.20**
Respiratory Therapy	☒	Quarter hour	2	586.69	18.55	**21766.20**	
Skilled Nursing Total:							**18906.26**
Skilled Nursing	☒	Occurrence	1	581.91	32.49	**18906.26**	

	GRAND TOTAL:	***34074756.16***
	Total: Services included in capitation:	*34074756.16*
	Total: Services not included in capitation:	
	Total Estimated Unduplicated Participants:	***600***
	Factor D (Divide total by number of participants):	***56791.26***
	Services included in capitation:	*56791.26*
	Services not included in capitation:	
	Average Length of Stay on the Waiver:	*344*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:							**340393.18**
Specialized Medical Equipment and Supplies	☒	Item	148	1755.69	1.31	**340393.18**	
Specialized Mental Health Counseling Total:							**8420.74**
Specialized Mental Health Counseling	☒	Quarter hour	3	178.33	15.74	**8420.74**	
Speech Therapy Total:							**30888.19**
Speech Therapy	☒	Quarter hour	7	238.39	18.51	**30888.19**	
Transportation Total:							**724989.46**
Transportation	☒	Trip	174	303.91	13.71	**724989.46**	
Assisted Living Total:							**1700020.31**
Assisted Living	☒	Day	70	31.45	772.21	**1700020.32**	
Behavior Analysis Services Total:							**437887.30**
Behavior Analysis Services	☒	Quarter hour	88	230.37	21.60	**437887.30**	
Behavior Assistant Services Total:							**55611.57**
Behavior Assistant Services	☒	Quarter hour	2	1984.71	14.01	**55611.57**	
Dietitian Services Total:							**967.08**
Dietitian Services	☒	Quarter hour	1	60.67	15.94	**967.08**	
Environmental Accessibility Adaptations Total:							**16600.07**
Environmental Accessibility Adaptations	☒	Occurrence	3	7.11	778.25	**16600.07**	
Home Delivered Meals Total:							**50529.41**
Home Delivered Meals	☒	Meal	64	108.60	7.27	**50529.41**	

GRAND TOTAL:	**34074756.16**
Total: Services included in capitation:	34074756.16
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**600**
Factor D (Divide total by number of participants):	**56791.26**
Services included in capitation:	56791.26
Services not included in capitation:	
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Life Skills Development Level 1 - Companion Total:							**2375133.57**
Life Skills Development Level 1 - Companion	☒	Quarter hour	147	2927.06	5.52	**2375133.57**	
Life Skills Development Level 2 - Supported Employment Total:							**79440.61**
Life Skills Development Level 2 - Supported Employment	☒	Quarter hour	24	321.05	10.31	**79440.61**	
Medication Administration Total:							**4782.05**
Medication Administration	☒	Administration	1	138.05	34.64	**4782.05**	
Medication Management Total:							**1710.92**
Medication Management	☒	Evaluation	1	74.13	23.08	**1710.92**	
Personal Emergency Response System (PERS) Total:							**811.43**
Personal Emergency Response System (PERS)	☒	Daily Maintenance	2	9.91	40.94	**811.43**	
Personal Supports Total:							**7633441.99**
Personal Supports	☒	Quarter hour	220	5117.62	6.78	**7633441.99**	
Private Duty Nursing Total:							**458393.63**
Private Duty Nursing	☒	Quarter hour	4	15591.62	7.35	**458393.63**	
Residential Nursing Total:							**218194.34**
Residential Nursing	☒	Quarter hour	2	15068.67	7.24	**218194.34**	
Specialized Medical Home Care Total:							**150153.41**

GRAND TOTAL:	**34074756.16**
Total: Services included in capitation:	34074756.16
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**600**
Factor D (Divide total by number of participants):	**56791.26**
Services included in capitation:	56791.26
Services not included in capitation:	
Average Length of Stay on the Waiver:	344

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Home Care	☒	Day	1	270.42	555.26	**150153.41**	
Supported Living Coaching Total:							**414558.90**
Supported Living Coaching	☒	Quarter hour	69	686.64	8.75	**414558.90**	
Unpaid Caregiver Training Total:							**232.69**
Unpaid Caregiver Training	☒	Quarter hour	1	7.42	31.36	**232.69**	

GRAND TOTAL:	**34074756.16**
Total: Services included in capitation:	34074756.16
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**600**
Factor D (Divide total by number of participants):	**56791.26**
Services included in capitation:	56791.26
Services not included in capitation:	
Average Length of Stay on the Waiver:	344