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State/Territory Name: Florida

State Plan Amendment (SPA) #:14-006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

September 26, 2014

Mr. Justin Senior
Deputy Secretary for Medicaid
2727 Mahan Drive, MS#8
Tallahassee, Florida 32308

Re: Florida State Plan Amendment, Transmittal #14-006

Dear Mr. Senior:

Florida submitted state plan amendment 14-006 that was received by the Centers for Medicare & Medicaid Services (CMS) on June 30, 2014. The proposed effective date of this amendment is April 1, 2014. The purpose of this amendment is to amend the Consumer Directed Care Option (CDC+) for individuals enrolled in the Traumatic Brain and Spinal Cord Injury (TBI/SCI) and the Aging and Disabled Adult (ADA) waivers. Participants from the ADA waiver were transitioned to the Managed Care-Long Term Care (MC-LTC) waiver program, and individuals enrolled in the TBI/SCI wavier will be offered the option to enroll in the MC-LTC program.

Based on the information provided, we are now ready to approve Florida SPA 14-006 as of September 26, 2014. The signed CMS-179 and the approved plan pages are enclosed.

A companion letter is also being issued with this approval to address concerns related to the waiver components of the SPA.

If you have any questions or need any further assistance, please contact Etta Hawkins at (404) 562-7429.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, GA 30303

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

September 26, 2014

Mr. Justin Senior
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mailstop #20
Tallahassee, Florida 32308

RE: Florida State Plan Amendment 14-006

Dear Mr. Senior:

This letter is being sent as a companion to our approval of Florida state plan amendment 14-006 which amends the Consumer Directed Care Option for individuals enrolled in the Traumatic Brain and Spinal Cord Injury (TBI/SCI) and the Aging and Disabled Adult (ADA) waivers. Participants from the ADA waiver were transitioned to the Managed Care Long-Term Care (MC-LTC) waiver program, and individuals enrolled in the TBI/SCI wavier will be offered the option to enroll in the MC-LTC program.

However, the CMS has the following concerns related to the waiver components of the SPA. They are as follows:

1. The state provided a copy of a notice sent to participants in the TBI/SCI waiver who were self-directing services through the CDC+ program, notifying them that they can choose a managed care plan and that CDC+ will not be offered by that plan or by the TBI/SCI waiver, effective March 1, 2014. If March 1 was the effective date of the change, the state is out of compliance with the current approved waiver, which still contains the option to self-direct services through the state's 1915(j). Please confirm the date this letter was sent to participants, and confirm that March 1, 2014 was the effective date of the change.
2. An amendment removing the 1915(j) concurrent authority from the TBI/SCI waiver is required in addition to a 1915(j) SPA removing the population and the services. Such a change to the 1915(c) waiver is considered a substantive change, and requires that the state provide public notice as outlined in 42 CFR §441.304. In addition, the date for waiver amendments including substantive changes cannot be retroactive, and must have a prospective effective date. The 1915(j) and (c) will need to have the same effective date.
3. The state provided a crosswalk of services available for participant direction in the CDC+ program as compared to the services in the MC-LTC waiver. Only five services are

available for participant direction in the MC-LTC waiver, which is considerably fewer than those available through CDC+. Please provide us with a list and description of the five services that are available for participant direction in MC-LTC. This represents a significant change to the scope and delivery of services available to these individuals. What form of notice was provided to consumers to indicate which services they would be able to continue to self-direct, and which they would not?

Within 90 days of the date of this letter, the state is required to submit a waiver amendment that resolved the issues, or a corrective action plan to resolve the issues, whichever is appropriate. During the 90-day period, we are happy to provide any technical assistance that the state requires. State plans that are not in compliance with requirements referenced above are grounds for initiating a formal compliance process.

If you have any questions or need any further assistance, please contact Etta Hawkins, R.Ph. at (404) 562-7429.

Sincerely,

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: 2014-006	2. STATE Florida
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE April 1, 2014	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Section 1915(j) of the Social Security Act	7. FEDERAL BUDGET IMPACT: (in thousands) FFY 2013-2014 $ (1,860) FFY 2014-2015 $ (1,890)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 4 to Attachment 3.1-A, pages: 1-19 Attachment 4.19-B page 47	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 4 to Attachment 3.1-A, pages: 1-21 Attachment 4.19-B page 47

10. SUBJECT OF AMENDMENT:

Self-Directed Care

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Reviewed by the Deputy Secretary for Medicaid who is the Governor's designee.

12. SIGNATURE OF STATE AGENCY OFFICIAL: //s//	16. RETURN TO: Mr. Justin M. Senior Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308 Attention: April Cook
13. TYPED NAME: Mr. Justin M. Senior	
14. TITLE: Deputy Secretary for Medicaid	
15. DATE SUBMITTED: 06-30-14	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 06-30-14	18. DATE APPROVED: 09-26-14
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 04-01-14	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Jackie Glaze	22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns

23. REMARKS:

FORM HCFA-179 (07-92)

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

State of __Florida__
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

i. Eligibility

The State determines eligibility for Self-Directed Personal Assistance Services:

A. __X_ In the same manner as eligibility is determined for traditional State Plan personal care services, described in Item 24 of the Medicaid State Plan.

B. __X_ In the same manner as eligibility is determined for services provided through a 1915(c) Home and Community-Based Services Waiver.

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

A. __X__State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.

Only children under 21 years of age, enrolled in the Developmental Disabilities waiver(s) will be self-directing their State Plan personal care services.

B. __X___Services included in the following section 1915(c) Home and Community-Based Services waiver(s) to be self-directed by individuals eligible under the waiver(s). The State assures that all services in the impacted waiver(s) will continue to be provided regardless of service delivery model. Please list waiver names and services to be included.

Service providers will be enrolled with the authorized state agency Fiscal Employer Agent (FEA) designated on behalf of the Consumer Directed Care Plus (CDC+). Providers must attest to the provision of services in order to receive payment for services. All providers must be at least 16 years of age and must satisfy the qualifications, requirements and applicable licensure for the service that is provided. Providers must also comply with the background screening requirements and provisions of the applicable Florida Statutes.

Individual Budgeting (iBudget) Waiver: Life Skills Development, Adult Dental Services, Behavior Analysis Services, Behavior Assistant Services, Personal Supports, Specialized Medical Equipment and Supplies, Dietitian Services, Environmental Accessibility Adaptations, Private Duty Nursing, Occupational Therapy, Personal Emergency Response System, Physical Therapy, Residential Habilitation, Respiratory Therapy, Respite, Skilled Nursing, Special Medical Home Care, Specialized Mental Health Counseling, Speech Therapy, Supported Living Coaching, Transportation, Family and Guardian Training, and Person-Centered Planning.

iii. Payment Methodology

A. __X__ The State will use the same payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. The State uses the same payment methodology for individuals self-directing their State plan personal care services.

B. __X__ The State will use a different payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. Amended Attachment 4.19-B page(s) are attached. The State uses a different payment methodology for individuals self-directing their section 1915(c) Home and Community-Based waiver services.

iv. Use of Cash

A. _____ The State elects to disburse cash prospectively to participants self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

B. __X___ The State elects not to disburse cash prospectively to participants self-directing personal assistance services.

v. Voluntary Disenrollment

The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

A program consumer may elect to discontinue participation in the Consumer-Directed Care Plus (CDC+) program at any time.

In the event disenrollment is requested, the consumer's consultant completes a CDC+ Change Form to disenroll the consumer and forwards the form to program staff. All disenrollments are effective the first day of the month following receipt of the disenrollment form.

Program staff notifies the Agency for Health Care Administration about all disenrollments. Upon disenrollment from CDC+ the consumer may access waiver services through traditional means.

The consumer's consultant is responsible for ensuring the consumer has traditional waiver services in place to begin the first day of the month. Therefore, there will be no lapse in services.

vi. Involuntary Disenrollment

A. The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to the traditional service delivery model are noted below. Consumers may be disenrolled by consultants and CDC+ program directors.

Reasons for involuntary disenrollment include:

- Consumer moved out of state;
- Temporary or permanent long-term care facility admission;
- Hospitalization for more than 30 consecutive days;
- Loss of Medicaid eligibility;
- Loss of waiver eligibility;
- Representative not available if necessary for participation;
- Death of consumer;
- Mismanagement of budget;
- Consumer health or safety at risk;
- Consumer can no longer be served safely in the community.
- Admission to a licensed facility (group home, ALF, etc.)

B. The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

In the event disenrollment is required, the consumer's consultant completes a Consumer-Directed Care Plus (CDC+) Change Form to disenroll the consumer and forwards the form to program staff. All disenrollments are effective the first day of the month following receipt of the disenrollment form.
Program staff notifies the Agency for Health Care Administration about all disenrollment. Upon disenrollment from CDC+ the consumer may access waiver services through traditional means.

The consultant is responsible for ensuring the consumer has traditional waiver services in place to begin effective the first day of the month. Therefore, there will be no lapse in services.

vii. Participant Living Arrangement

Any additional restrictions on participant living arrangements, other than homes or property owned, operated, or controlled by a provider of services, not related by blood or marriage to the participant are noted below.

The 1915(c) iBudget waiver allows individuals to live in licensed facilities. Those individuals will not be allowed to participate in the CDC+ program based on this requirement.

viii. Geographic Limitations and Comparability

A. __X__ The State elects to provide self-directed personal assistance services on a statewide basis.

B. _____ The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe:_____

C. _____ The State elects to provide self-directed personal assistance services to all eligible populations.

D. __X___ The State elects to provide self-directed personal assistance services to targeted populations. Please describe: Eligibility for the program is limited to individuals under 21 years of age enrolled in the iBudget Waiver.

E. __X___ The State elects to provide self-directed personal assistance services to an unlimited number of participants.

F. _____ The State elects to provide self-directed personal assistance services to _____ (insert number of) participants, at any given time.

ix. Assurances

A. The State assures that there are traditional services, comparable in amount, duration, and scope, to self-directed personal assistance services.

B. The State assures that there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for self-directed personal assistance services.

C. The State assures that an evaluation will be performed of participants' need for personal assistance services for individuals who meet the following requirements:

i. Are entitled to medical assistance for personal care services under the Medicaid State Plan; or
ii. Are entitled to and are receiving home and community-based services under a section 1915(c) waiver; or
iii. May require self-directed personal assistance services; or
iv. May be eligible for self-directed personal assistance services

D. The State assures that individuals are informed of all options for receiving self-Directed and/or traditional State Plan personal care services or personal assistance services provided under a section 1915(c) waiver, including information about self-direction opportunities that is sufficient to inform decision-making about the election of self-direction and provided on a timely basis to individuals or their representatives.

E. The State assures that individuals will be provided with a support system meeting the following criteria:
   i. Appropriately assesses and counsels individuals prior to enrollment:
   ii. Provides appropriate counseling, information, training, or assistance to ensure that participants are able to manage their services and budgets:
   iii. Offers additional counseling, information, training, or assistance, including financial management services:
      1. At the request of the participant for any reason; or
      2. When the State has determined the participant is not Effectively managing their services identified in their service plans or budgets.

F. The State assures that an annual report will be provided to CMS on the number of individuals served through this State Plan option and total expenditures on their behalf, in the aggregate.

G. The State assures that an evaluation will be provided to CMS every 3 years, describing the overall impact of this State Plan option on the health and welfare of participating individuals, compared to individuals not self-directing their personal assistance services.

H. The State assures that the provisions of section 1902(a)(27) of the Social Security Act, and Federal Regulations 42 CFR 431.107, governing provider agreements, are met.

I. The State assures that a service plan and service budget will be developed for each individual receiving self-directed PAS. These are developed based on the assessment of needs.

J. The State assures that the methodology used to establish service budgets will meet the following criteria:
   i. Objective and evidence based, utilizing valid, reliable cost data
   ii. Applied consistently to participants
   iii. Open for public inspection

iv. Includes a calculation of the expected cost of the self-directed PAS and supports if those services and supports were not self-directed.

v. Includes a process for any limits placed on self-directed services and supports and the basis/bases for the limits.

vi. Includes any adjustments that will be allowed and the basis/bases for the adjustments.

vii. Includes procedures to safeguard participants when the amount of the limit on services is insufficient to meet a participant's needs.

viii. Includes a method of notifying participants of the amount of any limit that applies to a participant's self-directed PAS and supports.

ix. Does not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

x. Service Plan

The State has the following safeguards in place, to permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider's influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

Not applicable.

xi. Quality Assurance and Improvement Plan

The State's quality assurance and improvement plan is described below, including

i. How it will conduct activities of discovery, remediation, and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and

The State will conduct activities of discovery, remediation and quality improvement by using tools to collect data, take action and continuously improve the program. The tools developed for CDC+ fit into a complete quality management plan. These tools include: consumer satisfaction surveys, toll-free helpline, Person Centered Planning process (PCP) and the same follow-up instrument for each group, data reports, a Quality Advisory Committee, and monitoring of consultants and consumers.

I. The Consumer Satisfaction Surveys will be distributed on a yearly basis. The surveys will be accompanied by a letter from the program director explaining its importance and that feedback is necessary for continuous program improvement. Confidentiality will be kept on the surveys, however there is an option to include the responders name and appropriate information if the responder feels necessary or would like to be contacted.

Discovery: The survey requests basic information regarding the consumer and respondent such as: the person filling out the survey (consumer or representative) and the city where the consumer resides. Location allows the program office to see how each area rates.

Remediation: Areas with low survey ratings or low submission to program offices will alert the program office to do necessary outreach or training in those particular areas. The performance indicators are listed in the survey. Performance indicators are goals that each program office found important for their particular consumer population. Performance Indicators are questions such as: 1) The training provided by my consultant included a complete user-friendly consumer notebook. 2) I am able to find qualified employees and/or vendors to provide my services. Consideration will be given to those answers in which the majority or a large portion of the consumer population is unhappy with a particular item. For example, if one consumer indicated that he/she is unhappy with the consumer notebook. However, the rest of the consumers were very happy with their notebooks. The program office might decide that changing the notebook in that situation would be unnecessary. The survey asks whether or not each performance indicator is important to the respondent as well as the respondent to rate how they feel about the answer to each question. The rating is a 5-point Likert scale ranging from 1-(Strongly Disagree) to 5-(Strongly Agree). There is also a box labeled "Not applicable" for those respondents who feel that question does not apply to them. Every performance indicator includes a comments/suggestion section. Respondents are asked to explain a rating of 3-(Neither Agree or Disagree) or less.

Quality Improvement: The surveys are compiled into a data system (such as excel) for reporting. The surveys are evolving documents, meaning if a significant percentage of the responders indicate a performance indicator is not appropriate or relevant, then the performance indicator may be removed or changed in the survey document. Also the program office will review performance indicators with a 3 or less that are not being met by 80% or more of the respondents for relevance and appropriateness. The State assures all CMS' assurances listed in this application regarding consumer services, options and support system will be addressed in the survey.

II. The toll-free helpline is provided at the main program office for the Agency for Persons with Disabilities (APD). In addition, APD provides their consumers an e-mail address for questions; the e-mail is answered daily during normal business hours Monday through Friday from 8:00 A.M. until 5:00 P.M. Eastern Standard Time (EST) excluding holidays.

Discovery: The helpline enables consumers, representatives, consultants, members of the general public, etc. to call about anything from requesting general information, payment problem trouble-shooting, or making complaints. The e-mail addresses assists consumers with budget plan issues as well as timesheet and vendor invoice questions.

Remediation: Calls and emails into the helpline and e-mail addresses will be logged, researched and responded to within 48 business hours (Monday through Friday from 8:00 A.M. until 5:00 P.M. Eastern Standard Time [EST] excluding holidays). Resolution does not guarantee that the caller is satisfied with the response of the call but was given an answer to their question or issue.

Quality Improvement: Helpline and e-mail logs will be reviewed on a quarterly basis as part of ongoing quality assurance. The logs will describe the type of caller (consumers or consultants) and how quickly the call was answered or resolved. The logs will aid the program office in quality assurance enabling them to see what issues are facing the callers. For example, prospective consumers may call with reports of false information being distributed concerning the program. This type of information will allow the program office to provide outreach to the public, identify and refute misinformation as well as distribute correct information about the program. Consumers use the helpline and the consumer e-mail addresses to resolve payment issues, questions about budget/purchasing plans, and general program questions. The operating agency also has a current web-site with current information and forms for consumers. The operating agency tracks consumer issues by a "Notes" section on its database and records any issue regarding the consumer. That way any staff member can access a consumer file for current consumer information.

III. The Person Centered Planning (PCP) process will provide waiver support coordinators/consultants with information gathering tools and techniques that are critical to identifying the strengths, abilities, interests and personal goals of individuals with developmental disabilities on the iBudget waiver.

Discovery: The PCP process for the iBudget waiver allows consumers to list their needs and goals and define what services and supports will help them to satisfy their needs and reach their goals. For example a personal goal might be to spend more time with family and friends. The service they can use to reach that goal may include a certain frequency of homemaker hours once a week so the consumer can feel comfortable having visitors.

Remediation: These tools help the consumer decide what services and supports should be listed on their purchasing plan. The PCP process for the iBudget waiver is implemented when the consumer begins the program and at their yearly assessment. A follow-up instrument is completed at the semi-annual visit.

Quality Improvement: The follow-up instrument asks the consumers if their goals have been reached. Questions include: 1) Have you met Goal #1 listed on the PCP Tool? 2) Do you want to change any of your current goals? From this point, the consumer might decide their goals have changed. The follow-up instrument will be conducted no less than once a

year at the consumer's annual reassessment. The follow-up instrument also incorporates a "mini-survey" from consumers concerning health, safety, and welfare, their service needs, and their feelings regarding the program. From the follow-up instrument, the program office can glean pertinent consumer issues for the annual consumer survey.

IV. Consultant services for individuals with developmental disabilities will be provided by certified support coordinators trained to assume the consultant's role and responsibilities. These certification and training requirements will help assure effective and competent consultants and preserve waiver consumers' choice of consultant. Consultants are trained by Consumer-Directed Care Plus (CDC+) program staff in the overall philosophy of self-direction and specifically in the operations of the CDC+ program. To provide services to CDC+ consumers, consultants are required to be Medicaid waiver service providers for consultant services only. Consultants cannot serve as the consumer's representative. Consultants who are not certified case managers/support coordinators will be considered for enrollment on a case-by-case basis and the Agency for Health Care Administration (AHCA) has the final approval authority. Approval will be granted to those individuals who have a valid provider agreement with the Medicaid agency and who must meet the same training and certification provider requirements as those on the iBudget 1915(c) Home and Community-Based Services (HCBS) waiver.

Discovery: Consultant monitoring will include desk reviews and individual participant interviews. Desk reviews will be conducted on a quarterly basis to a random sampling of no less than 10% of all consultants. For consultants serving five or more CDC+ consumers, the desk reviews will include monitoring the consultant file for at least five randomly selected consumers. For consultants serving less than five CDC+ consumers, two files shall be reviewed. The file must include all necessary documentation for that consumer.

Documentation includes items such as: annual Medicaid eligibility determination and a completed and signed Person Centered Planning (PCP) process for the iBudget waiver. The consultant must have monthly contact with the consumer and visit the consumer in their home or community activity no less than once per six-month period. Monthly contact may be in the form of phone calls or in person, whichever is the preferred method of the consumer. Documentation of home visits and monthly contact must be in the consultant files for each consumer.

There is a Monthly Contact Review Form that must be completed by the consultant and includes topics such as: 1) Reviewed Monthly Budget Statement with the consumer and services are purchased along with purchasing plan. 2) Change in service needs due to change in circumstances.

Remediation: The consultant receives a copy of the consumer's Monthly Budget Net Worth Statement from APD for the iBudget consumers. If the consumer is not making purchases in accordance with his/her approved budget/purchasing plan, the consultant must complete a Corrective Action Plan (CAP) with the consumer. Consumers must sign that they

understand the implications of the CAP as well following the required action. The CAP must be implemented immediately and all purchases should reflect the CAP by the next monthly consultant review. If the consumer's purchases are still outside the guidelines of CDC+ and/or the budget/ purchasing plan after 60 days, then the consumer will be disenrolled from the program and returned to the traditional 1915(c) HCBS waiver.

Quality Improvement: At the semi-annual home visit, the consultant must look for indicators of fraud, abuse, neglect or exploitation and must report any findings to the proper authorities within 24 hours of the visit. Failure of the consultant to perform the monitoring duties will terminate the consultant from providing services on the CDC+ program. The program office will immediately assist the consumer in locating a new, local consultant. The operating program office (APD) has a contingency plan for consultant deficiencies. The State assures that all of Centers for Medicare and Medicaid Services (CMS) assurances listed in this application regarding participant safeguards, participant eligibility and budget development will be addressed in the monitoring of consultants.

V. The Quality Advisory Committee (QAC) is comprised of key program stakeholders. . The QAC will serve in an advisory capacity on behalf of APD.

Discovery: All reporting data is shared with the QAC. Along with reviewing data, the QAC will also look at other ways to improve the program and make suggestions to the program offices. The QAC meets on a quarterly basis. The QAC may include consumers, program staff, consultants, consumer-representatives, care-givers, Area Office staff, (AHCA) external reviewers (if applicable), and community advocates. APD will recommend members to the QAC as appropriate, and AHCA will serve as the approval authority.

Remediation: The QAC will consist of a maximum of six members. All members are trained in expectations, roles and responsibilities, federal and state laws and program policies and procedures.

Quality Improvement: The QAC also reviews the Program Self-Assessment (PSA). The QAC will identify and advise the program office of the areas in which the program should improve itself and will aid in setting the priorities for improvement. The QAC reviews all program policies, consultant and consumer brochures and training materials.

VI. The program office is also charged in completing a PSA that assesses the program structure and policies to see if the program is meeting the performance indicators. The PSA is developed using the guidelines created by SCRIPPS' in the Guide to Quality in Consumer Directed Services.

Discovery: The PSA is developed by the program office in assistance with the QAC. The final document must be approved by AHCA. The PSA asks the program office to evaluate itself with statements such as:

1) Consumers, family members and advocates help design, develop, operate and evaluate the program.
2) Can consumers determine which services to use and can they select, hire and dismiss their workers? The main purpose of the PSA is to assist the program office in identifying program goals, having a plan to meet the goals, ensuring the goals are met and aiding the program office in re-assessing itself in an ongoing capacity. The PSA also alerts the program office of unmet goals or issues that the program office might need to address so the program office continues to excel in its efforts.

Remediation: The APD Program Office will work with the QAC on identifying performance indicators to list in the PSA. Performance Indicators will be identified from areas that are listed by the consumer in the satisfaction surveys and areas to be improved upon in consultant training gathered from the monitoring reports, etc.

Quality Improvement: The QAC reviews the PSA and helps the program office to determine what areas the program office is lacking and the priorities for correcting any deficiencies. The QAC also aids the program office in identifying program improvements needed by the program offices. During the QAC meeting, the program office is responsible for updating the QAC on steps taken to meet requirements of the PSA and any future activities related to program improvement.

VII. APD requires monthly bank reconciliation reports from its subagent to balance consumer accounts. The requirement for the monthly bank reconciliation is listed in the contract between APD and its subagent.

Discovery: APD submits Monthly Budget Reports to the consumer, consultant, and program office and keeps a helpline log for calls to their helpline. APD will review Monthly Budget Statements before they are sent out.

Remediation: APD requires copies of all state and federal filing completed by the subagent.

Quality Improvement: The State assures that all of Centers for Medicare and Medicaid Services (CMS) assurances listed in this application regarding provider agreements will be met by the subagent for APD.

i. The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.

Below is a list of the system performance measures, outcome measures and satisfaction measures of all aspects of the Consumer-Directed Care Plus (CDC+) program. Please note that the measures are evolving as they are based on performance indicators for the program.

System Performance Measures: All of the following reports/measures will be compiled from the program office database.

- The program office will submit an annual report to Agency for Health Care Administration (AHCA), which will demonstrate: client demographic data and a statement of future goals and activities. It will include detailed financial data, reports on performance measures and relevant facts about program operations. Among the data reporting is enrollment and disenrollment information and per member cost expenditures.
  - This report will help the program office to establish a baseline for performance indicators and to enhance or modify those indicators as necessary.
- The program office will submit a quarterly evidence report to AHCA with monitoring efforts and results. Also included will be actions taken/proposed to address deficiencies. All monitoring must address CMS assurances.
  - This report will allow AHCA to monitor program office performance and activities and to provide feedback to the program office.
- The yearly Program Self-Assessment (PSA) will be delivered to the Quality Advisory Committee (QAC) and the program office must be in compliance with the performance indicators for the program. If the program office is not in compliance, they must work on program improvement activities with the QAC.
  - This will allow the program office with the assistance of the QAC to monitor program progress as well as modify performance indicators as necessary.
- All consultants must use an incident reporting system as specified in the traditional 1915(c) Home and Community-Based Services (HCBS) waiver and all incident information must be reported to the program office. The incident information will be compiled and included with the annual report to Agency for Health Care Administration (AHCA). The incidents will be logged by type of incident and must include appropriate action taken to remedy the situation.
  - This will aid in monitoring of incident reporting and follow-up as well as possible discovery of abuse or neglect.
- The subagent for APD will maintain a current Medicaid Provider Agreement.
  - This is required in the assurances.
- APD maintains a Government Policies and Procedures Manual which reflects all requirements described in the subagent's Medicaid Provider Agreement and contract. The manual includes policies, procedures and internal controls for all operations tasks. The manual also includes a policy and procedure for staying up-to-date with all federal and state requirements and for updating the manual at least annually and as needed.
  - The manual acts as the "blueprint" for government FEA operations, is a training tool for new government FEA staff and is a key component of a quality management system.

- APD will implement a helpline call log.

  - This aids in monitoring so the program office is made aware of what types of complaints or questions are called in to the APD.

The Outcome Measures listed below are taken from the PCP process for the iBudget waiver and follow-up instrument; there are also quarterly monitoring items:

- The PCP process for the iBudget waiver must be completed before a consumer completes their first budget/purchasing plan.
  - This aids the consumer in identifying their goals and needs in order to input the services and supplies which will help them to complete their goals.
- Each consumer will need to list their personal goals and identify which services or supports will help them to reach those goals.
  - This will help the consumer to identify and achieve their goals. For example: Goal #1 might be to live in their own home and remain as independent as possible. In order to reach that goal, the consumer might need to hire someone during the week days to provide personal assistance.
- The follow-up instrument will be conducted at least every six months.
  - This will aid the consumer in determining if their goals are being met.
- The consumer will also be able to identify if they need to modify their goals at their bi-annual follow-up. All consumers must be able to request a change to their service plan based on a change in needs or health status. Service plans must be reviewed annually, or whenever necessary due to a change in a consumer's needs or health status.
  - This will allow the consumer to identify new goals or change current goals and identify the services and supports that will meet the new goals and include them on their purchasing plan, removing any services or supports that are no longer necessary.
- The consultant file must include the annual Medicaid eligibility document for each consumer. This helps to assure the State that there are not ongoing issues with consumers being ineligible for Medicaid because of a missed meeting or other situation that could have been taken care of by completing a document or attending a meeting.
  - This will aid the program office in ensuring all consumers retain their Medicaid eligibility and all consultants are tracking annual Medicaid meetings for their consumers.

- Every consultant must maintain a signed consent form. The form must be either signed by the consumer or representative, if applicable. The consent form will serve as verification that the consumer is responsible for directing their own care and fully understands the program.

- This will aid the State to ensure all consumers understand and consent to participate in this program.

The following Satisfaction Measures are taken from the Consumer Satisfaction Survey:

- The Budget/Purchasing Plan had clear instructions on how to complete.
  - The program office will verify information and instructions distributed to consumers are user-friendly. At least 80% of the consumers must agree that program materials are user-friendly. All results from the Satisfaction Survey will be given to the Quality Advisory Committee (QAC). The QAC will help determine the priorities for the performance indicators in which the State will need to meet. If the State is falling behind expectations on the performance indicators, the QAC will help determine how to correct or improve the processes.

- Payments for consumers' invoices and timesheets must be made in a timely manner.
  - This will inform the program office if the subagent is performing its duties and in a timely manner. If not, the program office will need to discuss a corrective action plan with the subagent.

- Payment issues were responded to within 48 business hours.
  - While a response is expected within 48 business hours (a response could include situations in which the issue is still being researched), 90% of issues should be resolved within 72 business hours.

- The consumer's net worth/monthly statement must be received every month.
  - This will aid the program office in determining if consumers are indeed receiving their statements. Statements must be received in order for the consumers to reconcile their balances monthly. Also consumers use their statements to ensure their purchases are accurately reflected.

Risk Management

A. The risk assessment methods used to identify potential risks to participants are described below.

Potential risks to the consumer are assessed during the service development process. Strategies to mitigate risk are incorporated into the budget/purchasing plan, subject to consumer needs and preferences. The budget/purchasing plan development process addresses emergency backup plans. Each consumer is screened for capacity to direct their own care and required to identify a representative if indicated.

B. The tools or instruments used to mitigate identified risks are described below.

I. Criminal Background Checks are mandatory for all employees, even family members. Criminal Background Checks are mandated by state law. The Criminal Background Checks are performed at no cost to the consumer but are to be paid by the employee. All individuals who will be rendering care to a consumer enrolled in this program must either:

- Be a Medicaid enrolled provider who received background screening at the time of their enrollment into the Medicaid program (and who remains in good standing with the Medicaid program); or
- Pass a background screening; or
- Provide proof of a State of Florida and/or a Federal background screening completed within six-months prior to employment, the outcome of which was a finding of no disqualifying offenses.

II. Each Consumer-Directed Care Plus (CDC+) consumer is required to develop an emergency back-up plan before starting to manage a budget on CDC+. The emergency backup plan should describe the alternative services delivery methods that will be used under any of the following circumstances: 1) if the primary employees fail to report to work or otherwise cannot perform the job at the time and place required, 2)if the consumer experiences a personal emergency, or 3) if there is a community-wide emergency(e.g., requiring evacuation). The personal emergency portion of the emergency back-up plan will allow the participant to identify circumstances that would cause an emergency for him/her based upon his/her unique needs. The emergency back-up plan must also address ways to assure that the needs of the individual are met should an unexpected shortage of funds occur.

III. The Consumer/Representative Agreement is a written agreement between a consumer and the consumer's representative that sets forth the CDC+ responsibilities of the representative. All consumers have the option of choosing one individual to act as a representative (friend, caregiver, family member or other person, etc.) to assume budget and care management responsibilities. Representatives may not work for the consumer

or be paid by the consumer. Consumers may also receive assistance with their CDC+ responsibilities without appointing a representative; however these individuals cannot sign documents, speak for or otherwise act on behalf of the consumer.

IV. The monthly monitoring of consumers by consultants will be used to assess for risks to the consumer. The consultant will monitor both the consumer's monthly budget to assess the consumer's spending and service utilization in comparison with the purchasing plan and the consultant will also assess the consumer's risk for abuse, neglect or exploitation at the semi-annual home visits.

C. The State's process for ensuring that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated, is described below.

Prior to enrollment in the CDC+ program, each consumer will receive a Home and Community-Based Waiver care/support plan based on an assessment of need that includes an identification of risks and potential mitigation strategies. All consumers in CDC+ must take part in an initial training prior to the development of the budget/purchasing plan. In this training, the consumer is given lists of roles and responsibilities, which provides a detailed description of the roles and responsibilities of the consumer in the program including a detailed description of the roles, responsibilities and support functions of the consultant, and APD staff. This document will be thoroughly reviewed with the consumer and/or the representative to ensure that there is a clear understanding of the responsibilities related to the health and safety and mitigation risks to be assumed by the consumer. The consumer will list all identified risks in the emergency back-up plan including the plan that each individual consumer will use in the case of an emergency. The consumer/representative will develop a purchasing plan to specify how the monthly budget will be used to meet the consumer's care needs, and how other identified needs might be met through generic, community supports, and Medicaid State plan services. Risks will be documented and updated at the consumer's semi-annual home visit or more frequently if needed.

D. The State's process for ensuring that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant's representative, if any, and others from whom the participant may seek guidance, is described below.

The consumer/representative is responsible for developing their own budget/purchasing plan to show how their budget will be spent each month. In that plan, the consumer will identify the risks that were discussed with the consultant during their initial and semi-annual monitoring assessment.

The consumer must identify and manage their personal emergency back-up plan/risk mitigation strategy in their PGS tool. Consultants will provide support and technical assistance in order to facilitate the development of the budget/purchasing plan by the consumer/representative.

Consultants will not assume responsibility for developing the budget/purchasing plan, but will review and approve the plan to ensure that proposed services are adequate, purchases are cost-effective and related to the consumer's needs, and that an emergency back-up plan is in place. The consultant reviews the proposed budget/purchasing plan with the consumer/representative and others identified by the consumer as a method to assess the consumer/representative's ability to assume service management responsibilities and to further generate discussion around risk management.

ii. Qualifications of Providers of Personal Assistance

E. __X__ The State elects to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

F. _____ The State elects not to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

iii. Use of a Representative

G. __X__ The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

i._____ The State elects to include, as a type of representative, a State mandated representative. Please indicate the criteria to be applied.

H. _____ The State elects not to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

iv. Permissible Purchases

I. __X__ The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

J. The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

xvi. Financial Management Services

A. _____The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

i. __X_ The State elects to provide financial management services through a reporting or subagent through its fiscal intermediary in accordance with section 3504 of the IRS Code and Revenue Procedure 80-4 and Notice 2003-70; or

ii. ____The State elects to provide financial management services through vendor organizations that have the capabilities to perform the required tasks in accordance with section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish financial management services, the procurement method must meet the requirements set forth Federal regulations in 45 CFR section 74.40 – section 74.48.)

iii. ____The State elects to provide financial management services using "agency with choice" organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.

B. __X__ The State elects to directly perform financial management services on behalf of participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

1915(j) SELF-DIRECTION METHODOLOGY

DEVELOPMENTAL DISABLED WHO HAVE THE OPTION TO REMAIN IN THE STATE PLAN SELF-DIRECTION METHODOLOGY

Florida's methodology for determining the consumer's budget is based on the assessment of needs and the development of the service plan. The cost of providing the services included in the service plan is calculated based on the expected reimbursement for services listed on page 2 of Supplement 4 to Attachment 3.1-A under the 1915(c) waiver and the expected reimbursement for the cost of State Plan personal care services. It is adjusted to account for the self-directed service delivery model. Based on historical utilization patterns and differences in set-up and oversight, the State will use an adjustment factor of 87.25% of the expected waiver/State Plan service reimbursement to calculate the consumer's service budget for self-directed personal assistance services.