Florida Consumer-Directed Care Plus Waiver Operational Protocol

A. Organization and Structural Administration

The State of Florida will implement the Consumer-Directed Care Plus program (CDC +) under the authority of an Independence Plus 1115 Waiver amendment granted by the Centers for Medicare and Medicaid Services (CMS). The Agency for Health Care Administration, as the single state agency responsible for Title XIX, will implement this waiver through interagency agreements with all participating departments for day-to-day program operation and administration. This waiver is being implemented to address the expansion of the Florida Consumer Directed Care Project authorized by the 2002 Florida Legislature. The Consumer-Directed Care Plus program is being developed and will be implemented under the guidance of an interdepartmental workgroup led by the Agency for Health Care Administration with representatives from the Department of Elder Affairs, the Department of Children and Families' Developmental Disabilities and Adult Services programs, and the Department of Health's Brain and Spinal Cord Injury Program.

The design of this program and plans for implementation have been developed by the interdepartmental workgroup with input provided by key stakeholders including consumers and representatives of individuals receiving services through the state's existing Consumer-Directed Care (a.k.a. "Cash and Counseling") 1115 Waiver. The program staffs referred to throughout this operational protocol are employees of the Department of Elder Affairs who are also responsible for the Consumer Directed Care Project. The terms "consumer" and "representative," referred to throughout this operational protocol, are interchangeable with respect to program responsibilities (i.e., the representative acts in place of the consumer). However, references to "employer of record" mean the consumer alone; the representative is not the employer of record.

Day-to-day management is carried out primarily by program staff of each department for their particular waiver program. The Consumer-Directed Care Program Director, under the supervision of the Department of Elder Affairs Volunteer and Community Services Division Director, is responsible for CDC database operations and management of the fiscal/employer agent contract. An interdepartmental workgroup will continue to meet for the duration of the program to provide oversight and management assistance.

Consumers participating in this program will direct their own care and manage the budget allocated for their care needs. The state will provide two distinct support services to assist consumers in assuming their management responsibilities: consultant services and fiscal/employer agent (FEA) services.

- The consultant will train, coach, and provide technical assistance to consumers, as needed. The training and technical assistance will help consumers to use the budget correctly and avoid overspending.
- The fiscal/employer agent (FEA) will provide assistance to consumers with paying employer and unemployment compensation taxes, retaining funds, processing employment information, reviewing records to ensure correctness, paying providers, paying employees in accordance with the fair labor standards act and state and federal

employment-related tax laws. The FEA provides a fiscal conduit service by receiving funds for consumer budgets from the state and making them available to consumers.

Participating agencies including program staff are also available to respond to consumer inquiries.

Consultant services for individuals with developmental disabilities will be provided by support coordinators trained to assume the consultant's role and responsibilities. A limited number of support coordinators in each District will be trained intensively to provide consultant services for the program. This will help assure effective and competent consultants and preserve Developmental Disabilities Program consumers' choice of consultant. Lead agency (case management) providers will provide consultant services for elders and adults with physical disabilities. Adult Services program staff will be responsible for case management in two geographical areas covered under District 8 and District 15; they will provide consultant services for adults with physical disabilities. Community Support Coordinators will provide consultant services for Department of Health consumers with traumatic brain or spinal cord injuries.

Consultants may not be a provider of services or supports other than consultant services to any consumer enrolled in the Consumer-Directed Care Plus program. Consultants cannot serve as the consumer's representative.

B. Reporting Items

Monthly Progress Calls: The State will hold monthly conference calls with CMS to discuss progress and address questions CMS may have regarding the program. CMS may, at any time, determine that quarterly monitoring calls are sufficient.

Quarterly Progress Reports: The State will provide a written progress report to CMS no later than 30 days after the end of each Federal Fiscal Year quarter, with an annual progress report provided for the fourth quarter. The report will include at a minimum:

- Events occurring during the previous quarter such as enrollment numbers, lessons learned and a summary of expenditures.
- A discussion of progress in completing program changes identified in the Infrastructure Redesign Plan.
- Notable accomplishments, including Quality Assurance outcomes, consumer survey responses and evaluation activities.
- Problems and issues identified as well as the actions taken to resolve these problems and issues.

Quarterly Utilization Reports: The State will provide the following quarterly reports to CMS.

- A service expenditure report to include expenditures made under the authority of this 1115 waiver consisting of expenditures for consumers' individual budget amounts and for the impacted state plan services (i.e., services subject to the budget neutrality cap). Form CMS-64.9 Waiver or CMS-64.9P Waiver will be used for this reporting and will be

submitted within 30 days of the end of each quarter. Quarterly expenditure reporting will continue for two years following the conclusion of the program for all claims for services, cost settlements or other adjustments in order to provide for a final accounting of expenditures specific to this program.

- An administrative cost report specifying expenditures for administrative costs that are directly attributable to this program.
- A supplement to the estimate of matchable Medicaid expenditures (reported on Form CMS-37) providing an estimate of the expenditures for services subject to the budget neutrality cap. The format for this report shall be agreed to by CMS and the State.
- A report of the actual number of eligible member months for demonstration eligibles. The format for this report shall be agreed to by CMS and the State.

Annual Utilization Reports

The state will provide a service expenditure report to include expenditures made under the authority of this 1115 waiver. The report will consist of expenditures for consumers' individual budget amounts and for the impacted state plan services (i.e., services subject to the budget neutrality cap). This report will be prepared for each demonstration year, and will include the expenditures by demonstration year and the cumulative total of all expenditures subject to the budget neutrality cap for all demonstration years up through the reporting period. Form CMS-64.9 Waiver or CMS-64.9P Waiver will be used for this reporting.

Financial Accounting

The State will construct and monitor a database that will be used to generate reports providing individual-level and aggregate data for all participants in the demonstration. The financial report should reconcile with CMS 64 reporting. The database will consist of all participants in the demonstration, whether the individual was enrolled in the State's home and community based waiver (HCBW) or regular Medicaid personal care services program before enrollment in the demonstration. This database shall at a minimum include identifying information for all participants (name, address, social security number, telephone number), participation start date, the effective date a participant no longer receives cash, the actual participation stop date (i.e., date participant ceases receiving any Medicaid personal care services or HCBW benefits), aggregate monthly enrollment totals and total cash payments (by quarter).

The CDC + program will be greatly enhanced by the new design for a web-based system that will integrate the consumer database and the new fiscal employer agent (FEA) functions. This system will allow for automation of account monitoring by the FEA, including "real-time" access to all financial and personal data information of consumers. This web system will provide the most current aggregate and individual-level data for all required reporting, including the demographic group the participant belongs to. Attachment D, Infrastructure Redesign Plan, provides a detailed explanation of the new system design.

Final Report: At the end of the demonstration, the State will submit a draft final report to CMS for review and comments. The final report with CMS' comments is due no later than 180 days after the termination of the program.

C. Essential Elements of Self-Direction

As a state Medicaid program that presents individuals with the option to control and direct Medicaid funds through individual budgets, the State will ensure that the program design contains the four essential elements necessary to operate a successful program:

- Individual Budgeting. The dollar value of services and supports determined by a Medicaid waiver care plan are under the control and direction of the participant.

- Person Centered Planning. The Medicaid waiver care plan and support plan identify client strengths, capacities, preferences, needs and desired outcomes. The CDC + participant training further identifies participant strengths, capacities, preferences, needs and desired outcomes. Finally, participants develop a purchasing plan based on their own self-identified needs and preferences.

- Self-Directed Supports. A consultant, a bookkeeper, agency and District Offices, state program offices, the quarterly newsletter and peer support groups assist participants in developing, implementing and managing services and supports.

- Quality Assurance and Improvement. The quality management plan effectively assures the health and welfare of program participants and the continuous improvement in the demonstration program. The program will include criminal background checks at no cost to the participant, a statewide emergency backup plan, and an incident management system. (Attachments A, B, & C)

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D. Benefits

Consumers participating in the Consumer-Directed Care Plus program must be participating in the Aged and Disabled Adult (A/DA) Waiver, Developmental Services (DS) Waiver or Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver at the time they seek to enroll in the Consumer-Directed Care Plus program. Therefore, before enrollment in the program, each consumer will have a HCBS waiver care plan/support plan based on an assessment of need. The HCBS waiver care plan/support plan is the first of three steps in developing the consumer's monthly budget and purchasing plan. During the enrollment visit, consumers will be told the budget amount they will receive. Consumers cannot negotiate a budget amount with consultants or outreach workers.

1. Verification of a current assessment of need and a current HCBS waiver care plan/support plan;
2. Establishment of the budget amount; and
3. Development of a purchasing plan.

These steps are described in greater detail below.

Step 1: Assessment of Need

The case manager/support coordinator, in cooperation with the consumer, develops the consumer's initial HCBS waiver plan of care. The care plan/support plan is based on the assessment of the consumer's needs and the HCBS waiver services that address the consumer's needs. These should be consistent with HCBS waiver services guidelines. The care plan/support plan identifies each necessary HCBS waiver service along with frequency, duration and unit cost of the service. This care plan/support plan represents what the consumer would have received had he/she remained enrolled in the HCBS waiver.

Step 2: Establishing the Budget Amount

The consumer's budget amount is based on the value of the HCBS waiver services authorized in the care plan/support plan and available in the community. Some state plan services may be included in the budget amount such as home health care and transportation if necessary. For developmental disabilities consumers, an individual cost guideline (ICG) will be administered prior to development of the care plan/support plan and purchasing plan. The ICG is a web-based resource allocation tool developed in cooperation with Mercer Human Resource Consulting, Inc. for the purpose of developing an individual budget in the 1915(c) HCBS waiver.

The total cost of Medicaid services on the care plan/support plan is adjusted downward by a percentage, or discount rate, which is used to adjust for the average difference between the costs of planned services versus actual expenditures in the originating HCBS waivers. This adjustment is made in order to ensure the overall budget neutrality of the Consumer-Directed Care Plus program. The adjusted amount is the annual budget amount available to the consumer for the services and supports that will be identified on the purchasing plan.

The discount rates calculated for each participating program population are:

Elders	89%
Developmentally Disabled	92%
Physically Disabled Adults	83%
Traumatic Brain/Spinal Cord Injured	83%

Step 3: Developing the Purchasing Plan

Consumers develop a purchasing plan to specify how the monthly budget will be used to meet the consumer's care needs. The purchasing plan documents services to be obtained from directly hired workers, community agencies and/or independent contractors. The plan includes service(s) or purchase(s), name of the worker/position or provider, frequency, duration and units of service, cost of the service or purchase, applicable taxes, and the total costs. The purchasing plan may address different needs, types of services, types of providers and payment amounts than those contained on the consumer's HCBS waiver care plan/support plan as long as the planned purchases are:

- Consistent with an assessed need;
- Necessary to ensure the consumer's health and safety and to permit the consumer to remain in his or her home;
- Not available from another community source;
- Cost-effective;
- Not a prohibited purchase as specified under "Allowable Alternative Health Related Services" later in this section; and
- Feasible based on the consumer's monthly budget.

Purchasing plans must include an emergency backup plan identifying arrangements that have been made for the provision of services and/or supplies in the absence of critical planned services and supports. Consumers may accumulate funds to make special purchases and/or to fund their emergency backup plan. Accumulated funds ("savings") must be used to purchase items listed in the savings plan and in accordance with the savings plan's purchasing schedule. The savings plan must indicate each item, the cost amount and the length of time necessary to save the required purchasing amount. Any deviations from the savings plan must be approved by the consultant through an updated purchasing plan.

To account for small monthly changes in spending, consumers may accumulate up to 1 ½ month's monthly budget amount in their account balances. However, any time the account balance grows to more than 1½ times the monthly budget amount, the excess of the monthly budget amount must be used or transferred to savings before the next monthly budget is received. Excess account funds transferred to savings may be used to fund existing savings purchases or used for new purchases. In either case, the savings plan must be updated to show the use of the funds and the savings purchase schedule adjusted as necessary. Every intended purchase with savings must be included in the savings portion of the approved purchasing plan. Accumulated funds are subject to recoupment under specific circumstances, as specified in Section I "Participant Protections."

Consultants will provide technical assistance, if needed, as the consumer/representative is writing the purchasing plan. Consultants will not assume responsibility for writing the plan. Consultants must review and approve purchasing plans to ensure that planned purchases are cost-effective, related to the consumer's care needs and that the emergency backup plan is adequate. In addition, consultants will assess the overall purchasing plan for the potential to encourage and/or facilitate fraud.

The consultant uses the process of reviewing the proposed purchasing plan with the consumer as a way to assess the consumer/representative's ability to assume care management responsibilities. The District Office or state program office of the funding entity must review and approve the purchasing plan before the first monthly budget is authorized. The fiscal/employer agent will disburse the monthly budget.

Consumers may not purchase goods or services not shown in the approved purchasing plan. However, an updated purchasing plan may be approved. This will allow flexibility if consumers

discover new or more creative ways to meet their needs. Changes in consumers' needs that will result in a change to the monthly budget amount require the use of the 3-step purchasing plan development process described previously.

Changes to the Budget Amount

The Consumer-Directed Care Plus program offers consumers the opportunity to adjust the level of support provided (either temporarily or permanently) in response to significant changes in needs. Consumers may inform the consultant of significant changes in needs such as changes in health or functional status or the loss of an unpaid caregiver. Additionally, a consultant may identify changes in need that would warrant an adjustment to the monthly budget amount, either upward or downward.

Changes to the budget amount will be made only after completion of the 3-step purchasing plan development process. The care plan/support plan will be used to determine the increased level of funds that would be provided to consumers receiving HCBS 1915 (c) waiver support. Purchasing plans are not relevant to determining the budget amount.

Increases in the monthly budget are not allowed to remedy consumers' mismanagement of funds.

Release of the Budget to Consumers

The budget will be made available to consumers on a monthly basis. The first monthly budget will be released to consumers when the consultant has notified program staff that the consumer has completed all necessary tasks and paperwork, and the authorizing entity has approved the purchasing plan. Consumers and consultants will work together to determine the budget start date. Program staff from the Department of Elder Affairs will send a letter to the consumer and consultant notifying them of the date the budget will start. Traditional Medicaid HCBS waiver services will be disallowed effective on the date the individual's budget begins.

A claim will be generated for each consumer from the Consumer-Directed Care Plus database at the beginning of the month. The claim will authorize payment for the budgets of all eligible consumers for the upcoming month. The total amount of each claim is paid to the FEA. The FEA will electronically track expenditures and cash requests separately for each consumer.

Accessing the Budget

Consumers may access their budget in one of three ways: payroll, invoices or cash. Payroll checks or electronic funds transfers will be generated from consumers' funds by the FEA when a consumer submits a time sheet(s). Payroll payments will be forwarded to consumers for distribution to their employees. Invoices sent to consumers by vendors will be approved by consumers and forwarded to the FEA for payment. The FEA will send payment for vendor services directly to the contract provider. Consumers will be able to have limited amounts of their budget sent directly to them as "cash" or on an as needed basis. Cash payments must be authorized on the purchasing plan.

Representatives

All participants have the option of choosing one individual to act as a representative (friend, caregiver, family member, or other person) to assume budget and care management responsibilities. Representatives act in place of and on behalf of consumers. A consultant may require the appointment or the replacement of a representative. A representative is designated by filling out a representative designation form, which is included in the consumer's program manual. Representatives may not work for the consumer or be paid by the consumer with monthly budget funds.

Consumers may also receive assistance with their responsibilities without appointing the helper as a representative. Such assistants cannot sign documents, speak for or otherwise act on behalf of the consumer.

Allowable Alternative Health-Related Services

Allowable alternative health-related services are limited to services and purchases that support the consumer's ability to live independently, avoid the need for admission to a nursing home or other long-term care facility and are consistent with established necessity criteria (i.e., not in excess of the consumer's need, not available from another source, not provided for the consumer's convenience). Consumers may purchase any of the services the state has previously identified as HCBS waiver services and other services approved by the consumer's state program office. Examples include:

- Help with errands or shopping
- Membership in a fitness facility
- After-school care
- Yard work
- Saving for the emergency backup plan
- Savings for a special purchase

Consumers may not use their monthly budget to purchase services or items that are available through Medicare, or the Medicaid state plan or that are free or at reduced cost through community organizations. In addition, the following list shows items/services for which the monthly budget may not be used. This includes, but is not limited to:

- Gifts for workers, family or friends
- Rent or mortgage payments
- Payments to someone to serve as the consumer's representative
- Clothing
- Groceries (with the exception of special foods required to maintain nutritional status of the consumer and which are not for consumption by any other member of the household)
- Lottery tickets
- Alcoholic beverages
- Entertainment activities
- Electronic entertainment equipment (e.g., television, stereo, radio, DVD player, VCR)
- Educational equipment or supplies

- Tobacco products
- Utility payments (electric, gas, sewer, garbage services)
- Services which will meet consumers' needs and are available, without charge or at reduced cost, from community organizations
- Swimming pools and spas

E. Outreach/Marketing/Education

Outreach, marketing and education will be accomplished through a combination of informational materials distribution, public events and personal contact with potential participants by case managers, consultants, outreach workers and program staff.

Types of Media Used

All Consumer-Directed Care Plus program materials for outreach, marketing and education will be available in standard print as well as large print, audiotape, Braille, on the CDC+ website, and in computer files.

Alternative Formats

Materials will be available in English and Spanish. An audiotape of the consumer notebook will be available upon request. Individuals who are interested in the Consumer-Directed Care Plus program may request a visit from a consultant or outreach worker to review outreach materials for the purposes of:

- Receiving additional information or clarifying information regarding the program guidelines and design;
- Accommodating the needs of individuals with a primary language other than English; and
- Accommodating the needs of individuals who have impairments in communication or cognition.

Geographical Areas for Outreach

Interested individuals may request information by phone from program staff at any time. Outreach materials will also be available on a statewide basis at the following locations:

- Local Area Agency on Aging Offices;
- A/DA waiver Lead Agencies;
- Department of Children and Families, Adult Services Offices in each DCF District/Region;
- Department of Children and Families, Developmental Disabilities Offices in each DCF District/Region;
- DS Waiver Support Coordination Agencies;
- Department of Health, Brain and Spinal Cord Injury Program Regional Offices; and
- Medicaid Area Offices in each Agency for Health Care Administration Region.

Areas of the state where the CDC Project is currently operating will be targeted for training updates. The training update will include an overview of differences between the two consumer-directed initiatives.

Outreach and Training Schedules

All CDC Project consumers will be contacted before program implementation regarding their interest in transferring to the Consumer-Directed Care Plus program. Consumers enrolled in the participating HCBS waivers will be informed about the program by their case manager/support coordinator. The state may conduct additional outreach efforts on an as needed basis, including providing information at public meetings.

The consultant will train the consumer within 30 business days after enrollment. Consultant training sessions will be conducted no more than 60 days before enrollment is implemented and periodically thereafter.

F. Eligibility/Enrollment

Eligibility for the program is limited to individuals enrolled in the CDC Project or in the A/DA waiver, DS Waiver or TBI/SCI Waiver. There are two types of eligibility for participation in the Consumer-Directed Care Plus program: functional and financial.

Functional eligibility criteria for each of the participating target populations will be the same as the functional criteria for the HCBS waiver program from which consumers were referred.

Financial eligibility criteria require all participants in the program to meet the income test for Florida's HCBS waiver program, special income group which is 300% of the SSI Federal Benefit Rate (FBR). The Department of Children and Families Office of Economic Self Sufficiency reassesses financial eligibility for all populations annually.

In addition, individuals seeking enrollment into this program must be able to direct their supports and services utilizing the services of a consultant and FEA, or may appoint a representative to assume their consumer responsibilities.

Intake and Enrollment

Enrollment in CDC + will be offered first to CDC Project consumers in the experimental group who have budgets, to experimental group consumers who do not have budgets, to the control group and then to new consumers.

The intake and enrollment visit will provide an opportunity for consumers and interested family members to participate in a face-to-face, in-depth explanation of the program and to ask questions. During the enrollment visit, consultants will inform consumers of the budget amount available to them. Consultants will make sure consumers have a thorough understanding of their responsibilities related to spending public funds and to being an employer. Consumers may complete an application for the program at the enrollment visit. The consumer may apply after

the enrollment visit has taken place, as long as the individual remains eligible for the Consumer-Directed Care Plus program and a slot is available. The informed consent form, signed by the consumer or representative, must accompany the application. Representatives must send a signed Representative Agreement with the application.

Applications will be processed by consultants on an on-going basis. Program staff will ensure consumer enrollment data is entered into the CDC database. Enrollment confirmation reports will be made available to consultants. Once the consultant completes the consumer's training, the consumer completes the tasks and receives approval for the purchasing plan from the consultant, District Office or state program office and other approval authorities as required. The consultant then enters the budget start date on the budget authorization form and returns it to DOEA . This form is the mechanism by which consultants verify the consumer is ready to begin participation. Program staff enters the budget start date in the Consumer-Directed Care database and submits a claim that authorizes the state to disburse the first monthly budget to the fiscal/employer agent.

Disenrollment

Consumers, representatives, consultants or the state program office may initiate disenrollment at any time. Reasons for disenrollment include, but are not limited to:

- Consumer moved out of state;
- Temporary or permanent long-term care facility admission;
- Hospitalization for more than 30 days;
- Loss of Medicaid eligibility;
- Loss of waiver eligibility;
- No longer requires waiver services;
- Representative not available;
- Death of consumer;
- Consumer or Representative request;
- Mismanagement of budget;
- Consumer health or safety at risk;
- Consumer can no longer be served safely in the community.

Mismanagement of funds requires the development of a corrective action plan or disenrollment from the program. If the consumer has mismanaged the monthly budget and health and safety is at risk because of insufficient remaining monthly budget funds, the consumer must be immediately disenrolled from the program and reenrolled in the HCBS waiver program. In most cases, consultants will offer consumers help in rectifying a situation in which the budget is mismanaged. If the situation cannot be rectified or persists, consumers will be disenrolled from the program.

In the event disenrollment is required or requested, the consultant completes a change form to disenroll the consumer and forwards the form to program staff. Non-emergency disenrollments will be effective on the first day of the following month. In emergency situations, the change will be effective immediately. Consultant determination of the disenrollment effective date will ensure a smooth transition from the program to the appropriate Medicaid HCBS waiver program.

Third Party Liability

All individuals eligible for this program are enrolled in one of three HCBS waiver programs. Information regarding third party liability (TPL) is gathered at the time the individual is determined Medicaid eligible and enrolled in the HCBS waiver program. Case managers/support coordinators and consultants are required to ensure that all sources of long term care supports are accessed before use of Medicaid state plan and HCBS or other Medicaid waiver services.

Responsibility for Eligibility/Enrollment Requirements

The Agency for Health Care Administration (AHCA) is the single state agency for the Medicaid program and assumes overall responsibility for eligibility, enrollment and disenrollment requirements. AHCA has an Interagency Agreement with each of the state agencies with eligibility, enrollment and disenrollment responsibilities as follows:

- Department of Children and Families is responsible for:
  - Determining Medicaid financial eligibility;
  - Ensuring that adults with disabilities meet eligibility requirements for the A/DA waiver and authorizing enrollment into the A/DA waiver;
  - Ensuring that individuals with developmental disabilities meet eligibility requirements for the DS Waiver and authorizing enrollment into the DS Waiver; and
  - Conducting Medicaid Fair Hearings for Medicaid recipients.
- Department of Health is responsible for ensuring that individuals with traumatic brain injury or spinal cord injury meet eligibility requirements for the TBI/SCI Waiver and authorizing enrollment into the TBI/SCI Waiver;
- Department of Elder Affairs is responsible for:
  - Ensuring that elders meet eligibility requirements for the A/DA waiver and authorizing enrollment into the A/DA waiver;
  - Ensuring that the Comprehensive Assessment, Review, and Evaluation Services (CARES) teams conduct nursing facility level of care evaluations;
  - Operating and maintaining the consumer directed care project database system; and
  - Managing the fiscal/employer agent contract.

Numbers of Individuals Receiving Community-Based Services With and Without the Waiver

Because the Consumer-Directed Care Plus program enrolls individuals who were previously enrolled in one of three of Florida's HCBS waivers, there is no impact on the actual number of individuals accessing community-based services with or without the demonstration.

G. Enrollment Ceilings

Enrollment is capped for each participating population. The following populations are eligible to apply for enrollment in the Waiver:

- Consumer Directed Care Project Control group-- Individuals originally assigned to the control group in Florida's Consumer Directed Care Project
- Consumer Directed Care Project Experimental group-- Individuals originally enrolled in the Consumer Directed Care Project experimental group
- Choice and Control-- Individuals formerly enrolled in the now defunct state-funded consumer-directed pilot program for individuals with developmental disabilities
- New Enrollees-- Individuals not enrolled in the original Consumer Directed Care project, but who now wish to enter the program

Table 1. Enrollment Limits

Group	Originating HCBS Waiver		
	A/DA	DS	TBI/SCI
CDC Control	550	1,172	6
CDC Experimental	249	873	6
Choice and Control	---	137	---
New Enrollees	330	0	27
Totals	1,129	2,182	39

Total Enrollment Limit: 3350

Individuals enrolled in the A/DA waiver, DS waiver or TBI/SCI Waiver requesting enrollment into the Consumer-Directed Care Plus program will also have access to spaces vacated by CDC Project enrollees.

Amendments to the ceiling subsequent to waiver approval will be submitted to CMS for review and authorization.

H. Quality

(See Quality Management Plan, page 19)

I. Education, Counseling, Fiscal/Employer Agent and Support Services

Education, counseling and support services are provided by the State or by Medicaid-enrolled HCBS waiver, CDC Waiver or Consumer-Directed Care Plus program consultants as specified in this operational protocol. The fiscal/employer agent is a contracted entity.

Fiscal/Employer Agent (FEA)

The role of the fiscal/employer agent (FEA) is to assist consumers in paying their employees and processing payments for providers according to state and federal labor and tax laws. The FEA will provide a full range of bookkeeping services, which includes generating payroll, writing checks, calculating and remitting taxes, reconciling consumer accounts and producing reports for the consumer and the consultant detailing the use of the budget. Consumers will not have the option to perform their own bookkeeping duties. Consumers will pay for the FEA service out of their monthly budgets.

The State has an existing contract with an FEA whose services were procured utilizing the Invitation to Negotiate process for the CDC Project. The State, using a formal procurement process, has secured a new FEA for CDC + with an anticipated startup date of January 2004. The new FEA will provide consumers with a web-based system and Interactive Voice Response (IVR) capabilities. The web-based FEA system will simplify procedures and provide greater accuracy and enhanced responsiveness to program participants. Details regarding the performance standards of this system can be found in the Quality Management Plan. The current FEA's contract will be extended through January 2004. This overlap is necessary in order to reconcile consumers' account balances before they are transferred to the new FEA.

The FEA will be monitored for financial and programmatic performance. Annual audits of financial performance will be required (please see the Quality Management Plan, page 28).

Training

A mandatory training session will be provided to all consumers participating in the Consumer-Directed Care Plus program. Individuals transitioning from the CDC Project may receive modified training based on individual needs. Consultants will provide mandatory training either in small groups or individually. This training must be completed in order for the consumer's first monthly budget to be disbursed. Major topics will include: understanding the program, understanding the role of consumers and consultants, using the consultant and bookkeeping services, being an employer, designing a purchasing plan, and selecting service providers.

Consumers will receive a program manual to provide additional information to support the mandatory training. Additionally, consumers will be encouraged to participate in peer support groups, share information with other participants, participate in other training workshops in their communities on related topics and to call the consultant to discuss ideas or ask questions as they gain experience and are exposed to new information.

Consultants will be responsible for providing a mandatory training session for consumers enrolled in the program and for ensuring the enrollment process progresses in a timely manner. Consumers may receive pre-training materials to help them prepare for the mandatory training session. Pre-training materials will provide an overview of the program, a self-assessment of skills tool, and information designed to assist the consumer in examining current services and evaluating preferences.

State program offices will ensure consultants are provided with adequate training to enable them to support consumers participating in the program. The Department of Elder Affairs program staff will provide training for all consultant providers for the A/DA and TBI/SCI Waiver programs. The Department of Children and Families, Developmental Disabilities program staff will provide for training of all consultant providers for the DS Waiver program.

Consultants will be involved in outreach and enrollment activities and will have an important supporting role in the self-selection process for consumers and representatives. Consultants will be responsible for teaching consumers care management and budget management skills, responding to requests for information, providing an adequate level of support, and identifying potential problems.

A standard training curriculum, modeled on the Consumer-Directed Care Project curriculum, will be used to train all program consultants. The use of a standard curriculum will ensure that consumers have consultants with the requisite knowledge and that the program will be implemented uniformly for all populations participating in the program. Each program may develop additional training unique to their population and program needs. Such specialized training may not conflict with the core curriculum.

Consultant service providers will be monitored for compliance with program standards as outlined in the Quality Management Plan. Periodic program updates will provide continuing education, support and networking opportunities for consumers and consultants and an opportunity to communicate quality improvement ideas.

Background Screening

Please see Attachment A.

J. Participant Protections

Participant protections include information provision, consumer training and skills assessment, consultant services, fiscal/employer agent (FEA) services, development of emergency back up plans, an incident reporting system and access to program staff. Consumers are required to use consultant and FEA services in order to assume and maintain care and financial management responsibilities. The consultant will train, coach, and provide technical assistance to consumers as needed. The training and technical assistance will help consumers use the budget to effectively meet their care needs and avoid overspending. The fiscal/employer agent will assist consumers with paying their employees and will assure compliance with state and federal labor and tax laws as the employer agent. The FEA will provide a fiscal conduit service by receiving funds for consumer budgets from the state and making them available to consumers.

Information Provision

Each consumer will receive a program manual that describes the program, roles and responsibilities, how to develop and use a monthly budget, how to search for and hire workers,

employment responsibilities, how to deal with quality of care problems, consumer rights, how to identify and deal with abuse, neglect and exploitation, and available peer support options.

Statewide Emergency Backup Plan

Please see Attachment C.

Incident Management System

Please see Attachment B.

Procedures Addressing Overspending

Consumers must sign a consumer/consultant agreement in order to participate in the program. The agreement specifies, among other requirements, that consumers keep all purchases within the monthly budget amount, review the monthly budget report from the FEA and contact the consultant if they have questions or concerns. The consultant is responsible for reviewing the monthly budget report and helping the consumer develop a corrective action plan to address problems managing the monthly budget.

If the monthly budget amount expenditure is exceeded, the consultant and consumer will determine whether this is the result of a change in the individual's needs or mismanagement of the budget. In the event the individual's needs have changed and additional services are required, the consultant will update the HCBS waiver care plan, determine the allowable increase in funding based on the consumer's change in needs, complete a change form for the new budget amount and assist the consumer in updating the purchasing plan.

If overspending is the result of mismanaging the monthly budget, the consultant will require that the consumer, representative or the representative's replacement develop a corrective action plan or recommend disenrolling the consumer from the program. If the consumer's budget mismanagement has jeopardized his or her health and safety because of insufficient remaining monthly budget funds, the consumer must be immediately disenrolled from the program and re-enrolled in the HCBS waiver program. The department responsible for each specific waiver program has ultimate authority to require disenrollment.

If a corrective action plan does not resolve overspending problems, the consumer will be disenrolled from the program and re-enrolled in the HCBS waiver program. The state will require consultant agencies to develop a specific process to be used by each agency to assure a smooth and timely transition for consumers from CDC+ and their return to traditional services. Independent Developmental Services HCBS waiver program consultants will contact their local District Office consumer-directed care coordinator to arrange the transfer.

Treatment of Accumulated Funds

In some cases, consumers will accumulate funds as a result of a temporary institutional stay (i.e., in a hospital, nursing facility, ICF/MR or rehabilitation facility). Consumers who are residing in

a facility to receive short-term services (not more than 30 days) at the beginning of the month will be allowed to retain their monthly budget amount during the period of their institutional stay in anticipation of their return to the community. Appropriate services that might be provided while the consumer is residing in an institutional setting include services necessary to maintain the consumer's home in a sanitary condition and payments necessary to retain the services of essential direct care providers in preparation for the consumer's return to the home. Training will include how consumers inform their consultant of their institutional facility admissions. Consumers who are admitted as permanent residents or who have institutional stays in excess of 30 days will be disenrolled from the program. Consumers who remain institutionalized for more than 90 days may not be reinstated in the program. However, consumers institutionalized for more than 90 days will be provided with priority access to the program should they return to the community; consumers must be eligible for the program and request re-enrollment. Re-enrollment requires that a slot and funding for that slot in the appropriate HCBS waiver program are available.

Consumers may accumulate funds in accordance with approved savings plans. Individuals may retain their approved savings plan funds, including emergency backup plan funds, from year to year. However, at the time of their annual eligibility re-determination, consumers must return funds in excess of approved savings plan amounts to the state. Funds may be retained in the accounts of consumers for up to three months after disenrollment in order to accommodate circumstances in which consumers are reinstated in the program. Three months after disenrollment, any funds in the consumer's account, including savings, will revert to the State.

Background Screening Costs

Consumers will not bear the cost of background screenings. Costs, excluding the costs for background screenings, which may be incurred in checking references, obtaining verification of credentials and other employer-related functions are the consumer's responsibility. Please see Attachment A for more details.

Confidentiality

The confidentiality of all participant records and transactions in accordance with federal and state laws and regulations is assured. All transactions will comply with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA).

Retention of Records

Unless otherwise stated, all participant files must be maintained for a period of five years from the end of the program or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. The records must be available to program staff and, where appropriate, authorized representatives of the Department of Children and Families, Department of Health, Agency for Health Care Administration, and Department of Health and Human Services.

K. Evaluation Design

Hypotheses

The Consumer-Directed Care Plus program is designed primarily as an expansion of the CDC Project. The CDC project tested a number of hypotheses, most of which are now being evaluated. This program will further refine and test three similar hypotheses.

1. Consumers report improved provider access as a result of increasing the potential pool of providers, especially because of the option to hire family members.

2. Consumers report higher levels of satisfaction than do consumers receiving traditional HCBS waiver services.

3. Consumers who express increased satisfaction with the program relative to traditional HCBS waiver services have a per capita cost comparable to traditional HCBS waiver consumers.

Outcome Measures

1. Percent of consumers enrolled in the Consumer-Directed Care Plus program reporting satisfactory access to providers as compared to traditional HCBS waiver programs, adjusted by waiver and geographic area.

2. Percent of consumers enrolled in the Consumer-Directed Care Plus program reporting overall satisfaction with the program as compared to traditional HCBS waiver programs, adjusted by waiver and geographic area.

3. Percent of consumers reporting increased satisfaction with the program as compared to traditional HCBS waiver programs who also have comparable per capita costs relative to traditional HCBS waiver programs, adjusted by waiver and geographic area.

Data Sources

The data for the evaluation will be collected from three sources: (1) Medicaid claims and enrollment data for all program participants and for the A/DA, DS and TBI/SCI Waiver program participants; (2) annual consumer satisfaction survey findings; and (3) state assessment findings.

1. Medicaid Claims and Medicaid Enrollment Data: At least two years of Medicaid claims data will be evaluated to assess program outcomes. Medicaid claims and enrollment data will be collected for all program participants and the A/DA, DS and TBI/SCI Waiver program clients statewide. This information will be used to assess enrollment and spending trends, and to attempt to isolate changes that may be occurring in areas other than those being reported on for the purposes of budget neutrality.

2. A statistically valid sample of program consumers and consumers enrolled in the A/DA,

DS and TBI/SCI Waivers will be afforded the opportunity to complete a consumer survey designed to assess consumer satisfaction. The state or an agent of the state will administer the survey.

3. The final report that includes a review of expenditure data, participating departments' administrative procedures and consumer satisfaction.

All data gathered for the evaluation will be adjusted for key indicators as available at the time the data is generated, including age, geographic variation, assessment scoring (if refined assessment scoring has been implemented) and for changes in the overall service system impacting the delivery and funding of HCBS waiver and impacted state plan services. The Department of Elder Affairs will be responsible for the annual consultant and fiscal/employer agent services consumer satisfaction survey.

Evaluating, Measuring, and Reporting New to Continuing Client Ratio

All CDC + consumers come to the program already enrolled in one of three Home and Community–Based Services waivers: Developmental Services waiver, Aged/Disabled Adult waiver, or Traumatic Brain/Spinal Cord Injury waiver. Therefore, this evaluation is not applicable to our program.

L. Quality Management Plan

The goal of the Quality Management Plan (QMP) for the Consumer-Directed Care Plus program is to integrate quality management for each party participating in the program: consumers, representatives, consultants, the fiscal/employer agent and the peer support network. The QMP will be used as a mechanism to continuously improve the quality of support services provided to consumers. Workgroup members have incorporated the principles of consumer direction in the QMP. Participation of consumers and representatives in the QMP is encouraged and supported.

Standards

The QMP defines standards for CDC + and how monitoring will evaluate compliance with those standards. Monitoring includes an evaluation of four main quality indicators: (1) Care Management, (2) Financial Management, (3) Abuse, Neglect and Exploitation, and (4) Use of Community Resources. The choice of these indicators was made in response to the most common questions and concerns heard in meetings with key stakeholders in the project. These meetings were held with providers, consumers, state analysts, policy makers and the project interdepartmental workgroup representing the Department of Elder Affairs, the Department of Children and Families, the Department of Health and the Agency for Health Care Administration.

Monitoring and Training

Consultant monitoring involves desk reviews and site visits to consultant providers to evaluate compliance with program standards. Specific standards for consultant providers are outlined in the monitoring section of the QMP.

Fiscal/employer agent (FEA) monitoring includes a review of all consumer or representative complaints submitted to program staff. Reports provided to the state by the fiscal/employer agent provider will be used to monitor quality and performance standards. Specific standards for the fiscal/employer agent are outlined in the monitoring section of the QMP (Section II).

Quality management is supported by strong prevention activities that involve program consumers, representatives, consultants, the fiscal/employer agent, and the peer support network. Prevention strategies include comprehensive training of consultants and consumers, convenient feedback loops to workgroup staff, a program newsletter and the involvement of the peer support network.

The comprehensive consultant training and the mandatory training of all consumers are key components in the prevention of quality problems. Consultants are case managers who have undergone extensive training in their field in order to handle all manner of contingencies regarding their clients, including emergency situations. As an example, case managers for Developmental Disabilities clients undergo a minimum of 60 hours of pre-service training hours after graduation from an accredited university. These same case managers accept additional training in order to become consultants for the CDC + program. Only when this training is complete can the consultant provide consultant services to consumers. The consultant training includes the following topics: understanding the consultant role and responsibilities, training consumers/representatives, providing technical assistance and an adequate level of support, responding to emergency situations and the use of the emergency backup plan, monitoring responsibilities, assessing the need for a corrective action plan, assessing risk for abuse, neglect and/or exploitation, and reviewing quality management standards for consultant service providers.

The uniform consumer/representative training is mandatory. However, the training can be customized to meet the unique needs of the person being trained. Major topics included in the consumer training are: understanding the program; understanding the roles of consumers, representatives and consultants; using the consultant and fiscal/employer agent; being an employer; designing a purchasing plan; selecting services; assessing the quality of goods and services received; and preventing abuse, neglect and exploitation.

Written Complaints

Program consumers have the opportunity to provide written complaints to DOEA project staff regarding the quality of fiscal/employer agent services. A Complaint Form is submitted directly to the program director. Information obtained from consumer complaint forms about the quality of fiscal/employer agent services is forwarded to the fiscal/employer agent. The fiscal/employer agent is responsible for correcting or clarifying the problem and reporting corrective actions

taken to resolve the problem to DOEA staff. DOEA will provide a response to the consumer about the FEA complaint within ten days of receipt.

Each state CDC + program office (Developmental Services, Traumatic Brain and Spinal Cord Injury, Adult Services and Elder Affairs) will receive, review and resolve all consultant and other program related complaints. If the consultant is an independent practitioner, not affiliated with an agency, the state program office will contact the consultant directly. Consumer complaints about the quality of agency consultant services will be addressed by the appropriate state CDC + program office with the agency supervisor from the consultant services provider agency.

The feedback obtained from the consultant and the consumer complaint forms may result in a revision of the consumer training to focus on issues identified as consistently problematic or challenging. Consultants will be encouraged to share strategies they have identified to improve the quality of consultant services to consumers and representatives. Consultant service provider monitoring will include an identification of creative or innovative ways the consultant has used to meet standards and responsibilities. This information will be shared in the newsletter and therefore, made available to all providers, consumers/representatives and the peer support network.

Newsletter, Peer Support

The CDC + newsletter developed by the DOEA staff is used as a communications tool to inform consumers about ways of avoiding quality problems. The newsletter is published quarterly. Articles which present creative ways consumers or representatives have used their Consumer-Directed Care Plus budget will help others understand the range of choices available while using the budget within established guidelines. Articles that describe the difficulties some consumers have encountered and the actions taken to resolve those difficulties may prevent others from experiencing similar problems. Results of the tally of Consumer Complaint Forms for the consultant and fiscal/employer agent may be reported in the newsletter. The nature of issues individuals are complaining about and how these issues have been resolved may be discussed in the newsletter.

Due to grant funding from the Robert Wood Johnson Foundation, peer support groups have been formed throughout the state by Consumer Directed Care Plus agencies. Consultants have been encouraged to promote these support networks to their consumers. The peer support network has a supportive role in the prevention of quality problems through on-going education and in providing opportunities for consumers to learn from the successes as well as the problems experienced by other participants in the program.

Oversight and Responsibility

Management and oversight responsibilities for the Quality Management Plan are assigned to each state CDC + program office. The Consumer-Directed Care interdepartmental workgroup will meet regularly for the duration of the waiver period to monitor quality assurance and quality

improvement. Each state program office is responsible for carrying out the monitoring responsibilities for their consumers.

Medicaid Fair Hearing

The right to a fair hearing is available to all Medicaid waiver recipients and is available to Consumer-Directed Care Plus consumers. Consumers received written notification of appeal and due process rights when they enrolled in an HCBS Medicaid waiver program. The consultant agency shall provide an opportunity for a fair hearing, as described in 42 Code of Federal Regulation (CFR), Part 431, subpart E.

Other Due Process Rights

Consumers and/or their representatives may appeal the following actions specific to Consumer-Directed Care Plus:

- Consultant recommendation that a representative must be selected for a consumer to participate in CDC +.
- Consultant recommended terms of a corrective action plan.
- Consultant recommended or state program office recommended disenrollment of consumer from the Consumer-Directed Care Plus program and transfer to the HCBS waiver program.

Consumers or representatives file appeals by completing the Consumer Appeal Form. These forms are submitted to the consultant provider agency or District Office. The Consumer Appeal Form must contain a summary of the recommendation or action, which is being appealed, the consumer's objection to the recommendation or action, and any proposed solution or compromise. The Consumer Appeal Form must be submitted to the consultant agency or District Office within fourteen (14) days of the consumer receiving notice of the contested action. An appeal form is included in the consumer program manual (consumer notebook) for the convenience of consumers and representatives.

The consultant provider agency, independent consultant or District Office shall forward the Consumer Appeal Form to the appropriate agency or state program office (Elder Affairs, Developmental Services, Adult Services, local Area Agency on Aging (AAA) or Traumatic Brain Injury/Spinal Cord Injury Program) within three (3) business days.

The local District Office or Area Agency on Aging reviews the appeal, makes a determination and informs the state program office within two (2) business days. The state program office shall contact the local district or AAA within two (2) business days to sign-off on the District Office/AAA determination. The state program office under which the consumer is eligible for Consumer-Directed Care Plus reviews all appeals and related materials forwarded by the AAA, consultant provider agency or independent consultant. If the state program office does not support the AAA or district's decision, a suggested solution will be offered.

The District Office or AAA shall inform the consultant provider agency or the independent consultant of the determination. The consultant or consultant agency, in turn, notifies the consumer or representative of the determination.

Appeals and appeal determinations are recorded in the consumer record. The consultant shall provide copies of agency, district or AAA recommendations and any written response from the state program office to the consumer or representative who filed the appeal.

Standards and Monitoring

I. Consultant Provider Monitoring

Each states CDC + program office is responsible for records review and on site monitoring for its consumers. Based on the record review and formal complaints, each state CDC + program office will determine if on site monitoring is necessary and will conduct on site monitoring as required.

Records review will follow statistical sampling methodology. State CDC + program offices may accomplish records review through program office staff, AAA Medicaid waiver specialists, District office staff or through a contractor.

1. Care Management

A. Standard: Before enrolling in Consumer-Directed Care Plus, the applicant shall be enrolled in a Medicaid Home and Community-Based Services (HCBS) Waiver Program and Medicaid eligibility will have been determined. All HCBS eligibility criteria and standards are applicable.

***Monitor*:** Each client record will include documentation of Medicaid waiver eligibility determination.

B. Standard: Interested consumers and their families or caregivers will receive information about the opportunity to participate in CDC +.

Monitor: The case manager or support coordinator provides written information about CDC + to consumers. State CDC + program offices may prepare flyers and/or letters for the consultant and for direct mailing to eligible consumers.

C. Standard: The enrollment visit will provide the consumer and/or representative with adequate information to make an informed decision about participation in CDC +.

Monitor: The consultant or outreach worker provides consumers and/or the representative with a detailed overview of the monthly budget amount, employer related responsibilities, and rights and responsibilities as CDC + participants.

The consultant or outreach worker will complete a CDC + application form for consumers/representatives who want to enroll after CDC + is explained. Each consumer record contains a copy of the application form and the original consent form signed by the consumer

and, if applicable, the original Representative Agreement. In applicable circumstances, the representative signs the consent form. The original signed Representative Agreement is in the consumer record.

D. Standard: All consumers shall be trained to assume responsibility for care management and budget management responsibilities before disbursement of the first monthly budget. Training may be customized to assist consumers in the areas most needed and minimize training in areas in which the consumer already possesses adequate skills. A program manual (consumer notebook) shall be provided to all consumers or their representatives. The training informs consumers how to file the Consumer Appeal Form and the Complaint Form.

***Monitor**:* The consultant documents, in the consumer record, all contacts made to schedule Consumer-Directed Care Plus training. The consultant documents all reasons why a consumer has not received training within 15 business days. The consumer record documents the date Consumer-Directed Care Plus training was provided to the consumer. If a consumer intends to have a person assist with budget management responsibilities or employer responsibilities such as hiring and supervising workers, the person should attend the Consumer-Directed Care Plus training. The representative, but not the consumer who appointed the representative, is required to attend the training. The consumer record indicates all individuals who received consumer training.

Documentation of training indicates the consumer/representatives strengths and weaknesses identified during the training session. The state program staff or workgroup staff may observe a session of consumer training to assess the quality of the training provided.

The consultant documents, in the consumer record, all reasons why a consumer does not progress in the enrollment process and receives a Consumer-Directed Care Plus budget within eight weeks after the date of the mandatory training.

E. Standard: Consultants will provide an adequate level of post-training contacts and support to answer questions, approve the purchasing plan and address challenges that might delay the interviewing, screening, selection and registration of workers with the FEA.

***Monitor**:* The consultant documents all post-training contacts with the consumer and/or representative in the consumer record. All consultant recommendations, such as the appointment of a representative to assume CDC + responsibilities, shall be documented.

The consumer/representative completes the purchasing plan, hires workers, and forwards the employment information (to register workers for payroll) to the fiscal/employer agent before the first Consumer-Directed Care Plus budget is authorized. The consultant verifies the consumer/representative has completed all responsibilities related to hiring workers and planning the budget. Within two business days of verification, the consultant transmits the budget authorization form to the appropriate District Office CDC + coordinator or to DOEA as authorization for starting the Consumer-Directed Care Plus budget**.**

F. Standard: Consultants will provide consumers with adequate support and technical assistance.

The consultant must keep case notes on all contacts with consumers in the consumer record.

***Monitor**:* The consumer record contains documentation of contacts at least once each month after a consumer receives a Consumer-Directed Care Plus monthly budget. Consultant contacts other than those requiring a home visit may take place by telephone. Documentation includes an assessment of the purchasing plan implementation and notes any problems or concerns identified. Successes should also be documented. Each contact includes the consumer's or the representative's assessment of quality of care received.

The consultant must make a home visit with the consumer during the second month after the consumer begins receiving a Consumer-Directed Care Plus budget. In addition to the assessments listed above, the home visit will include an assessment of potential abuse, neglect and/or exploitation risks. The assessment results will be documented in the consumer record.

G. Standard: Every consumer must develop a backup plan to ensure the continuation of a critical service(s).

Monitor: During the mandatory training, the consultant explains that a backup plan is required and provides assistance in developing the backup plan, as needed. Before approving a purchasing plan, the consultant evaluates and approves the adequacy of a consumer's backup plan. The cost, if any, of the backup plan services and whether services will be obtained from backup workers hired directly or from an agency must be documented by the consumer. At least two backup providers are required for each critical service.

Mandatory consultant contacts with the consumer or representative shall include an inquiry about use of the backup plan. If applicable, an evaluation of the plan's implementation should be documented in the consumer record and include the assessment of the backup plan's effectiveness and any changes made to the plan. The use of the Interactive Voice Response (IVR) system allows for further monitoring of the use of the emergency backup plan by consumers. The system allows for recording the option of "emergency services" when an employee checks in for work. This option notates the use of emergency funding rates into the system and alerts the consultant when he/she checks the consumer's account on the website. A report can be run through the system that will list all consumers who have accessed their emergency backup services.

H. Standard: A corrective action plan is initiated for any consumer who experiences significant and/or consistent difficulties with any aspect of care management including management of employer responsibilities.

Monitor: All information available to the consultant that indicates a significant and/or consistent problem with care management responsibilities, is documented in the consumer record. The consultant initiates a corrective action plan. Consumer/representative involvement in the development and implementation of the corrective action plan is conducted in accordance with

the "Process Steps for Corrective Action Plans," provided to consultants during mandatory training.

Within 48 business hours of identification of a problem the 10 step process for a corrective action plan will be followed. The corrective action should be put into action within 14 days. The consultant will ensure that a copy of the corrective action plan is:

- sent to the appropriate district or state program office;
- included in the consumer record; and
- provided to the consumer or representative.

I. Standard: The reassessment of functional status or of continued need for services is done annually. Department of Elder Affairs and Adult Services program consumers will be reassessed using the "Uniform Client Assessment."

An annual reassessment of the consumer's continued need for services is conducted for all Developmental Services and Traumatic Brain Injury/Spinal Cord Injury Program consumers.

The consultant provides verification of consumer participation in or disenrollment from the Consumer-Directed Care Plus program to the Office of Economic Self Sufficiency staff as part of the annual reassessment process, which includes re-determination of Medicaid eligibility.

Monitor: Consultants will complete the Uniform Client Assessment form annually for all elder consumers and adult consumers served by the Department of Children and Families. The completed assessment form is included in the consumer record. The consultant documents the continued need for services for all Developmental Services and Traumatic Brain Injury/Spinal Cord Injury Program participants in the consumer record. Consultants' reassessment of consumers' potential risk for abuse, neglect and/or exploitation will be documented in the consumer record.

All contacts with the Office of Economic Self Sufficiency staff for the purposes of Medicaid redetermination are documented in the consumer record. The consultant responds promptly (within 5 business days) to requests for information from the Office of Economic Self Sufficiency staff engaged in Medicaid eligibility redetermination.

2. Abuse, Neglect and Exploitation

A. Standard: The Consumer-Directed Care Plus program is a resource for the prevention of abuse, neglect and exploitation. Consultants will use their professional judgment to assess consumers' potential risk for abuse, neglect and/or exploitation before enrollment in Consumer-Directed Care Plus and at regular intervals thereafter, but at least annually during the reassessment process.

Monitor: Consultants may recommend a plan to reduce the risk of abuse, neglect, or exploitation. The mandatory home visit, which occurs within the second month after the first disbursement of a consumer's budget, shall include a specific assessment of the consumer's

potential risk for abuse, neglect or exploitation. Referrals or recommendations made as a result of an assessment of potential risk shall be documented in the consumer record.

All occurrences or suspected occurrences of abuse, neglect or exploitation shall be reported to the Florida Abuse Hotline in accordance with Chapter 415.1034, Florida Statute (F.S.), "Mandatory reporting of abuse, neglect and exploitation of disabled adults or elderly persons" and Chapter 415.504, F.S., "Mandatory reporting of child abuse or neglect."

The consumer record documents all actions or recommendations made by the consultant. Protective Services emergency procedures shall be followed for Consumer-Directed Care Plus participants.

Consultants should follow-up with the Abuse Investigator regarding the outcome of any investigation.

3. Financial Management

A. Standard: The purchasing plan shall be developed by the consumer or representative and reflect the planned services and other purchases from the Consumer-Directed Care Plus budget which will best meet the consumer's long-term care needs. The purchasing plan is developed by the consumer or representative and approved by the consultant and appropriate district program office or DOEA before authorizing a budget start date.

Monitor: A copy of the most recent care plan or support plan is included in the consumer record.

A copy of the purchasing plan is included in the consumer record. The purchasing plan is signed and dated by the consumer or representative. The signature of the consultant is required to document approval of the consumer's purchasing plan.

As a consumer's purchasing decisions change, the purchasing plan is updated and sent to the consultant and appropriate district or state program office for approval and inclusion in the consumer's record. The reasons that have led to consultant, agency or state program office requests for an updated purchasing plan are to be noted in the consumer record.

B. Standard: A corrective action plan shall be initiated within 48 business hours for any consumer/representative who experiences significant and/or consistent difficulties with any aspect of their Consumer-Directed Care Plus budget. The consultant reviews the fiscal/employer agent's bi-monthly report, which details the consumer's use of the budget. The consultant contacts the fiscal/employer agent and/or consumer to gather additional information if the fiscal/employer agent reports differ significantly from the purchasing plan, the consultant is aware of any inappropriate use of the budget, or there are any other indications of mismanagement of budget responsibilities.

Monitor: Problems with budget management are to be documented in the consumer record and a corrective action plan initiated by the consultant as appropriate. A copy of the corrective

action plan is to be included in the consumer's record, a copy sent to the appropriate state program office and copy provided to the consumer or representative.

Consumer and/or representative involvement in the development and implementation of the corrective action plan shall be in accordance with the Process Steps for Corrective Action Plans provided to consultants during consultant training.

C. Standard: The consultant fulfills a monitoring role for the state to ensure the Consumer-Directed Care Plus budget is used to meet the long-term care needs of the consumer and to assure the needs of a vulnerable population are met.

Monitor: The consultant reviews the reports from the fiscal/employer agent detailing the consumer/representative's use of the budget. The consultant contacts the consumer/representative to gather additional information, as needed, and assess indicators of possible misuse or mismanagement of the Consumer-Directed Care Plus budget. The consultant documents monitoring of the cash log and receipts and appropriateness of purchases in the consumer record. Electronic tracking may be used to confirm consultants' consumer financial report monitoring.

4. Use of Community Resources

A. Standard: Consumers will utilize community services to augment Consumer-Directed Care Plus budget purchases. The Consumer-Directed Care Plus budget should not be used to purchase items that are available from community resources unless problems with access or quality prevent consumers from using the community resource. Community resources include Medicaid state plan and Medicare services and supports.

Monitor: The consultant develops a written list of community resources, which is given to consumers or representatives during training. Consumers are trained to obtain long-term care services and supports before using the Consumer-Directed Care Plus budget to purchase such services.

The consultant's mandatory review of the monthly fiscal/employer agent report identifies Consumer-Directed Care Plus budget purchases that might be obtained from another funding source or community resource. This information will be communicated to the consumer/representative in a timely manner and documented in the consumer file.

II. Fiscal/Employer Agent Service Monitoring

Although workgroup staff may conduct an informal site visit as often as once a quarter, the formal monitoring visit of the fiscal/employer agent will occur annually. The fiscal/employer agent may be monitored more often, as necessary. Performance standards have been developed for the new fiscal/employer agent (FEA) for CDC +. Quality management monitoring of the FEA will be incorporated with overall contract monitoring to be performed by the state. Only the Financial Management indicator applies to monitoring for the FEA.

1. Performance Standards for the Fiscal/Employer Agent (FEA)

A. Standard: Provided the FEA is furnished with current addresses and properly completed and submitted timesheets or through the Interactive Voice Response (IVR) system, employees will receive Electronic Funds Transfer (EFT) payments within five business days and paychecks will be mailed within three days after the cut off date for receiving timesheets for that particular payroll period. Postmarks will be used to determine the date's timesheets are submitted and payroll checks are mailed.

***Penalty*:** Forfeit the transaction fee for each late or missing payroll payment.

B. Standard: Provided the FEA is furnished with current addresses and properly completed purchasing plans, consumers will receive cash EFT payments within five business days and cash checks will be mailed within three days after the cut off date for receiving timesheets for that particular payroll period. Postmarks will be used to determine the dates purchasing plans and checks are mailed.

***Penalty*:** Forfeit the transaction fee for each late or missing consumer payment.

C. Standard: The FEA system will send consumers cash payments in accordance with the purchasing plan 99% of the time.

***Penalty*:** Forfeit the transaction fee for each incorrect cash payment.

D. Standard: Provided the FEA is furnished with current addresses and properly completed and submitted invoices, vendors will receive EFT payments within five business days and check payments will be mailed within three days after the cut off date for receiving timesheets for that particular payroll period. Postmarks will be used to determine the dates invoices are submitted and checks are mailed.

***Penalty*:** Forfeit the transaction fee for each late or missing invoice payment.

E. Standards: The FEA system will collect employee time worked from consumer-submitted timesheets and the IVR system. The FEA will then calculate correct payroll payment amounts to employees 99% of the time.

***Penalty*:** Forfeit one-half the transaction fee for each incorrect employee payment.

F. Standards: Provided the FEA is furnished with current addresses, bi-monthly budget reports will be mailed to consumers and consultants within three days after the payroll period.

***Penalty*:** Rebate $3.00 of the FEA fees to the consumer for each late or missing bi-monthly budget report.

G. Standard: The FEA system will accurately report consumer account activity on bi-weekly budget reports to consumers and consultants 99% of the time.

***Penalty*:** Rebate $3.00 of the FEA fees to the consumer for each incorrect budget report.

H. Standard: The FEA system will accurately transfer funds from and to the consumer account and savings account 99% of the time.

***Penalty*:** Rebate $3.00 of the FEA fees to the consumer for each incorrect transfer.

2. Care Management

Not applicable

3. Abuse, Neglect and Exploitation

Not applicable

4. Financial management

A. Standard: The fiscal/employer agent (FEA) shall notify the consultant when a consumer submits a time sheet, or an invoice for payment for which the consumer has inadequate funds.

Monitor: The workgroup staff will select a random sample of consumer records to review during consultant service provider monitoring visits. To assess compliance with this standard, the consumer record review will include an analysis of the FEA reports on consumers' cash withdrawals.

B. Standard: Consumers will have a convenient mechanism to report concerns or problems with the FEA services. The FEA shall establish and maintain a toll-free telephone line and respond within 48 business hours to consumer complaints or concerns regarding the quality of any fiscal/employer agent service.

Consumers may submit written complaints to the state about the quality of FEA services.

Monitor: As part of the monitoring visits with the fiscal/employer agent, workgroup staff will observe, whenever possible, how consumer calls to the customer service line are answered and concerns are addressed. Workgroup staff will work with the FEA to identify the types of calls received.

The consumer program manual contains a "Consumer Complaint Form" for consumers to notify the state of fiscal/employer agent service problems that are not being resolved to the consumer's satisfaction. The form may be used, even though the fiscal/employer agent may have resolved the particular problem successfully, when the consumer decides notification to the state is warranted. Program staff will review all consumer complaint forms received and compile information for analysis and quarterly reporting. In some circumstances, the state may intervene immediately to resolve quality problems. Program staff will investigate further, as indicated in

specific cases, and develop a corrective action plan with the fiscal/employer agent to resolve quality problems.

5. Use of Community Resources

Not applicable

III. Prevention

Comprehensive training to equip consumers and representatives with tools they need to successfully manage responsibilities will prevent many quality problems.

A. Consumer and/or Representative
Training is mandatory for all consumers, and/or their representatives. The consumer training includes all of the topics in items 1 - 4 listed below. Consultants may customize training as long as the consumer or representative possesses adequate skills in each area. Training to prevent abuse, neglect or exploitation is mandatory regardless of consumers' perception of their current prevention skills.

1. Care Management
   - reviewing purchasing plan guidelines during training and informing consumers/representatives that assistance may be provided by consultants, as needed, in writing the purchasing plan
   - selecting, screening, and training workers
   - assessing quality of services
   - providing feedback to service providers/workers about quality of services delivered
   - planning for emergencies

2. Financial Management
   - defining appropriate uses for the budget amount and specific exclusions
   - preventing overspending
   - determining salaries
   - determining independent contractor fees and payments
   - understanding tax responsibilities
   - planning for emergencies
   - planning for costly expenditures
   - preventing financial exploitation

3. Abuse, Neglect and Exploitation
   - identifying types of provider/worker fraud
   - preventing abuse by a worker
   - using the monthly benefit to provide an adequate level of care
   - preventing financial exploitation by workers and family members

- learning how to use a consultant for assistance in cases of abuse, neglect or exploitation

4. Use of Community Resources
   - using the consumer resource manual chapter on "Where to Go for Additional Help"
   - learning how to use a consultant for assistance with identification of community services
   - using peer support networks

B. Consultants

Quality problems will be prevented to the greatest extent possible by requiring comprehensive training of consultants. Consultants must complete the entire training before providing consultant services to Consumer-Directed Care Plus participants. A workgroup staff member will be identified as a contact person to answer any questions consultants might have or to provide direction in unusual situations. The consultant training will include the following:

1. Care Management
   - clearly defining and communicating the roles and responsibilities of the consultant
   - clearly defining and communicating the roles and responsibilities of the consumer and representative
   - reviewing standards for mandatory contacts with consumers/representatives
   - assessing care management
   - reviewing the criteria for approving consumer purchasing plans
   - assessing the need for a corrective action plan
   - understanding the QMP

2. Financial Management
   - defining appropriate uses for the budget
   - defining exclusions from the budget
   - assessing usual and customary community fees for various services
   - understanding payroll tax expenses
   - using and interpreting the monthly fiscal/employer agent reports
   - understanding the monitoring function of consultants by assessing the monthly fiscal/employer agent report review
   - assessing the need for a corrective action plan

3. Abuse, Neglect, and Exploitation
   - identifying risk factors for abuse, neglect, exploitation
   - preventing financial exploitation
   - reviewing the purchasing plan to assess possible risks for abuse, neglect, or exploitation
   - assessing risk for abuse, neglect or exploitation during the mandatory month two face-to-face contact
   - monitoring fiscal/employer agent reports to ensure needs of the vulnerable population are being met

- assessing the need for a corrective action plan

4. Use of Community Resources
   - identifying local resources
   - implementing a corrective action plan if the consumer/representative is using the budget to make purchases that have another funding source for which the consumer qualifies and that will meet the consumer's needs satisfactorily.

C. Peer Support

Providing training and information to the peer support network will contribute to its ability to assist consumers in preventing quality problems. The following tools will be provided to the peer support network:

1. Care Management
   - peer support volunteers will be provided consultant training materials before offering assistance or group meetings to consumers and representatives
   - a description of the program design will be provided to train peer support volunteers about the philosophy, goals and consumers' responsibilities within the CDC + program
   - a staff person from each state program office will be identified as a contact to answer questions and provide direction, if needed

2. Financial Management
   - appropriate uses of the benefit defined
   - exclusions for use of the budget defined

3. Abuse, Neglect and Exploitation
   - identifying potential abuse, neglect and exploitation situations
   - providing support for choices or changes made to prevent or reduce risk of abuse, neglect or exploitation

4. Use of Community Resources
   - sharing information

ATTACHMENT A
Essential Elements of Self-Direction
Background Screening

The Consumer-Directed Care Plus program will enact a procedure whereby either a Level I or Level II background screening will be available, at no charge to its participants, for all employees hired by the consumer to provide services. The Special Terms and Conditions of Approval stipulate this policy for the CDC + amendment, as did the Florida Legislature in authorizing the expansion of the Consumer-Directed Care Project. All individuals who will be rendering care to a consumer enrolled in this program must either:

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

Statute Reference

The background screening shall be conducted in accordance with Chapter 435, Florida Statutes (F.S.) and shall be at a minimum a Level I (Florida Department of Law Enforcement) background screening. The consumer shall not incur the cost for background screening.

Individuals whose originating Home and Community Based Service waiver is the Developmental Service (DS) Waiver may only receive direct care services from non-family members who have successfully completed a Level II (fingerprint and FBI check) background screening. Level II screening is required in Chapter 393, F.S., for direct service providers who provide services to individuals with developmental disabilities, excluding family members. Family members who provide care to a consumer whose originating waiver is the DS Waiver are subject to a Level I background screening.

Background Screening Process - DS Waiver

Service providers for DS Waiver consumers will receive their screening instruction packets from their district Developmental Disabilities office. The completed packets will be returned to the district office and sent to the Background Screening Unit of the Department of Children and Families. This Unit will send the information to the FBI and will then review the returned screening for any offenses, per Chapter 435.04, F.S., that would disqualify the service provider. The provider will be notified by letter of the results of the background screening and, if found to be disqualified, their right to appeal the disqualification. The district staff will ensure a copy of the Level I and Level II background screening is given to the CDC + consultant who will provide the copy to the program participant. The service provider will pay all costs associated with the background screening.

Background Screening Process – A/DA & TBI/SCI Waiver

A/DA and TBI/SCI waiver consumers will receive their provider's Level I background screening through the Fiscal/Employer Agent (FEA) contracted with the Department of Elder Affairs for the CDC + program. Information from the service provider, submitted through the consumer, will be processed by the FEA. The FEA will screen the background checks for disqualifying offenses as referenced in Chapter 435.03, F.S. The FEA will return the information to the CDC + program staff at DOEA who will contact the provider if there are any disqualifying offenses. If found to be disqualified, the service provider will be advised of their right to appeal the disqualification. The service provider will be responsible for all costs associated with the screening.

ATTACHMENT B
Essential Elements of Self-Direction
Statewide Incident
Management System

The Florida Consumer-Directed Care Plus program will institute and maintain a statewide incident management system specifically for CDC + participants. This system will define, identify, investigate and resolve reported incidents, events, and occurrences that jeopardize the health and welfare of participants. This reporting system will not replace the abuse, neglect and exploitation reporting system currently in place in the state of Florida. All allegations of possible abuse, neglect or exploitation must be reported immediately to the Florida Abuse Hotline and the appropriate district human rights advocacy committee as required by law.

Definition

The definition of incident for the CDC + Incident Management System will include:

- ✓ Consumer was without needed services for 24 hours
- ✓ Consumer was missing from home for 24 hours
- ✓ Consumer was involved in an altercation with an employee that resulted in an injury requiring medical attention by a licensed health care professional and/or police intervention
- ✓ Consumer's employee misconduct/neglect/criminal activity
- ✓ Consumer sustained an accidental injury requiring medical attention by a licensed health care professional
- ✓ Consumer was involved in an incident resulting from an error in medication management, requiring the intervention of a licensed health care professional
- ✓ Consumer was a victim of sexual battery
- ✓ Consumer attempted suicide
- ✓ Consumer death
- ✓ Other serious incident _____

Incident Management Process

A database will be established at the Department of Elder Affairs to receive incident information from any part of the CDC + system. This will be incorporated into the CDC + database. The "Incident Report" form will be distributed to all consumers, representatives, guardians, families, consultants, and districts. It will be available in both paper version and electronically over the CDC + website. The CDC + website is integrated with, and hosted by, the Department of Elder Affairs secure data center which is compliant with all federal regulations governing the Health Insurance Portability and Accountability Act (HIPAA). This will enable the state to track incidents and their resolutions, allowing problems in care situations to be more readily identifiable and more closely monitored by local personnel. CDC + staff already track complaints and issues relating to the fiscal/employer agent and consultants.

When an incident occurs, the first priority is the health and safety of the consumer. Once the situation is stabilized, but no later than twenty-four hours from the discovery of the event, the incident must be reported to the CDC + district coordinator or the appropriate program office. The consumer, representative, or consultant will fill out an "Incident Report" form.

The person reporting the incident and the consultant who represents that consumer must sign the form. A copy of the Incident Report form will be given to the district and another copy placed in the consumer's file. A copy of the original form will be faxed, mailed, or sent electronically within 3 days to the Department of Elder Affairs (DOEA).

After the incident is notated, the original form will be sent for investigation to the consumer's originating program office (i.e., developmentally disabled children and adults to the Developmental Disability program office, elders to DOEA, physically disabled adults to Adult Services, Department of Children and Families, and Brain and Spinal Cord Injury consumers to the Department of Health).

Each program office will appoint an individual to investigate the incident. Within ten working days of the incident, the program office will complete the investigation and report its findings and resolution on the original form. When the investigation and resolution of the incident is completed, the original form will be returned to DOEA, which will then record the final resolution into the CDC + database. The original Incident Form will then be filed in the consumer's folder at DOEA.

Incident Form

The Incident Report form will include the following information:

What happened?
Who was involved?
When did it happen?
Where did it happen?
Why did it happen?
How did it happen?
What has been done about the incident?
Who has been notified?
Final Resolution

ATTACHMENT C
Essential Elements of Self-Direction
Statewide Emergency Backup Plan

The Essential Elements of Self-Direction require participant protection procedures, including a statewide emergency backup system. This system will provide emergency response and backup in the event the consumer's own two critical backup plans fail to ensure services and supports necessary to the consumer's health and safety. The primary emergencies faced by consumers in the CDC + program are the failure of personal care providers to report for work and natural or man-made disasters. To maximize consumer choice and the principles of self-determination, consumers will select the providers of their choice for both the purchasing plan and the emergency backup plan.

The levels of emergency backup provisions presented below, while providing necessary services, still reflect the philosophy of consumer choice. While adding additional layers of protection for the participant, it allows the consumer to select the plan that best fits his/her needs. The consumer will continue to rely on the consultant as a first resource. The CDC + consultants carry pagers and will remain available as consumers' first contact for all emergency situations. District-level CDC + coordinators will also be available during office hours to assist the consumer.

Hierarchy of Emergency Backup

The Consumer-Directed Care Plus program will ensure the consumer's health and safety in the event of an emergency by the following hierarchy of backup protections. The levels vary by degree of emergency need. Generally a consumer will access these levels of backup in order, starting with Level 1. In case of an extreme emergency, however, they may need to go directly to Level 4.

1. Consumer's emergency backups for critical services incorporated into the purchasing plan
2. Informal network of family and friends
3. Enrolled Medicaid provider network
4. Extreme emergency

These levels are described in greater detail below.

Level 1: Consumer Purchasing Plan Emergency Backups

The Consumer-Directed Care Plus program requires each consumer to include an emergency back up plan within his or her purchasing plan. The emergency backup plan must identify specific arrangements necessary to provide critical services and maintain the health and safety of the consumer in the event of a breakdown in the routine plan of care. For the consumer, a critical service is one without which the participant would suffer an immediate risk to their health, safety, or well-being.

Consumers are required to have two backup providers for each critical service in their purchasing plan; the plan provides check-off boxes to note which are the critical services and a page devoted to the emergency backup plan. This page requires a description of each critical service, estimated hours of care needed to cover the critical service and the cost of the emergency service. The plan must be detailed, realistic, and updated to keep pace with changes in the individual's care plan. Consultants will work with consumers and their families to develop this plan. The emergency backup providers on the purchasing plan may be existing CDC+ employees, employees of an enrolled Medicaid provider such as a home health agency or nurse registry, or informal caregivers such as family members, friends, or neighbors.

Level 2: Informal Network

In the event that the backup providers listed in the purchasing plan are not able to provide backup as planned, consumers may reach out to their network of family, friends, and neighbors to provide interim supports. Most consumers already rely on family and friends to provide some caregiving and personal care services, and in the event of an emergency, these individuals may be able to provide additional care in the absence of the paid caregivers.

Level 3: Enrolled Medicaid Provider Network

If the backups planned in Levels 1 and 2 are not adequate in an emergency, Level 3 will be accessed. This level of backup involves accessing enrolled Medicaid providers such as home health agencies, nurse registries, or other home and community based services providers. Due to the diverse nature of the populations participating in CDC+, separate plans for accessing Level 3 of the emergency backup plan have been developed for each of the following groups: 1) elders; 2) consumers with developmental disabilities; 3) adults with physical disabilities; and, 4) consumers with brain and spinal cord injuries. These plans are activated only in the event of a breakdown of the two emergency backup plans on the consumer's purchasing plan and a failure of the informal care network.

Elders

The Florida Department of Elder Affairs will sign Memoranda of Agreement with the department's contracted Lead Agencies across the state. Lead Agencies provide case management to elders in a specified geographical area. These agreements will specify that elderly CDC + consumers may access each agency's 24 hour on-call telephone number. The on-call operator will be able to assist the consumer by contacting available service providers or by sending an agency employee to the consumer's home to assess the situation and provide needed services. The consumer's consultant will discuss this arrangement with the consumer during initial program training and again when the purchasing plan is developed

Consumers with Developmental Disabilities

The Developmental Disabilities program office will work with enrolled Medicaid providers to supply emergency service workers to the consumer when called. With the assistance of the consultant, an Agency Agreement for Provision of Services form will be completed between the consumer and the chosen Medicaid provider agency. This form will be documented in the consumer's record and available to the consumer and consultant. If necessary, consumers will

set aside funding, through their purchase plan, into "savings" for estimated additional costs for the Medicaid provider backup. The consumer, consultant, or representative can contact the agency to initiate emergency back up services.

Adults with Physical Disabilities
The Adult Services program will provide an emergency backup for their consumers through Memoranda of Agreement with Medicaid enrolled provider agencies that will supply emergency service workers to the consumer when the consumer's two emergency backup providers on his/her purchasing plan fail to provide critical care. The agreement will be negotiated within the disabled adult provider network, between the agency and the consumer. The consultant will help the consumer with these arrangements and provide guidance on choosing an area provider agency. The consumer will then estimate any additional cost of the emergency service and set aside funds in their purchase plan savings. The consumer, consultant, or representative may contact the service in the emergency situation.

Consumers with Traumatic Brain or Spinal Cord Injuries
The Brain and Spinal Cord Injury Program will contract for emergency backup services with an enrolled Medicaid home health agency. This local agency will provide home health care service workers to the consumer through a written agreement. This agreement will be between the agency and the consumer, acknowledging the agency's role as a backup service provider in the event the consumer's own emergency backup plans fail. The consultant will assist the consumer in contacting the agency and arranging for the written agreement. The consumer must factor any extra cost into the purchasing plan.

<u>Level 4: Extreme Emergency Backup</u>

Beyond the above-required emergency backup plans, and in the event of an extreme emergency, the following services can be utilized.

Adult and Child Protective Services
In an emergency situation where there is possible abuse, neglect, and/or exploitation, Adult or Child Protective Services will be called. If Adult or Child Protective Services are called to a consumer's home, an investigator is sent to that home and an investigation is automatically opened. The case will be investigated until a safe resolution for the consumer is made. In cases where a consumer is in immediate jeopardy, Protective Services investigators and caseworkers have 24-hour access to a network of providers that can provide safe placement for consumers. This network includes providers such as assisted living facilities, nursing facilities and foster care homes. The consultants provide information and telephone numbers to consumers and their families for Adult Protective Services and Child Protective Services upon enrollment. In addition, Protective Services will investigate reports by any citizen that suspects abuse or neglect; reports are frequently made by neighbors, friends, or even mail carriers.

Division of Emergency Management
In the event of natural or man-made disasters, the Florida Division of Emergency Management coordinates disaster relief through Florida County Emergency Management Agencies. These regional offices in turn coordinate with community-wide organizations in the event of a disaster.

Each state agency has in place contingency plans for their particular constituency in the event of fire, tornado, hurricane, flooding, or terrorism. These plans include assisting individuals with disabilities with evacuation and/or continuity of critical services.

911

All CDC + consumers are advised to call the emergency telephone number 911 in the event of a crisis where health or safety are in immediate jeopardy.

ATTACHMENT D
Florida Consumer-Directed Care Plus Waiver
Infrastructure Redesign Plan

The Consumer-Directed Care Plus program is committed to providing the highest standards and support mechanisms possible for its consumers. It is the intention of the CDC + workgroup to continually strive for improvement through policy, procedures, training, and monitoring: all incorporating the philosophy of consumer direction and choice. The administration and management of the program will encompass quality through consumer access, consumer-centered service planning and delivery, consumer safeguards, and consumer outcomes and satisfaction.

Automated Account Monitoring & Management System

The CDC + program will be greatly enhanced by the new design for a web-based system that will integrate the consumer database and the new fiscal employer agent (FEA) functions. The website will be integrated with, and hosted by, the Department of Elder Affairs over a password-protected, secure server that meets all federal standards for the Health Insurance Portability and Accountability Act (HIPAA). The website will feature a Spanish language version for consumers who do not speak, or are limited in, the English language. Also available to the consumer will be the AuthenticCare system, an Interactive Voice Response (IVR) program. This option eliminates the need for paper timesheets and provides "real-time" reporting of worker hours. Consumers will also be able to speak with a customer service representative.

The use of electronic processes will maximize efficiency and improve the quality of service while increasing oversight. CDC + consumers will have "real-time" access to their budget information including tracking their expenditures, thereby decreasing the potential for overspending their monthly budget. The web-based system will also identify for DOEA program staff when a consumer has expended 65% of their monthly budget by the fifteenth of the month. Both the consultant and the consumer will be able to take corrective action before the monthly budget is overspent. The consumer and consultants will receive bi-weekly budget reports.

Electronic filing of bills, invoices, and timesheets submitted via the website will enhance the turn around time for payment for consumer employees and services. Paper submission of timesheets and invoices will still be an option for all consumers.

The new web design and development system in support of financial administration and reporting will allow for the total automation of account monitoring by the FEA, including bi-weekly budget reports to consultants and consumers; DOEA program staff will monitor the CDC + database management system. Consistent with the principle of participant-centered responsibilities, consumers will be encouraged to access their financial information either through the secure data center or the AuthentiCare system to reconcile their account balances. The contract with the fiscal intermediary details the exact system specifications that will be utilized.

Development of Purchasing Plans

Purchasing plans for CDC + consumers are based upon care plans for elders and adults with disabilities and support plans for developmentally disabled consumers. The care plans are based on authorized Medicaid Waiver services. The value of the services is adjusted by a "discount rate," which represents the actual amount of services that traditional Medicaid Waiver clients receive. The "discount rate" varies for each program area (Adult Services, Elders, Developmentally Disabled). For a more detailed discussion on the development of purchasing plans, please refer to pages 5 and 6 in the Operational Protocol.

Procedures for Inactive Funds and Recoupment of Funds

Continual monitoring of the automated FEA's system processes will enable CDC + staff to identify consumers who have become inactive, thereby allowing a quicker recoupment of unexpended Medicaid funds. Consultants will receive their consumers' budget reports on a bi-weekly basis, allowing a "real time" accounting of their balances. During the required monthly contact with the consumer, the consultant will discuss account and saving balances with the consumer and monitor spending trends to avert overspending and the need for corrective action. For further information on disenrollment, accumulation of funds, and when funds are to be recouped, please see pages 16 and 17 in the Operational Protocol.

Management of Undesignated Funds and Revision of Purchase Plans

Guidelines for managing excess and undesignated funds have been detailed throughout the Operational Protocol (pages 16, 17, 18). Consumers are allowed to accumulate up to 1.5 times their monthly budget amount. Any funds in excess of that amount must be transferred to savings and designated for current savings purchases or used for new purchases. The purchasing plan must be updated to reflect these changes. For a detailed discussion on this topic, please reference the above sections in the Protocol as well as the Standard and Monitoring procedures under "Financial Management" in the Quality Management Plan. The consumers have the option of revising their purchasing plans with the technical guidance and approval of the consultant. The policy and procedures for changes in individual budgets are referenced on page 7of the Protocol, under "Changes to the Budget Amount."

Consultant and Consumer Training on Budget Management

Consultant training of consumers on the development and management of individual budgets is extensive and ongoing in the CDC + program. The consultant is required to make a home visit with the consumer during the second month after the consumer begins receiving a budget. Included in this visit are documentation of any problems or concerns and a written assessment of the purchasing plan implementation. Training on and development of the individual's monthly budget begins during the enrollment visit and consists of a three-part process: 1) assessment of need; 2) establishment of the budget amount; and 3) development of the purchasing plan. Consultants maintain monthly contact with consumers and technical assistance and training are available to consumers as needed. The Operational Protocol references this subject (pages 5, 6,

7). Monitoring standards for consultant training and care management policy and procedure are discussed in the Quality Management Plan (pages 23, 24, 25, 26) in the Operational Protocol.

On-going monitoring of quality improvement within the CDC + program will focus on all aspects of the delivery of efficient services and satisfactory outcomes for all consumers. System performance will be greatly enhanced through the new contract for the fiscal employer agent, the redesign of the database, and the installation of the AuthentiCare Interactive Voice Response system. The commitment to revisiting program policy and procedures will ensure a continual monitoring of program integrity.