

Hardee, Amy

From: Margaret Hooper [MargaretD@fddc.org]
Sent: Friday, July 27, 2012 3:22 PM
To: Robleto, Michelle
Subject: EHB Comments
Attachments: Specialty Health Care for for PWDD - FINAL.docx; Recommended Standards to Assess Managed Care Plans that serve Individuals with Disabilities 7-26-12.docx; EHB comments.pdf
Importance: High

Dear Ms. Robelto,

Attached are our comments regarding the Essential Health Benefits(EHB) decision that Florida must make by September 30, 2012.

We understand that comments are due by July 30th,2012.

I have also attached our Specialty Health Care Plan and a summary of the Recommended Standards for care for Individuals with Developmental Disabilities that are also discussed in the larger attachment of the full plan.

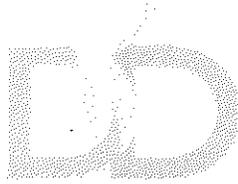
Please contact me if you have questions.

Best Regards,

Margaret J. Hooper, MSW
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Florida
Developmental
Disabilities
Council, Inc.

Reneé Valletutti, Chair
Debra Dowds, Executive Director

Commissioner Kevin McCarty
Florida Office of Insurance Regulation
200 East Gaines Street
Tallahassee, FL 32399-0308
C/O Michele Robello

July 26, 2012

Dear Commissioner McCarty:

The Florida Developmental Disabilities Council recently learned about the impending decision regarding Florida's Essential Health Benefits (EHB) package under the Affordable Care Act (ACA).

We respectfully request that you recognize the importance of the potential impact of that decision on the health, well-being, quality of life, and productivity of millions of Floridians, specifically, the impact on health care for individuals with developmental disabilities and their families.

Our understanding is that the federal Department of Health and Human Services has deferred to states regarding the establishment of the EHB package. In particular, Florida will have its own EHB package, and this package will determine the minimum set of benefits that health insurance coverage must include in order to be sold in the Health Insurance Exchange, to satisfy the criteria for "minimum essential coverage" referred to in the ACA.

Florida has ten "benchmark" benefit package options from which it may select one that can serve as a baseline for the development of Florida's EHB package, and then has additional choices to make to finalize that package. Although the EHB package only provides a minimum requirement and does not limit what insurers may cover, the EHB decision will have a far-reaching impact on Floridians for several years.

The Florida Developmental Disabilities Council recently completed a project of recommended standards to assess managed care plans that serve individuals with developmental disabilities. These standards were used to develop a *Specialty Health Care Plan for Persons with Developmental Disabilities (SHPDD)* in Florida. We think you will find these guidelines useful as you decide on minimum requirements for Florida's Essential Health Benefits Package.

Please find attached the recommendations from the advisory group that the Council worked with to determine these requirements. We look forward to working with you and hope you will consider the Florida Developmental Disabilities Council as a resource.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kathy McAllister', is written over a horizontal line.

Kathy McAllister,
Vice-Chair

Florida Developmental Disabilities Council, Inc.

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Specialty Health Care Plan for Persons with Developmental Disabilities

January 2012

Facilitated by Celeste Putnam

Chrysalis Consulting Group, Inc.



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Sponsored by United States Department of Health and Human Services, Administration on Developmental Disabilities and the Florida Developmental Disabilities Council, Inc.

Acknowledgements

The Chrysalis Consulting Group and the Advisory Group wish to thank Debra Dowds, Executive Director of the Florida Developmental Disabilities Council (FDDC) and the Council's Health Care and Prevention Task Force for recognizing the need to establish an understanding of the medical needs of persons with developmental disabilities and the value of providing consistent and quality health care to this population. We also want to thank Holly Hohmeister, Health Care and Prevention Program Manager with FDDC, for her extensive work and insight in helping us complete the Specialty Health Care Plan for Persons with Developmental Disabilities. Although the Advisory Group unanimously does not recommend prepaid managed care for persons with developmental disabilities, we do hope that some of our recommendations will be used to improve health care services to persons with developmental disabilities.

Chrysalis Consulting Group and our sub-contractors want to especially thank the Advisory Group for all their dedication and hard work on this project. Each member brought a unique perspective and knowledge base to the project which contributed to our overall understanding and work.

Advisory Group Members

Michael Bolin -	Agency for Health Care Administration
Rebecca Crosby -	Self-Advocate
Dr. Robert Fifer -	University of Miami, Mailman Center for Child Development
Lori Gephart -	Agency for Persons with Disabilities
Holly Hohmeister -	Florida Developmental Disabilities Council
Dr. Mark Hudak -	University of Florida, College of Medicine, Jacksonville
Patty Houghland -	Florida Family Care Council- Family Advocate
Debra Linton -	Arc of Florida
Suzanne Sewell -	Florida ARF
Courtney Swilley -	Florida ARF
Phyllis Sloyer -	Department of Health, Children's Medical Services
Becky Maguire -	Department of Health, Children's Medical Services
Melissa Vergeson -	Agency for Health Care Administration
Dr. David Wood -	University of Florida, College of Medicine, Jacksonville

Chrysalis Consulting Group and Subcontractors

Celeste Putnam	Chrysalis Consulting Group, Inc.
Joshua Peirce	Research Assistant, Chrysalis Consulting Group, Inc.
Leslie Schwalbe	National Independent Managed Care Consultant
Shelly Brantley	Innovative Health & Business Solutions, Inc.

Advisory Group Recommendations for State Plan Services for Persons with Developmental Disabilities

The Specialty Plan requirements that follow and the recommendations below were developed with the Advisory Group listed on the previous page. This group worked diligently to develop recommendations for how the state should provide State Plan services for persons with developmental disabilities. The advisory group for the Specialty Health Care Plan for Persons with Developmental Disabilities recommends the following:

- Persons with developmental disabilities have more complex medical needs than do the general population and require access to medical care from a network of providers that are knowledgeable in treating persons with developmental disabilities.
- Prepaid managed care programs for persons with developmental disabilities are not recommended either for State Plan services or Home and Community Based Services provided through Waivers. However, if the Legislature does determine that persons with developmental disabilities must receive Medicaid State Plan services through managed care, then special provisions must be in place to address their needs.
- Should it be required by the Legislature, a health plan for persons with developmental disabilities should be a statewide specialty plan with programs throughout the state and should be operated by an organization that is knowledgeable about providing medical services to persons with developmental disabilities.
- The statewide managed care program should deliver services through a network of medical homes, specialty providers and an array of other health care practitioners.
- All practitioners providing services must have experience or receive training in providing services to persons with developmental disabilities.
- Services should be provided through a multi-disciplinary team approach with the medical home, led by the primary care physician, providing the coordination.
- The primary care providers should operate within a person- and family-centered medical home model.
- Enrollment in the Specialty Health Care Plan for Persons with Developmental Disabilities should be voluntary.
- Persons eligible for enrollment should be persons on a Developmental Disabilities Home and Community Based Services Waiver or on the waiting list for one of the waivers.
- The Specialty Health Care Plan for Persons with Developmental Disabilities should include two services not currently in the State Plan for adults. The Advisory Group's recommendation to include these services is based upon the extensive needs of persons with developmental disabilities. These services are dental services and therapy services.
- The capitation rate for the Specialty Health Care Plan for Persons with Developmental Disabilities must be established through a population-based risk adjustment mechanism. In this context, risk adjustment refers to the establishment of rates that reflect the particular needs of the population. Consideration should be given to: past utilization adjusted for the documented under-utilization of services; modifications in the service package to include dental and therapy; the additional complexity of the population to treat; the additional time necessary to address their needs during a medical encounter and other population-based factors that will significantly impact the cost and care of this population.

- Providers should receive enhanced rates for providing services to persons with developmental disabilities. If providers render services through a prepaid mechanism, then their payment should be risk-adjusted based upon the complexity of the patients that they are seeing.

Specialty Plan Requirements for State Plan Services for Persons with Developmental Disabilities

The Specialty Health Care Plan for Persons with Developmental Disabilities was developed in response to a request by the Florida Developmental Disabilities Council. The purpose of this document is to present a set of requirements to be considered in the event that managed care for State Plan services is mandated for persons with developmental disabilities. This document in no way is intended as a recommendation for managed care services for persons with developmental disabilities.

Section I: Purpose

The purpose of the Specialty Plan Requirements for State Plan Services for Persons with Developmental Disabilities is to implement and operate Medicaid State Plan-covered services in a manner that acknowledges the special needs of persons with developmental disabilities. This health plan will be referred to as the Specialty Healthcare Plan for Persons with Developmental Disabilities (SHPDD or the Plan).

A. Specialty Network Guiding Principles

1. Person-Centered Health Care Management

Individuals with developmental disabilities, their families, and/or significant others, as appropriate, must be fully involved in their care. Medical care must be provided to assist persons with developmental disabilities to reach their optimal level of wellness. Information must be presented in a manner that is understandable by the individual with developmental disabilities and their family and/or significant others.

2. Consistency and continuity of services

The services are provided to ensure that the individual with developmental disabilities receives consistent and continuous medical care from a primary care provider who is responsible for coordinating all medical services and ensuring that covered services are fully integrated with long-term care services.

3. Accessibility of Network

Covered services must be developed to address the special needs of the population. Provider medical necessity guidelines, clinical protocols, and provider requirements must be developed in accordance with the needs of this special population and must be developed to be complementary to Developmental Disabilities Home and Community Based Services (HCBS) Waivers. All locations providing covered services must be physically accessible.

4. Collaboration with Stakeholders

The Plan will establish ways to include individuals with developmental disabilities, family members, primary care physicians, HCBS Waiver services providers, and related community resources in the review and evaluation of the service network and quality improvement.

Section II: Definitions and Acronyms

A. Definitions

Agency- State of Florida Agency for Health Care Administration (AHCA)

Agency for Persons with Disabilities- State of Florida Agency for Persons with Disabilities (APD) that, in conjunction with AHCA, manages the services for persons with developmental disabilities including the HCBS waivers for persons with developmental disabilities.

Behavioral Health Services- Services listed in the Community Behavioral Health Services Coverage and Limitations Handbook and the Targeted Case Management Coverage and Limitations Handbook for case management services for persons with mental illness.

Choice Counseling- The state's designated party to provide choice counseling for persons with developmental disabilities.

Community Outreach- The provision of health or nutritional information or information for the benefit and education of, or assistance to, a community in regard to health-related matters or public awareness that promotes healthy lifestyles. Community outreach also includes the provision of information about health care services, preventive techniques, and other health care projects and the provision of information related to health, welfare, and social services or social assistance programs offered by the State of Florida or local communities.

Durable Medical Equipment- Medical equipment that can withstand repeated use, is customarily used to serve a medical purpose, is generally not useful in the absence of illness or injury, and is appropriate for use in the enrollee's home.

Emergency Behavioral Health Services- Those services required to meet the needs of an individual who is experiencing an acute crisis, resulting from a mental illness, which is at a level of severity that would meet the requirements for an involuntary examination and, in the absence of suitable alternative or psychiatric medication, would require hospitalization.

Emergency Medical Condition- A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in any of the following: 1) serious jeopardy to the health of a patient, including a pregnant woman or fetus; 2) serious impairment to bodily functions; 3) serious dysfunction of any bodily organ or part.

Emergency Services and Care- Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If such a condition exists, emergency services and care include the care or treatment necessary to relieve or eliminate the emergency medical condition within the service capability of the facility.

Grievance- An expression of dissatisfaction about any matter such as the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or health plan employee or failure to respect an enrollee's rights.

Grievance Procedures- The procedure for addressing enrollees' grievances.

Grievance System- The system for reviewing and resolving enrollee complaints, grievances and appeals. Components must include a complaint procedure process, a grievance process, an appeal process, access to an applicable review outside the health plan and access to a Medicaid Fair Hearing through the Department of Children and Families.

Health Plan- An entity that integrates financing and management with the delivery of health care services to an enrolled population. It employs or contracts with an organized system of providers which delivers services, and may share risk with providers. The term includes health plans contracted with the Agency to provide Medicaid services under the Florida Medicaid Reform program as well as 1915(b) managed care waiver areas, and includes health maintenance organizations authorized under Chapter 641, F. S., exclusive provider organizations as defined in Chapter 627, F. S., health insurers authorized under Chapter 624, F. S., and provider service networks as defined in s. 409.912, F.S. including the SHPDD.

Individuals with Special Health Care Needs- Adults who face physical, mental or environment challenges daily that place at risk their health and ability to fully function in society. These factors include individuals with intellectual disabilities or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; and individual with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes. Persons eligible for the Plan are considered individuals with special health care needs.

Long-Term Care- For the purpose of this description of the Plan, long-term care refers to an array of services designed to provide the non-Medicaid State Plan services needed by persons with developmental disabilities. For the purpose of the SHPDD, long-term care means the services covered through the HCBS Waivers operated by APD.

Medicaid- The medical assistance program authorized by Title XIX of the Social Security Act, 42 U. S. C Section 1396 et seq., and regulations administered in the State of Florida by the Agency under s. 409.901 et seq., F. S.

Medicaid Recipient- Any individual whom the Department of Children and Families (DCF), or the Social Security Administration on behalf of DCF, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods or services for which the Agency may make payments under the Medicaid program, and is enrolled in the Medicaid program.

Medical Home- A family-centered delivery system, in which the primary care provider partners with the individual with developmental disabilities, family members, and other support persons to coordinate and facilitate care. Health care is provided consistently with assistance available 24 hours a day, 7 days a week. The medical home staff assists

the patient in navigating the complexities of the health care system and coordinating their needs with the HCBS Waiver.

Medical Record- Documents corresponding to medical or allied care, goods or services furnished in any place of medical services. The records may be on paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible, and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 CFR 456.111 and 42 CFR 456.211.

Medically Necessary or Medical Necessity- Services that include medical or allied care, goods, or services furnished or ordered to meet the following conditions:

- be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
- be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the patient's needs;
- be consistent with the generally accepted professional medical standards as defined by the Medicaid program, and not be experimental or investigational;
- be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker or the provider.

For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

When interpreting medical necessity for persons with developmental disabilities, it must be remembered that services must be continued to maintain functioning in many areas and may need to be provided more frequently and more intensely than for persons without disabilities.

Physician's Assistant (PA)- A person who is a graduate of an approved program or its equivalent or meets standards approved by the Board of Medicine and is certified to perform medical services delegated by the supervising physician in accordance with Chapter 458, F. S.

Primary Care- Comprehensive, coordinated and readily accessible medical care including health promotion and maintenance, treatment of illness and injury, early detection of disease and referral to specialists when appropriate.

Primary Care Provider (PCP)- A Plan staff or contracted physician practicing as a general or family practitioner or internist who provides provide primary care services to persons with developmental disabilities.

Quality Improvement (QI)- The process of monitoring the delivery of health care services to ensure that it is available, accessible, timely and medically necessary. The Health Plan must have a quality improvement program that includes standards of

excellence, a written quality improvement plan and a monitoring system to measure provider performance and customer satisfaction.

Specialty Plan- A health plan that addresses Medicaid State Plan services designed for a specific population and whose enrollees are primarily composed of Medicaid recipients with special health care needs.

Urgent Care- Services for conditions which, though not life threatening, could result in serious injury or disability unless medical attention is received, or which substantially restrict an enrollee's activity.

B. Acronyms

DCF- Department of Children and Families

DME- Durable Medical Equipment

FQHC- Federally Qualified Health Care Center

HCBS- Home and Community Based Services

HMO- Health Maintenance Organization

NCQA- National Committee for Quality Assurance

PCP- Primary Care Provider

SHPDD- Special Health Plan for Persons with Developmental Disabilities

UM- Utilization Management

Section III: General Overview

A. Responsibilities of the Agency

1. AHCA is responsible for administering the Medicaid program

The Agency will administer contracts, monitor (in partnership with APD) SHPDD performance, and provide oversight in all aspects of Plan operations.

2. Timely enrollment

Enrollment in SHPDD will be effective at 12:01 a.m. on the first calendar day of the month following notification of eligibility by APD that occurs between the first calendar day of the month and the penultimate Saturday of the month. When APD notifies Medicaid of a new enrollee between the Sunday after the penultimate Saturday and before the last calendar day of the month, enrollment in a Plan will be effective on the first calendar day of the second month after choice or assignment.

3. Notification to SHPDD

The Agency or its agent will notify the SHPDD of an enrollee's selection or assignment to the Plan.

4. Confirmation of enrollment to enrollees

If the person is on a Developmental Disabilities HCBS Waiver or on the waiting list for such a waiver, the person will be notified of their choice of the SHPDD or any other Medicaid health plan operating in the geographic area. If the person does not choose a health plan, the person will be assigned to the SHPDD. The Agency or its agent will send written confirmation to enrollees of their choice of or assignment to the SHPDD. If the enrollee has not chosen a primary care physician, a letter will be sent urging the enrollee to do so. If the enrollee does not respond in 15 days, the Plan will contact the person as part of new enrollee services and provide them information about how to select a primary care provider.

5. Automatic re-enrollment after temporary loss of eligibility

The Agency or its agent will automatically re-enroll a former Plan enrollee into the Plan if the enrollee has a temporary loss of eligibility. Temporary loss is defined for purposes of this Plan as less than one-hundred and eighty (180) calendar.

6. Missing open enrollment period during temporary loss of eligibility

If a temporary loss of eligibility causes the enrollee to miss an open enrollment period, the Agency or its agent will enroll the person back into the Plan. The enrollee will have ninety (90) calendar days to dis-enroll without a specific reason.

7. Final determination of disenrollment requests

The Agency or its agent will make final determinations about granting disenrollment requests.

8. SHPDD operations monitored for compliance with the Contract and federal and state laws

The Agency and APD will monitor the Plan's operations for compliance with the provisions of the specialty requirements and applicable federal and state laws and regulations.

B. General Responsibilities of the Plan

The SHPDD is responsible for the following duties:

1. Verification of enrollment

The Plan is responsible for ensuring that a person is eligible for enrollment in the program and is eligible for the SHPDD. The Plan must verify the person's status with AHCA and with APD to determine waiver enrollment or "on waiting list" status.

2. Ensuring that providers address cultural and linguistic awareness

The Plan must ensure that the services are provided in a manner that reflects the cultural and linguistic characteristics of the population served.

3. Providing all covered services in accordance with state, federal and contractual requirements

The Plan must comply with all current Florida Medicaid Coverage and Limitations Handbooks for the services that are included in their contract. The Plan may not impose more stringent limitations or exclusions than are included in the handbooks. The Plan may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness or condition. The Plan may exceed the limits in the handbooks and offer expanded services. The interpretation of any possible limits or exclusions must take into consideration the special health care needs of persons with developmental disabilities.

4. Coordinating all health care services provided to a member, including specialty and tertiary care

The Plan is responsible for coordination of all services. For members served by the SHPDD, the health care coordination must be comprehensive. Each member will be assigned a health care coordinator who is responsible for providing coordination of all primary, specialty, and tertiary care and coordination with HCBS Waiver services. The plan must ensure that, in the process of coordinating care, each member's privacy is protected in accordance with federal privacy requirements.

5. Coordinating and integrating all health care services with long-term care services

Persons enrolled in the SHPDD will receive their long-term care services from a HCBS Wavier operated by APD, or will be on a waiting list for a HCBS Waiver, and will have been determined eligible for these waiver services. The SHPDD is responsible for all the State Plan services listed in this Plan description. It is therefore essential that the SHPDD have a written coordination of services agreement with APD. At a minimum, this agreement must address the integration of physical health, behavioral health, home health services (including nursing services), medication management, care coordination and support coordination. Special attention must be given to home health services, transportation, therapy services and personal care assistance to ensure that there is no confusion as to which entity is responsible for providing care and which is responsible for payment of the service. This information must be included in the enrollee handbook.

6. Coordinating with family and caregiver

Services must be coordinated with the family and the caregiver. The integrated medical and long-term care must be in accordance with the family or the caregiver's capacity to provide complementary services. Schedule of services must be developed in a manner that addresses the family's and caregivers' availability. Medical necessity determination must address reasonable expectations for family and natural supports.

7. Sharing data and reports with APD, Department of Education (DOE), Department of Health (DOH) and Department of Elder Affairs (DOEA)

The Plan must develop an agreement with APD, DOE, DOH, and DOEA for the appropriate sharing of data between the long-term care service providers and the

health care providers rendering services under the Plan. The Plan must agree to request necessary releases of information from their members to allow treatment information to be shared without impediment between APD, long-term care waiver providers, and Plan providers.

8. Ensuring services are provided by appropriately credentialed providers

The Plan will ensure that services are provided by appropriately credentialed providers that have special training to serve persons with developmental disabilities.

9. Consistently applying medical necessity authorization

The Plan will have a mechanism in place to ensure consistent application of medical necessity authorization of service in an amount, duration and scope that is appropriate to the needs of persons with developmental disabilities. The process of requests for initial and continuing authorizations of services must be in writing and the Plan must have a mechanism in place to ensure that the authorization of services is consistently applied. The determination must be made by a professional who has appropriate clinical expertise in treating the person with developmental disabilities and the service under consideration.

10. Notifying providers and enrollees of denial or reduction of services

The Plan will have policies in place to give written notification to providers and enrollees of denial or reduction of services. This information will also include information regarding how to file for a reconsideration or appeal.

11. Ensuring communication between providers and members

The Plan will ensure that the providers have the ability to freely communicate with members regarding their health care, medical needs and treatment options.

12. Notifying enrollees of termination of service providers

The Plan shall notify enrollees regarding provider termination of one of their providers. The Plan is responsible for arranging for the transition of care to another equally qualified and accessible provider. The Plan shall notify the agency regarding termination of a provider 60 days prior to termination of the provider. If termination is for "cause", the health plan shall provide AHCA the reasons for termination. The Plan must assure that the network has the necessary providers to continue the service rendered by the terminated service provider.

13. Ensuring appropriate and timely payments

The Plan will ensure that all claims are appropriate for services actually rendered and payment is timely in accordance with established timeframes in Florida

14. Reporting Fraud and Abuse

The Plan is responsible for reporting to AHCA any suspected fraud and abuse on the part of a provider or an enrollee.

- C. Responsibility of the member (person with developmental disabilities)**
- 1. Maintain Medicaid eligibility requirements**
 - 2. Select the health plan when requested**
 - 3. Select a primary care provider (PCP) when requested**
 - 4. Coordinate all necessary covered medical services through the PCP**
 - 5. Notify the health care coordinator of all changes in demographic situations**
 - 6. Keep scheduled appointments**
 - 7. Provide necessary medical information to the PCP**
 - 8. Keep the PCP notified about health insurance coverage**
 - 9. Follow appropriate procedures for notifying parties of complaints and grievances**
 - 10. Notify the PCP of changes in health care status**

Section IV: Eligibility and Enrollment Services

A. Eligibility

1. Eligible Populations

Persons eligible for enrollment in the Plan must have been found eligible for the Developmental Disabilities HCBS Waiver and are either enrolled in a DD Waiver or on a waiting list for one of these Waivers in Florida.

2. Clinical Requirements

To be eligible for a Plan, the person must have a condition identified in Chapter 393 of the Florida Statutes as a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely. Note that the term mental retardation is still used in the statute. For the purpose of these specifications, the term intellectual disability will be used instead of mental retardation.

3. Eligibility Determination

All persons currently on a HCBS Waiver or on the waitlist for one of these waivers and who have a confirmed developmental disability as determined by APD are eligible. If a person is identified by another Plan as likely having a developmental disability and if the person grants permission, the person will be referred to APD for eligibility determination and placed on the waiting list. APD will have 30 days to determine eligibility and notify AHCA of the request for enrollment.

B. Choice Counseling

Persons with identified developmental disabilities will be provided the choice of a SHPDD, a general Health Maintenance Organization (HMO) or a Provider Services Network (PSN). At the initiation of managed care in a specific area, everyone with an

identified developmental disability as determined by APD will be offered enrollment in a SHPDD. Choice counseling will be provided in a manner appropriate for this population and will include information on the qualifications of the PCP in the Plan, the range of services, the number of providers with expertise in serving persons with developmental disabilities, and any enhancements addressing the special needs of persons with developmental disabilities.

Annually, based upon the date set by AHCA, members are given the opportunity to change health plans and may choose to either join or exit a SHPDD. If a person is identified as possibly having a developmental disability, determined eligible for a HCBS Waiver, and chooses to be placed on the waiting list, the person may disenroll from a general HMO or PSN and join the SHPDD at any time.

C. Enrollment

AHCA is responsible for enrolling members. AHCA must confirm that the person has a developmental disability as determined by APD.

D. Disenrollment

1. General Provisions

AHCA is responsible for disenrollment of members if requested under allowable provisions by the Plan or by the member. The original plan must provide services until disenrollment is completed and the person is served in the new plan.

2. Involuntary Disenrollment

The following conditions are not cause for disenrollment for the Plan: an adverse change in an enrollee's health status, utilization rate of medical services, uncooperative or disruptive behavior, need for special accommodations to access services, failure to keep scheduled appointments, failure to adhere to the recommended treatment, the need for out-of-plan or out-of-area services, or interaction problems with the member, family, guardians, or other care givers.

With proper written documentation, the following are reasons for which the Plan shall submit Involuntary Disenrollment requests to the Agency or its Choice Counselor/Enrollment Broker, as specified by the Agency:

- enrollee has moved out of the State of Florida,
- enrollee death,
- determination that the Enrollee is ineligible for Enrollment based on the criteria specified in SHPDD in Section I.V. Eligibility and Enrollment Services, and
- fraudulent use of the Enrollee ID card.

3. Disenrollment

A person may request disenrollment from a Plan within 90 days of enrollment or annually thereafter. If the person develops a health condition that makes them eligible for another specialty health plan they may request disenrollment at any time.

Section V: Enrollee Services, Community Outreach and Marketing

A. Enrollee Services

The SHPDD is responsible for providing enrollee services to facilitate and guide enrollees in accessing health care services and information about the Plan. The responsibilities are as follows:

1. Orientation and education of new enrollees

The Plan will contact the enrollee within 15 business days of enrollment and provide them with information about the plan and offer assistance in contacting choice counselors to select a primary care provider.

2. Member Handbook and Member Communications

The SHPDD must have staff available by phone for general member information during normal business hours. The phone line must be easy to access without multiple choice selections of different departments. All information prepared by the Plan must receive prior approval from APD and AHCA before distribution. All information should be translated to the primary language of persons who constitute 5% of the population served or 1,000 enrollees, whichever is the least.

The Plan must develop and provide printed information to each member of the Plan, and to their family members and/or caregivers if appropriate. The information must be provided within 10 business days of the person joining the Plan. The handbook must contain at least the following information:

- a general description about how managed care works, particularly with regard to the member's responsibilities, appropriate utilization of services, and the medical home's role in managing services;
- description of all available covered services and an explanation of any service limitations or exclusions from coverage. The description should include an explanation of the Plan's approval and denial process for services that require prior authorization;
- procedures for obtaining required services, including second opinions and authorization requirements;
- description of out-of-network use, information regarding the enrollee's rights and responsibilities, including the extent to which and how enrollees may obtain services from out-of-network providers;
- information on how to work successfully with their medical home, including the roles and responsibilities of the medical home;
- information on how to file a complaint with the Plan. This must include the member's right to file a complaint with the Plan and the member's right to contact AHCA or APD if issues are not resolved to the member's satisfaction;
- procedures to follow in case of an emergency and instructions for receiving ongoing advice on getting care in case of an emergency;
- description of emergency services and procedures for obtaining services both in and out of the SHPDD established network, including an explanation that prior authorization is not required for emergency or post-stabilization services, the

- locations of emergency settings and other locations at which providers and hospitals furnish emergency services, and post-stabilization requirements;
- a description of health care coordination and the Plan's responsibility to coordinate services with the HCBS Waiver providers and support coordinators;
 - description of all covered behavioral health services and how to access these services. The description should clarify the difference between behavioral health services by the Plan for mental health care and behavioral health services provided through the HCBS Waiver;
 - an explanation of how the out-of-plan services operate;
 - information on filing a grievance and/or a request for a hearing;
 - contributions the member can make towards his/her own health, member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Plan;
 - advance directives information, including what is an advance directive, how to prepare an advance directive, and the need to ensure informed consent in the preparation of the advance directive;
 - use of other sources of insurance; and
 - a description of fraud and abuse, including instructions on how to report suspected fraud or abuse.

3. Newsletter

The Plan must develop and distribute, at a minimum, two member newsletters during the contract year. The following types of information are to be contained in the newsletter at least annually:

- educational information on chronic illnesses and ways to self-manage health care issues;
- reminders of flu shots and other prevention measures at appropriate times;
- insurance issues, such as Medicaid and Medicare issues; and
- cultural competency issues.

4. Operate a Toll-Free Help Line

The Plan shall operate a toll-free help line to provide information to the enrollees as needed, including information on the enrollee status, resolving complaints, and filing grievances

5. Community Outreach

The community outreach representatives may provide community outreach materials at health fairs and public events as noticed by the Plan to the Agency. The Plan must send the Agency a description of their community outreach program on an annual basis. The Plan may provide written material to HCBS Waiver services support coordinators regarding the community outreach activities.

Section VI: Covered Services

A. State Plan Mandatory Services

1. ARNP Services

Services rendered by a licensed Advanced Registered Nurse Practitioner (ARNP) must be provided in collaboration with a physician. Reimbursement for anesthesia, obstetrical, and psychiatric services is limited to ARNPs who have completed the educational program in the appropriate specialty and are authorized to provide these services by Chapter 464, F. S., and protocols filed by the Board of Nursing. There is no Florida formal specialty for serving persons with developmental disabilities. ARNPs providing services in the SHPDD shall have experience in treating persons with developmental disabilities or shall receive training in the special needs of persons with developmental disabilities. The training shall be arranged by the SHPDD. ARNPs may provide services to recipients individually under a formal relationship with a licensed physician. The ARNP shall serve on multi-disciplinary teams when requested.

2. Home Health Services

Home Health Services are provided in a recipient's home or other authorized setting to promote, maintain, or restore health, or to minimize the effects of illness and/or disability. Medicaid reimburses for home health services rendered by licensed Medicaid participating home health agencies. However, the SHPDD is authorized to credential individual licensed registered nurses to provide nursing services in the home as well. SHPDD may enroll licensed nurses credentialed by APD to provide nursing services under home health care. Home health services include:

- home visit services provided by a registered nurse or licensed practical nurse;
- home visits provided by a qualified home health aide; and
- medical supplies, appliances, and durable medical equipment.

The home health provider must develop, with the person receiving services, a backup plan for situations when the scheduled provider is not available. This contingency plan must be updated at least every 90 days.

The SHPDD must coordinate the provision of all home health care services closely with the HCBS Waiver services through a multi-disciplinary staffing process. The provision of nursing services must ensure that the person's needs are fully covered. Although not required, the SHPDD is authorized to provide personal care services and private duty nursing services to Plan members when necessary to address gaps in services. If the Plan does provide some private duty nursing services or personal care services, and the person is enrolled in a Developmental Disabilities HCBS Waiver, these services must be complementary to those available through the Waiver

For persons enrolled in a Developmental Disabilities HCBS Waiver, the SHPDD must coordinate services with the provider of HCBS Waiver services when providing nursing services in a residential program. State Plan services covered by the SHPDD must be used before Waiver services up to the limit set by the Medicaid State Plan. The frequency, duration and scope of services must be coordinated with the operator

of the residential program and the developmental disability Waiver nursing provider to ensure the most efficient and effective arrangement of nursing services.

3. Hospital Inpatient

Inpatient services are medically necessary services, ordinarily furnished by a state-licensed acute care hospital, for the medical care and treatment of inpatients. These services are provided under the direction of a physician or dentist in a hospital maintained primarily for the care and treatment of patients with disorders other than mental diseases. Inpatient services include, but are not limited to, rehabilitation hospital care (which are counted as inpatient hospital days), medical supplies, diagnostic and therapeutic services, use of facilities, drugs, room and board, nursing care, and all supplies and equipment necessary to provide adequate care (see the Medicaid Hospital Services Coverage & Limitations Handbook). Inpatient services also include inpatient care for any diagnosis including tuberculosis and renal failure when provided by general acute care hospitals in both emergency and non-emergency conditions. Persons with developmental disabilities may need to have an attendant with them during the hospital stay. If determined medically necessary, the SHPDD is responsible for providing attendant services during the hospital stay. Medical necessity will be determined based upon the individual's ability to manage the hospital stay independently or the availability of a natural support person to be available during the stay. The Plan must ensure that there is an established process to determine the ability to give informed consent and, if the individual with developmental disabilities is not able to give consent, there must be a person given that responsibility. This person must have the authority to make decisions for the individual with developmental disabilities if he/she is determined not to be able to make health care decisions.

4. Hospital Outpatient

Outpatient hospital services consist of medically necessary preventive, diagnostic, therapeutic or palliative care under the direction of a physician or dentist at a licensed acute care hospital. Outpatient hospital services include medically necessary emergency room services, dressings, splints, oxygen, and physician-ordered services and supplies for the clinical treatment of a specific diagnosis or treatment.

5. Laboratory Services

Independent laboratory services are clinical laboratory procedures performed in free-standing laboratory facilities. A physician or other licensed health care practitioner authorized within the scope of practice to order clinical laboratory tests must authorize the services. The Plan must not restrict the use of laboratory services as follows:

- to test for developmental disabilities if the results of the test will provide essential information to help the physician determine appropriate treatment, and
- to test for and monitor the medications prescribed by the medical home physicians.

The Plan must ensure that laboratory services are easily accessible to persons with developmental disabilities. Strategies to accomplish this include the location of pharmacies in proximity to HCBS Waiver service sites and near public health transportation services.

The Plan must ensure that the laboratories have been trained in providing services to persons with developmental disabilities, schedule appointments to allow for the additional time it may take to acquire the blood samples, and be prepared to work with family members or other caregivers to assist the person in receiving appropriate medical care. The local APD offices and local waiver providers may be able to assist the Plan in the determination of efficient and cost-effective ways to provide laboratory services.

6. Physician Services

Covered services include services rendered by licensed, Medicaid-participating doctors of allopathic or osteopathic medicine. Services may be rendered in the physician's office, the patient's home, a hospital, or other approved place of service as necessary to treat a particular injury, illness, or disease.

7. Transportation

Transportation services include the arrangement and provision of an appropriate mode of transportation so enrollees can receive services covered by the Plan. If necessary, the Plan is required to provide for an attendant to assist with the transportation.

Transportation time should not exceed a typical amount of time to travel to the appointment and back. Persons with disabilities must not be in the transport vehicle for an extended period of time. The SHPDD must offer transportation to enrollees in order to assist them to keep, and travel to, medical appointments. The transportation must be accessible to persons with physical disabilities and must accommodate the special needs of the individual regarding the amount of time in the transport vehicle, level of supervision provided, and other medical or behavioral considerations.

Specifically, for non-emergency transportation, transportation services shall provide transportation as follows when a request for transportation is received 48 hours in advance of the requested date of transport:

- the enrollee arrives in time for the appointment but no sooner than one hour before the appointment, and
- the enrollee does not have to wait more than one hour after calling for transportation, after the conclusion of the appointment, to be picked up.

If a person is discharged from emergency placement, transportation providers shall respond within an hour of the request and transport enrollee within three hours of the notification.

The plan must develop and implement a quarterly performance auditing protocol to determine compliance with the standards above for all sub-contracted transportation vendor/brokers and require corrective action if standards are not met.

The plan's transportation system shall be able to accommodate the special needs of the plan members when identified. These may include, but are not limited to, the need for a family member or responsible person to assist the member during the appointment, medication(s) which prohibit prolonged exposure to heat during the summer months, or some member's inability to utilize public transportation systems.

B. Covered State Plan Optional Services

1. Adult Dental Services

Dental services are those services and procedures rendered by a State of Florida licensed dentist in an office, clinic, hospital, ambulatory surgical center, or elsewhere when dictated by the need for diagnostic, preventive, therapeutic, or palliative care, or for the treatment of a particular injury as specified in the current Medicaid Dental Services Coverage and Limitations Handbook. SHPDD dental services include diagnostic services, preventive treatment, restorative treatment, endodontic treatment, periodontal treatment, surgical procedures and/or extractions, orthodontic treatment, and complete and partial dentures, as well as complete and partial denture relines and repairs. Also included are adjunctive general services, injectable medications, and oral and maxillofacial surgery services. Specific requirements are as follows:

- The SHPDD shall follow the generally accepted dental standards of the American Dental Association. The current Medicaid Dental Services Coverage and Limitations Handbook shall take precedence in the event of a conflict.
- The SHPDD will urge members to see their primary dental provider at least once every six (6) months, or more frequently if medically indicated, for regular check-ups, preventive pediatric dental care, and any services necessary to meet the member's diagnostic, preventive, restorative, surgical, and emergency dental needs.
- The SHPDD shall exclude the provision of experimental and clinically unproven procedures.
- The SHPDD shall adopt annual dental screening and participation goals to achieve at least an eighty percent (80%) screening and participation rates for dental services.
- The SHPDD shall provide for emergency dental services and care. Prior authorization will not be required for emergency services. When an enrollee presents at a hospital seeking emergency services and care, the determination that an emergency dental condition exists shall be made, for the purposes of treatment, by a physician or dentist of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital dentist. The SHPDD shall cover post-stabilization care services without authorization, regardless of whether the enrollee obtains a service within or outside the Plan's network. The SHPDD shall cover all screenings, evaluations, and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the enrollee's condition is an emergency dental condition.
- Oral and maxillofacial surgery services are medically necessary dental treatment of any disease or injury to the maxillary or mandibular areas of the head or any structure contiguous to those areas, and the reduction of any fracture in those

areas. These are services furnished by a dentist that would be considered physician services if a physician had furnished those services. The more complex of these procedures are usually provided in an inpatient or outpatient hospital or ambulatory surgical center setting, although not exclusively. Oral and maxillofacial surgery is provided for an enrollee through procedure codes listed in Appendix B of the current Medicaid Dental Services Coverage and Limitations Handbook.

- Orthodontic services are limited to a person whose malocclusion creates a disability and impairs his or her physical functioning. The SHPDD is not obligated to provide orthodontic services that are primarily for cosmetic purposes.
- The SHPDD shall provide timely approval or denial of authorization of out-of-network dental services use through the assignment of a prior authorization number, which refers to and documents the approval. The SHPDD must approve out-of-network provider services when the services are medically necessary and no provider within the network has the experience and credentials to provide the service. The out-of-network provider is responsible for seeking prior authorization. The Plan is not liable for services provided out-of-network without a prior authorization.

2. Ambulatory Surgical Centers

Ambulatory surgical centers provide scheduled, elective, medically necessary surgical care to patients who do not require hospitalization. Services include diagnostic or therapeutic services or items directly related to providing surgical procedures.

3. Behavioral Health Services

Behavioral health services include mental health and substance abuse services and are provided for the maximum reduction of the recipient's mental health or substance abuse disorder and restoration to the best possible functional level. Services are expected to improve the member's condition, prevent further regression, or/and provide recovery services so that the individual will not require additional services. Services include assessments; treatment planning; medical and psychiatric services; individual, group and family therapies; community support; and rehabilitative services. For persons with developmental disabilities that can benefit from verbal based therapy, services must be provided in a manner appropriate for a person with developmental disabilities. Therapeutic techniques must be adapted for persons with intellectual disabilities. Behavioral health services must be provided if appropriate before Waiver mental health services are considered. In many cases, behavioral management services provided through the HCBS Waiver should be integrated with State Plan behavioral health services covered under the Plan.

4. Chiropractic Services

Chiropractic services include manual manipulation of the spine, spinal x-rays, and related services. Any provider rendering this service must be familiar with serving persons with developmental disabilities.

5. Dialysis Center Services

Freestanding dialysis center services include in-center hemodialysis, in-center administration of the injectable medication Erythropoietin, other Agency-approved drugs, and home peritoneal dialysis. These services must be provided under the supervision of a physician licensed to practice allopathic or osteopathic medicine in Florida. The dialysis routine treatment includes laboratory tests, dialysis-related supplies, and ancillary items. Dialysis Centers must be prepared to adapt their practices to the needs of patients with developmental disabilities.

6. Durable Medical Equipment and Medical Supplies

Durable Medical Equipment (DME) is equipment that can be used repeatedly, serves a medical purpose, and is appropriate for use in the patient's home. Medical supplies are medical or surgical items that are consumable, expendable, disposable or non-durable, and are appropriate for use in the patient's home. Medicaid reimburses for DME and medical supplies provided by Medicaid participating providers. DME may be rented or purchased. Examples of reimbursable equipment and supplies include, but are not limited to:

- Ambulatory assistive equipment
- Augmentative and assistive communication devices
- Blood glucose meters and strips
- Commodes
- Diabetic supplies
- Enteral nutritional supplements
- Heparin lock flush syringes
- Hospital type beds and accessories
- Insulin syringes
- Orthotics and prosthetics
- Ostomy and urological supplies
- Oxygen and oxygen-related equipment
- Peak flow meters
- Spacers
- Suction pumps
- Urine ketone test strips
- Wheelchairs and customized wheelchairs

Medical necessity for DME or supplies must be documented by a prescription, a statement of medical necessity, a plan of care or hospital discharge plan. Persons with developmental disabilities have a higher than typical need for DME. The guidelines for the quality, frequency, and other related issues must address the unique needs of this population.

The Plan is responsible for developing and implementing policies and/or protocols that ensure enrolled individuals have information available about the process for obtaining DME, including the plan's identified timelines for each step. The policy and/or protocol must include who to contact with questions, and which companies are

contracted through the plan. The plan must provide the enrolled individuals with a DME guide to help enrolled individuals understand the DME process.

7. Health Care Coordination

Health care coordination provides for continuity and coordination of care across the health care spectrum and through a multi-disciplinary team approach. The service is provided by licensed clinical practitioners. A health care coordinator will be assigned to each plan member upon enrollment. The health care coordinator is responsible for working with the member and their family/caregiver if appropriate, to integrate all elements of the adult services and supports with the member's special health care needs. This work is done in coordination with the PCP as part of a medical home. The care coordinator is the critical link in obtaining the appropriate clinical care and services, integrating behavioral health services and coordination of services with HCBS Waiver services.

8. Medication management services

Services include prescriptions, medication monitoring visits, laboratory and other diagnostic tests necessary for diagnosis and treatment of medical and behavioral disorders. For persons taking medications for behavioral health disorders, the provider must use clinical guidelines for medications that take into consideration the possible different reactions to medication by persons with developmental disabilities. The same physician must review all medications taken by the enrollee to ensure that there are no contraindications in taking these medications. Also, the physician will monitor the use of multiple medications. The SHPDD must use recognized tools/evidence-based guidelines. The Plan must develop a monitoring process to ensure that the PCP use appropriate tools/guidelines when prescribing medications for behavioral disorders. If the member receives behavioral health services and takes psychotropic medication, the medication management must include coordination of medication management with the behavioral health care services.

The Plan must establish a drug utilization committee to review and recommend the drug formulary and the use of prior authorization for certain medications. The committee must be knowledgeable about the use of medications with persons with developmental disabilities and ensure that the drug formulary and educational/training materials recognize the special health care needs of persons with developmental disabilities.

9. Physician Assistant Services

Covered services include medical services provided by a licensed physician assistant. The services must be in collaboration with a practitioner licensed pursuant to Chapter 458 or 459, F.S. Physician Assistant services must be provided within an approved medical home.

10. Podiatry Services

Covered services include podiatry care rendered by licensed podiatrists, as defined in Chapter 461, F. S., who are participating in Medicaid. Services can be provided in the same sites as the physician's services listed above. Routine foot care is provided

if the recipient is under a physician's care for a metabolic disease, has conditions of circulatory impairment or has conditions of desensitization of legs or feet.

11. Portable X-Ray services

These covered services are interpretive and technical mobile X-ray services that are provided in the recipient's residence. A physician or other licensed health care practitioner may authorize these services within their scope of practice. The equipment, transportation costs, and the presence of staff in the home are also allowable costs. The practitioner providing the X-ray in the home must be trained in working with persons with developmental disabilities or must arrange for a person to be available to explain the procedure to the individual and assist in obtaining the X-ray.

12. Prescribed Drugs

Licensed pharmacies that are approved by the Plan to provide medication may provide these medications in accordance with the Preferred Drug List or formulary that is adopted by the SHPDD. Most drugs that are on the Preferred Drug List should be available without prior authorization. At the discretion of the SHPDD, some medications may require prior authorizations. Because many medications, especially psychotropic medications, may have a different effect on persons with developmental disabilities, the SHPDD must have developed a clinical protocol system that alerts the pharmacy when medications may be inappropriate for the individual, in too high of a dose or in combination with other medications that could present problems with persons with developmental disabilities. In these cases, the pharmacy should be required to seek prior authorization from the Plan and alert the Plan of the reason why the prior authorization is being requested.

The Plan cannot restrict the use of medications if the prescription is prescribed by the physician from the person's approved medical home and is for the treatment of the developmental disability or for any complications due to the developmental disability.

The Plan, in cooperation with APD and the Waiver providers, is responsible to monitor and track the pharmaceutical usage for the Plan to conduct ongoing quality improvement reviews on the patterns of pharmaceutical use. The pattern of usage must be shared with APD on a quarterly basis in a form that APD can use to compare pharmaceutical usage with HCBS Waiver service patterns, such as behavioral health services, medical residential programs, personal care services, nursing services and others.

The Plan must have a process to evaluate requests to add products not on the drug formulary to the formulary if related to the treatment of persons with developmental disabilities.

13. Registered Nursing First Assistant Services

The Plan is required to provide for registered nurse first assistant services for surgical assistants and services that are rendered in accordance with Chapter 464, F. S.

14. Therapy Services

Therapies are not provided currently for adults in the State Plan. Due to their medical nature, these services shall be included in the SHPDD.

These services are provided in the home, clinic or other appropriate settings and include the following:

- **Occupational Therapy Services**
These services include evaluation and treatment to prevent, maintain, or correct physical and emotional deficits, or to minimize the disabling effect of these deficits. Typical activities are perceptual motor activity exercises to enhance functional performance and other techniques related to improving or maintaining motor development.
- **Physical Therapy Services**
These services include evaluation and treatment related to range-of-motion, muscle strength, functional abilities, and the use of adaptive or therapeutic equipment. Activities include rehabilitation and maintaining functioning through exercises, massage, and use of equipment through therapeutic activities.
- **Speech-Language Pathology Services**
These services involve the evaluation and treatment of speech-language disorders. Services may be provided individually or in groups.

Therapy services must be provided by a practitioner licensed in the appropriate field and who has experience or special training in working with persons with developmental disabilities. The SHPDD must establish its credentialing requirements to ensure that all therapists working for the Plan have an adequate amount of training and/or experience working with this population prior to providing services. In locations where access to licensed therapists is limited and the available licensed therapists do not have the required experience, the licensed therapist can work directly under the supervision of a licensed therapist with the appropriate experience and training. Medical necessity criteria for this population must clearly indicate that therapy should be continued when maintaining the therapeutic goal. The therapists shall work through a multi-disciplinary team when requested to do so by the health care coordinator.

Intervention plans must include education and involvement of family members and primary caregivers. The purpose of this education is not to transition family members or primary caregivers into the role of primary therapists. Rather, the purpose is to provide continuity of appropriate techniques observed during the therapy session. Family members and/or primary caregivers must also be made aware of activities that may be inappropriate because of the special need(s) of the individual. The education element is necessary to ensure ongoing improved health and wellbeing derived from the direct therapist-provided intervention services.

15. Vision and Hearing Services

Covered services must be provided by an ophthalmologist, optometrist, or optician. Diagnostic evaluation and intervention for hearing disorders may include use of behavioral and objective tests of auditory function, hearing aids and accessories,

cochlear implants, and osseointegrated stimulator devices. Services include eyeglasses, eyeglass repair, prosthetic eyes, and medically necessary contact lenses. The time frames for new lenses must be adjusted if the need for the lenses is directly related to the person's disability or other medical condition. Services must be rendered in accordance with the clinical guidelines developed by the SPHDD by a licensed audiologist or a board certified otolaryngologist or otologist.

Section VII: Service Provision Requirements

A. Emergency Services

The SHPDD shall advise all enrollees of the provisions governing emergency services and care. The Plan shall not deny claims for emergency services and care received at a hospital due to lack of guardian's consent. In addition, the Plan shall not deny payment for treatment obtained when a representative of the Plan instructs the enrollee to seek emergency services and care in accordance with s. 743.064, F.S. The Plan shall require out-of-network providers to coordinate with respect to payment and must ensure that cost to the enrollee is not greater than it would be if the covered services were furnished within the network.

The Plan shall cover post-stabilization care services without authorization, regardless of whether the enrollee obtains a service within or outside the Plan's network, for the following situations:

- post-stabilization care services that were pre-approved by the Plan,
- post-stabilization care services that were not pre-approved by the Plan because the Plan did not respond to the treating provider's request for pre-approval within one hour after the treating provider sent the request, or
- the treating provider could not contact the Plan for pre-approval.

B. The SHPDD shall not:

- require prior authorization for an enrollee to receive pre-hospital transport or treatment for emergency services and care;
- specify or imply that emergency services and care are covered by the Plan only if secured within a certain period of time;
- use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered; or
- deny payment based on a failure by the enrollee or the hospital to notify the Plan before, or within a certain period of time after, emergency services and care were given.

C. The SHPDD shall:

- Provide pre-hospital and hospital based trauma services and emergency services and care to enrollees.
- When an enrollee presents at a hospital seeking emergency services and care, a determination that an emergency medical condition exists shall be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital physician.

- Provide a contact number for medical assistance in treating the emergency for the person seeking care at the hospital.
- Cover all screenings, evaluations, and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the enrollee's condition is an emergency medical condition.
- Ensure that enrollees with developmental disabilities receive at minimum the same level of medical services as the general population and that enrollees' symptoms are not attributed to their developmental disability in lieu of a full medical evaluation. If the provider determines that an emergency medical condition does not exist, the Plan is not required to cover services rendered subsequent to the provider's determination unless authorized by the Plan.
- When the enrollee presents at the hospital for emergency services and the enrollee notifies the hospital or the hospital emergency personnel otherwise have knowledge that the patient is an enrollee of the SHPDD, the hospital must make a reasonable attempt to notify:
 - the enrollee's PCP, if known; and
 - the Plan's emergency contact who must be available 24 hours a day, 7 days a week to assist the hospital in managing the emergency. The emergency contact must be a licensed registered nurse, PA or physician and be knowledgeable about developmental disabilities. The contact can provide the hospital with assistance via telephone or other electronic resources. The Plan will ensure that the treating physician is contacted by the PCP or the physician on call for the practice to ensure that the treating physician is provided the necessary information regarding the enrollee's special needs. The hospital physician and the PCP must discuss the appropriate care and treatment of the enrollee, and the hospital must participate in the treatment of the enrollee within the scope of the physician's hospital staff privileges.
- Cover any medically necessary duration of stay in a non-contracted facility which results from a medical emergency until such time as the Plan can safely transport the enrollee to a participating facility. The Plan may transfer the enrollee, in accordance with state and federal law, to a participating hospital that has the service capability to treat the enrollee's emergency medical condition and provide the necessary support to address any special needs related to the developmental disability. The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment.
- Notwithstanding any other state law, a hospital may request and collect from an enrollee any insurance or financial information necessary to determine if the patient is an enrollee of the Plan, in accordance with federal law, as long as emergency services and care are not delayed in the process. The hospital must have available information about the possible health plans, including the SHPDD, in the area and be able to research the enrollee's eligibility electronically.

D. Behavioral Health Care Emergency Services

The SHPDD is responsible for providing all behavioral health care emergency services when associated with a diagnosed mental health or substance abuse condition. The emergency services must be managed by a mental health or substance abuse professional in coordination with the medical home. The services can include both mobile crisis services and facility based services. If providing mobile crisis services, the crisis personnel must ensure that the person can be appropriately served on an outpatient basis and does not present a danger to themselves or others in their living environment.

If services are provided in a facility, the Plan must ensure that the services are appropriate for persons with developmental disabilities and do not place them with other populations that may present a danger to them and in a facility with mental health staff not trained to work with persons with a dual diagnosis of developmental disabilities and mental health. If the person has a physical disability, the facility must have the necessary accommodations to safely serve the individual and to address both their physical and mental health needs.

Crisis services must be available 24 hours a day, seven days a week. A telephone number must be published that can be easily accessed by the individual, family members, caregivers, and medical home personnel. Crisis services must be immediately available in every geographical area of the state.

The Plan is encouraged to work with the local law enforcement agencies regarding the response to emergency crisis calls and the immediate coordination of services with a qualified professional who has been trained in providing crisis services for persons with developmental disabilities and behavioral health disorders.

E. Out-of-Network Use of Non-Emergency Services

Out-of-Network services will be provided when the service that someone requires is not available within the network or if the wait time for a PCP to schedule an enrollee's appointment with the Plan's specialty provider is longer than 30 days. All out-of-network services require prior authorization. The Plan shall provide timely approval or denial of authorization for out-of-network services.

F. Family Planning Services

Family Planning Services for persons with developmental disabilities must be individualized based on their specific condition. If conducting examinations, the facility must have appropriate equipment and trained staff to examine individuals with physical and developmental disabilities. Counseling should be offered to the enrollee, and those providing counseling should take into consideration the enrollee's physical condition and the impact that giving birth could have on her physical health and the health of the baby. Also, the counseling must be geared to the functional level of the enrollee and involve, at the enrollee's consent, family members' or other support persons' participation.

G. Hospital Services - Inpatient

1. Inpatient services are medically necessary services, ordinarily furnished by a state-licensed acute care hospital, for the medical care and treatment of inpatients. These

services are provided under the direction of a physician or dentist in a hospital maintained primarily for the care and treatment of patients with disorders other than mental diseases.

2. Inpatient services include, but are not limited to, rehabilitation hospital care (which is counted as inpatient hospital days); medical supplies; diagnostic and therapeutic services; use of facilities, drugs, room and board, nursing care and all supplies; and equipment necessary to provide adequate care (see the Medicaid Hospital Services & Limitations Handbook).
 3. Inpatient services also include inpatient care for any diagnosis including tuberculosis and renal failure when provided by general acute care hospitals in both emergency and non-emergency conditions.
- H.** The Plan shall cover physical, speech, and occupational services when medically necessary and when provided during an enrollee's inpatient stay.
- I.** The SHPDD shall provide up to twenty-eight (28) inpatient hospital days in an inpatient hospital substance abuse treatment program for pregnant substance abusers who meet ISD Criteria with Florida Medicaid modifications, as specified in InterQual Level of Care Acute Criteria-Pediatric and/or InterQual Level of Care Acute Criteria-Adult. Providers should reference McKesson Health Solutions, LLC, - McKesson, the most current edition, for use in screening cases admitted to rehabilitative hospitals and CON-approved rehabilitative units in acute care hospitals. Special considerations must be made to address the needs of the person with developmental disabilities and/or their caregivers' ability to provide post-hospitalization services.
- J.** In addition, the Plan shall provide inpatient hospital treatment for severe withdrawal cases exhibiting medical complications that meet the severity of illness criteria under the alcohol/substance abuse system-specific set, which generally requires treatment in a medical unit where complex medical equipment is available. Withdrawal cases (not meeting the severity of illness criteria under the alcohol/substance abuse criteria) and substance abuse rehabilitation (other than for pregnant women), including court ordered services, are not covered in the inpatient hospital setting.
- K.** The SHPDD shall coordinate with the medical home, hospital, and institution in the discharge planning for substance abuse detoxification to ensure inclusion of appropriate post-discharge care. The planning shall include a multi-disciplinary team approach to determine the supports and services necessary after discharge. Ongoing follow-up must be addressed and substance use disorder treatment must be arranged. Additional supports may be necessary to ensure that the enrollee attends the treatment program.
- L.** The Plan shall adhere to the provisions of the Newborns and Mothers Health Protection Act (NMHPA) of 1996 regarding post-partum coverage for mothers and their newborns. Therefore, the Plan shall provide for no less than a forty-eight (48) hour hospital length of stay following a normal vaginal delivery, and at least a ninety-six (96) hour hospital length of stay following a Cesarean section. In connection with coverage for maternity care, the hospital length of stay is required to be decided by the attending physician in consultation with the mother. This service must cover screening for post-partum depression. The Plan also must work with the mother and family members to determine

the level of additional support and education that the mother may need to appropriately address the needs of the infant. The Plan must work with the family and other community resources to establish the range of necessary services and support to ensure the safety and well-being of the infant and the parents.

- M. The Plan shall cover any medically necessary duration of stay in a non-contracted facility that results from a medical emergency until such time as the Plan can safely transport the enrollee to a Plan-participating facility.
- N. For all pregnant adults, the SHPDD shall be responsible for providing up to three-hundred and sixty-five (365) days of health-related inpatient care, including behavioral health, for each state fiscal year.

O. Transplants

The SHPDD shall provide medically necessary transplants and related services. The presence of a developmental disability must not be included when determining the appropriateness of a transplant.

P. Transition to the SHPDD

Children's Medical Services (CMS) provides health care for financially eligible children with special health care needs including children and youth with developmental disabilities. Children with developmental disabilities may also be enrolled with other health plans. When the youth turns 18 years of age, and if enrolled in a HCBS for persons with developmental disabilities waiver or on the waiting list for such a waiver, the youth will be given the choice of transitioning to the SHPDD or remaining with CMS. If the youth remains with the CMS Network and wishes to eventually transition to SHPDD, the CMS Network will begin to plan with the SHPDD to transfer the youth at age 20. The Plan must begin immediately to plan for the health care transition of the youth to the Plan.

Additionally, persons will be newly enrolling in the SHPDD plan on a regular basis from other health care plans. The transition planning for all individuals must have at least the following elements:

- be family-centered and based on the individual needs of the youth, their family and/or other caregivers;
- maintain the PCP when possible and appropriate;
- coordinate the transition of the medical records and all information associated with the person's health care;
- coordinate care with the transferring and receiving physician so services are not interrupted;
- address the health care needs of the individual in their living, working, or other daily environments;
- ensure that long-term care services can continue to be provided in the most inclusive environment appropriate for the individual;
- address all health care education and skills necessary for the individual to manage their health care to the greatest extent possible; and

- work with the school systems or institutions of higher learning, to ensure that the necessary health care services needed to continue educational and/or vocational pursuits are in place.

The following circumstances require special considerations and detailed transitional planning:

- enrollees receiving home health and nursing services with significant needs, such as supports for feedings, oxygen, wound care, and ventilators;
- plan members receiving ongoing services such as frequent (multiple times a week) nursing services and/or home health care, behavioral health care, dialysis, home health, pharmacy, medical supplies, transportation, chemotherapy, and/or radiation therapy or who are hospitalized at the time of the transition;
- members who have conditions requiring ongoing monitoring or screening for chronic medical conditions;
- members with significant medical conditions, such as a high-risk pregnancy, pregnancy within the last 90 days and diagnosed with post-partum depression, or the need for organ or tissue transplantation;
- members who have experienced crisis situations, either medical or behavioral, within the last year; or
- persons who reside in a specialized residential program for behavioral or medical supports.

Section VIII: Primary Care Provider Requirements - General Requirements for Medical Homes for Persons with Developmental Disabilities

Given the complexity of the necessary medical care for persons with developmental disabilities and the necessary coordination of services across both medical and HCBS Waivers, it is required that primary care services be provided through medical homes. Persons with developmental disabilities need more support to ensure they are getting the medical care and/or medications they need. Participating primary care practices will deliver intensive health care coordination for patients with high needs. By engaging patients, other allied medical providers and/or HCBS Waiver providers, the primary care providers shall create a plan of care that uniquely fits each patient's individual circumstances and values. A multi-disciplinary team approach will be used when the individual has multiple health care needs.

Medical homes are responsible for comprehensive, coordinated, and continuous care. In this family-centered delivery system, the primary care provider partners with the individual with developmental disabilities, family members, and other support persons to coordinate and facilitate care in order to help the individual navigate the complexities of the health care system and coordinate their needs with the HCBS Waiver. Below are the general requirements that the medical homes must address:

A. Medical Home Principles

The medical home should strive to provide services in accordance with the Joint Principles of the Patient-Centered Medical Home which are reproduced below and are retrievable from <http://medicalhomeinfo.org>. The principles are as follows:

1. **Personal physician** – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
2. **Physician directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
3. **Whole person orientation** – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, and end of life care.
4. **Care is coordinated and/or integrated** across all elements of the complex health care system, e.g., sub-specialty care, hospitals, home health agencies, nursing homes, and the patient’s community, e.g., family, public and private community-based services. Care is facilitated by registries, information technology, health information exchange and other means to ensure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
5. **Quality and safety are hallmarks of the medical home:**
 - Medical homes advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care-planning process driven by a compassionate, robust partnership between physicians, patients, and the patient’s family.
 - Evidence-based medicine and clinical decision-support tools guide decision-making.
 - Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement
 - Patients actively participate in decision-making and feedback is sought to ensure patients’ expectations are being met.
 - Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
 - Primary care practices go through a voluntary recognition process by an appropriate, non-governmental entity, to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.
 - Patients and families participate in quality improvement activities at the practice level.
6. **Enhanced access** to care is available through systems, such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
7. **Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should include the work completed by the physician and other staff that falls outside of the traditional face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support the adoption and use of health information technology for quality improvement.
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
- It should recognize the value of physician work associated with remote monitoring of clinical data through the use of technology.
- It should recognize case mix differences in the patient population being treated within the practice and provide compensation accordingly.
- It should allow physicians to share in savings from reduced hospitalizations associated with health care management.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

C. Medical Home Functional Requirements

1. The medical home must operate their offices and provide medical services in a manner that fully involves the individual, the family, and support persons. Communication is often a barrier to medical diagnosis and treatment. The medical home office will have systems in place to address cultural, language or literacy barriers, including materials and teaching methods that address communication barriers and the developmental level of the individual. The medical home, at a minimum, must have the functional capacity to provide for the following:
 - health promotion by working with the individual, family members, and support persons;
 - a PCP for every person enrolled in the plan;
 - methods to address communication and language barriers;
 - person, family and youth-centered care (working with the individual to be able to address as many of his/her medical care needs as possible) that includes:
 - health education and guidance to the individual, youth, family members, and support persons;
 - individualized disease prevention by providing appropriate screenings and health evaluations that are in accordance with the needs of the individual and his or her developmental disability;
 - health maintenance, providing for healthy check-ups and following any medical issues;
 - diagnosis and treatment of acute and chronic illness;
 - coordination of care with the HCBS Waiver or other service delivery mechanisms; and
 - formal integration of primary, specialty, and tertiary care, as well as behavioral and HCBS Waiver services.
 - accessibility 24 hours a day, seven days a week.

- comprehensive care by qualified practitioners trained in providing services to persons with developmental disabilities.
- up-to-date information on individual patients' procedures, tests, medications, etc, that are prescribed through the medical home or other specialty providers.
- evidence-based clinical protocols that specifically address the needs of persons with developmental disabilities.
- electronic health information storage and exchange.
- National Council Quality Assurance (NCQA) certification within two years of operation.

D. Clinical Protocols

The Plan will provide services to its members through medical homes. The Plan must adopt or develop medical guidelines that address the unique needs of persons with developmental disabilities that:

- are based on valid and reliable clinical evidence or a consensus of health care professionals;
- address physical health care, therapy services, medication management, mental health services and dental services; and
- consider the unique health care needs of persons with developmental disabilities including limited abilities in communicating and hearing along with any medical issues known to be related to the person's diagnosed syndrome.

The medical guidelines will be:

- adopted in consultation with the physicians that are members of the network and operate the medical homes;
- updated periodically as appropriate;
- disseminated by the Plan to all contracting health care professionals;
- available to members at their request; and
- used as a basis for making consistent decisions for utilization management, member education, and as a guide for coverage of service.

E. Medical Homes - Health Care Evaluations and Health Plan

The SHPDD, through medical homes, shall provide each enrollee a comprehensive health care evaluation within the first 90 days of enrollment in the Plan. The health care evaluation shall consist of a comprehensive health and developmental history (including assessment of past medical history, developmental history, and behavioral health status); comprehensive unclothed physical examination; nutritional assessment; appropriate immunizations; laboratory testing (including blood lead testing); health education; dental screening; vision screening, including objective testing as required; hearing screening, including objective testing as required; diagnosis and treatment; and referral and follow-up as appropriate. Information regarding the person's functional level and level of supports will be determined. A comprehensive health plan will be developed for each enrollee based on the findings from the comprehensive health care evaluation. Health plans for persons with multiple needs will be completed through a multi-disciplinary team. The type and frequency of health care evaluations and services should be based on

the special needs of the person with developmental disabilities and should occur at least annually.

F. Behavioral Services requirements

1. Behavioral services covered through the State Plan and included in the Plan's covered services should be provided through multi-disciplinary health care teams. The Plan must ensure that either the medical home has qualified behavioral health care professionals on staff (psychiatrist, licensed psychologist, licensed clinical social worker, or psychiatric nurse) or that there is a written agreement with a locally available behavioral health care provider to render the services to persons with developmental disabilities.
2. Practitioners must have special training in providing behavioral health care services to persons with developmental services.
3. When behavioral problems are present, always assess possible physical, environmental, and emotional factors such as pain, stress, grief, etc. when evaluating the behavioral problems and/or prior to considering psychiatric medication.
4. Services must be provided through a multi-disciplinary team that includes the PCP, individual, family members, support persons, and other providers to create a treatment plan and crisis plan to address potential acute behavioral issues. The plan should be updated at least annually.
5. A comprehensive psychiatric formulation must take into consideration the person's level of functioning, their environmental factors, and the person's presentation of the issues. Communication methods should be modified to ensure that the person with the developmental disability is given an opportunity to personally express their emotional status.
6. Working with the individual, family members, and other support staff, the practitioner must identify the specific behaviors that are the focus of treatment.
7. Practitioners must work closely with other providers to ensure that the targeted behaviors are tracked and information is available to the physician to determine the effectiveness of treatment.
8. The Plan must ensure that the person is considered for other mental health services and not just psychotropic medications. Consider cognitive behavioral therapy for decreasing anger and addressing depression.
9. Screenings must be completed for the presence of substance use disorders.
10. When working with persons with limited verbal ability or hearing loss, the practitioner must obtain input from specialists in psychiatry, psychology, or speech-language pathology in the context of a family-centered interdisciplinary team to determine a psychiatric diagnosis.
11. The Plan must require the PCP to screen for early signs of Dementia and Alzheimer's, especially for persons with Down syndrome and educate family members about the early signs of these symptoms/disorders.

12. For patients whose syndrome places them at risk for Dementia or neuropsychological conditions, testing to establish a baseline of cognitive functioning should be done at age 40.

G. Dental Requirements

The dental providers must be prepared to make special accommodations, if necessary, for persons with developmental disabilities as follows:

1. Obtain the necessary medical information from the PCP to properly prepare for the appointment.
2. Allow extra time for the appointment to enable the patient to be comfortable with the dentist and the staff.
3. If the person with developmental disabilities has behavioral challenges, the dental office must make appropriate arrangements to manage the behavioral issues during the appointment.
4. Be prepared to address other challenges such as physical disabilities, seizure disorders, visual impairments, and hearing loss or deafness.
5. Provide instruction to the person with developmental disabilities and their caregiver, if necessary, regarding proper oral hygiene and dental care.
6. Include dentists that are able to serve persons with severe physical disabilities and provide the full array of specialty dental services.

H. Diabetes Supplies and Education

SHPDD shall provide coverage for medically-necessary services related to diabetes, certified by an appropriate physician that includes supplies and services used to treat diabetes, including outpatient self-management training and educational services. The medical home's PCP is responsible for managing these services. Special materials and curriculum must be developed for use with persons with developmental disabilities. These materials must be in a form understandable to the population and address any special dietary concerns or limitations. The materials must also be developed and the education provided, to the maximum extent possible, for the individual to self-manage their conditions.

I. Special Primary Care Issues

1. Whenever possible, the etiologies of the developmental disabilities should be identified. There are numerous co-morbid conditions associated with the various syndromes that impact the overall health of persons with developmental disabilities.
2. The level of adaptive functioning should be documented and understood as it relates to the person's special needs for assistance in participating in their medical care and maintaining good health. Persons may need special assistance during health care visits and in maintaining appropriate health care regimes.

J. Primary Care Provider Incentive Program

The SHPDD must establish a payment incentive plan to provide reimbursement at a higher rate than currently available through Medicaid fee-for-services.

Section IX: Staffing Requirements

The Plan must have in place an adequate number of key staff to carry out the provisions of the contractual requirements. The staff must be located in Florida and be appropriately credentialed to carry out their specific responsibilities. The Plan must have the following key positions as part of the management team:

- A.** Administrator/CEO/COO or their designee must be available during working hours to fulfill the responsibilities of the position and to oversee the entire operation of the Plan including oversight of medical records. The Administrator shall devote sufficient time to the Plan's operations to ensure adherence to program requirements and timely responses to AHCA and APD.
- B.** Medical Director must be a Florida-licensed physician. The Medical Director must be actively involved in all major clinical programs, training and quality management components. The Medical Director must have substantial experience in treating persons with developmental disabilities.
- C.** Chief Financial Officer must have fulltime responsibilities to oversee the budget and accounting systems associated with the Plan and be able to work with AHCA and APD data systems.
- D.** Chief Financial Officer must have full-time responsibilities to oversee all aspects of management of information technology. The officer must have knowledge of information technology and data management.
- E.** Pharmacy Director must be a Florida-licensed consultant pharmacist who oversees and administers the prescription drug and pharmacy benefits. The pharmacist must have knowledge in medication management for persons with developmental disabilities including the use of psychotropic medications for persons with disabilities. This position must have oversight over the medication management program and must be directly involved with the quality management program related to the use of the medications. This position must coordinate that quality management program with both APD and with behavioral services providers.
- F.** Dental Director must be licensed as a dentist in Florida and have substantial experience in providing dental services to persons with developmental disabilities and persons with physical disabilities.
- G.** Quality Management Coordinator must be a Florida licensed ARNP, physician or physician's assistant, or a Certified Professional in Healthcare Quality or have a comparable education and experience in data and outcome measurement. The primary functions of the Quality Management Coordinator are:
 - focus organizational efforts on improving clinical quality performance measures,
 - develop and implement performance improvement projects,
 - utilize data to develop intervention strategies to improve outcomes,
 - report quality improvement and performance outcomes, and

- coordinate the design of quality improvement programs and data collection systems with APD and AHCA to ensure that the quality of services is measured across both health care and HCBS Waiver services.
- H.** Utilization Management Coordinator must be a Florida-licensed ARNP, physician or physician’s assistant (if required to make medical necessity determinations); or have a Master’s degree in health services or health care administration. The Utilization Management Coordinator must have substantial experience in medical systems that provide services to persons with developmental disabilities and must have received training in the special medical needs of persons with developmental disabilities. The primary functions of this position are to:
- ensure adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria;
 - ensure that appropriate concurrent review and discharge planning of inpatient stays is conducted;
 - develop, implement and monitor the provision of the care coordination, disease management and case management function; and
 - monitor, analyze and implement appropriate interventions based on utilization data, including identifying and correcting over- and under-utilization of services.
- I.** Behavioral Health Coordinator must be a Florida licensed clinical social worker, mental health counselor, psychologist, or psychiatrist. The Behavioral Health Coordinator must have experience directly providing behavioral health services, including mental health and substance abuse services, to persons with developmental disabilities. The primary functions of the Behavioral Health Coordinator are:
- develop processes to coordinate behavioral health care with the PCP, behavioral health care services provider covered by the Plan, and when necessary, HCBS Waiver providers;
 - participate in the identification of best practices for behavioral health care for persons with developmental disabilities in primary care practice settings;
 - coordinate behavioral health care with medically necessary services; and
 - provide oversight to service delivery that includes behavioral services provided by, mental health or substance abuse services practitioners, and the use of psychotropic medications.
- J.** Provider Network Coordinator must have experience in providing medical services to persons with developmental disabilities and be knowledgeable about the expertise necessary to provide services for persons with developmental disabilities. The Provider Network Coordinator responsibilities are:
- develop a provider network that has the expertise and capacity to provide the full array of required services to persons with developmental disabilities,
 - coordinate communications between the Plan’s management and the providers,
 - ensure providers are clear on all their responsibilities under the provider agreement,
 - provide assistance to providers in resolving problems,
 - educate providers about providing services to persons with developmental disabilities,

- ensure that the providers understand how to interpret medical necessity criteria for persons with developmental disabilities, and
- work closely with the University Affiliated Medical Resource Center to provide technical assistance and training to network providers.

Section X: Provider Networks

A. Network Development

The Plan must develop and maintain a provider network that has the capacity to provide all services required by the Plan. The provider network also must have the ability to meet the required access standards. There must be sufficient personnel for the provision of all covered services including emergency medical care on a 24-hours-a-day, 7 days-a-week basis. The network must be sufficient to provide covered services and meet the travel time and distance requirements. The network must be designed to reflect the cultural and linguistic characteristics of the population.

The Plan must have a network that is geographically convenient for the members and reflects the special needs and service requirements of persons with developmental disabilities. The provider network must use medical homes as the means to provide primary care services and locate these medical homes in community-based primary practices or university-affiliated sites. Specialty services must also be community-based or affiliated with a university and convenient to the members. If some services cannot be provided locally due to the special needs of the member, the Plan must provide reasonable alternatives for members to access care. These alternatives must be in writing and approved by AHCA. If the network of providers is not able to sufficiently provide services, the Plan must use out-of-network providers until capacity is sufficient. The Plan must ensure that any out-of-network providers used on a non-emergency basis have received information on providing medical services to persons with developmental disabilities.

AHCA and APD must review the Plan's provider network to ensure that it is sufficient to address access requirements, and geographic location requirements. AHCA is also responsible, in conjunction with APD, to review and approve the network's ability to provide medical services to persons with developmental disabilities.

B. Workforce Development

The SPHDD must have a structure in place to work with the medical residency and dental student training programs in Florida to promote and increase the level of training in providing services to persons with developmental disabilities. The Plan is encouraged to contract with graduate health care education programs including physicians, nursing, physician's assistants, therapists, and others to provide services when appropriate and when there is adequate licensed supervision to meet the requirements of the contract. The Plan should work with the graduate education programs to provide for internships or residency placements in sites where the students are exposed to the special health care needs of persons with developmental disabilities.

The Plan will also work with the health care university education programs whenever possible to encourage inclusion and/or expansion of the curriculum to include exposure to the needs of persons with developmental disabilities. This work will be coordinated

through the University Affiliated Medical Resource Center for Persons with Developmental Disabilities.

The Plan must have a training program designed to provide education and support to health care providers rendering services to members of the Plan. The training must address at minimum:

- the unique medical needs of persons with developmental disabilities,
- the role of the family and/or caregivers in the health care of the individual with developmental disabilities,
- the additional preventive screening required by persons with developmental disabilities due to their high risk for several physical conditions,
- the need for additional planning and time to support the person's appropriate involvement in their medical care,
- the need for support and individual education regarding the members participating in their own medical care, and
- the need for specialized equipment and special medical procedures for persons with developmental disabilities.

The training must be provided to all PCP practices within the first month that the PCP is enrolled in the network. The training may be electronically delivered but must receive prior approval from AHCA and APD. The training should be developed through or with the involvement of the University Affiliated Medical Resource Center for Persons with Developmental Disabilities. The Plan must also establish a program for ongoing in-service training and professional seminars on medical services to persons with developmental disabilities.

C. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

The Plan must use FQHCs and RHCs in Florida to provide covered services. AHCA requires the Plan to negotiate rates of payment to FQHCs/RHCs for non-pharmacy services that are comparable to the rate paid to providers that provide similar services. AHCA reserves the right to review a Plan's negotiated rates with the centers for reasonableness and to require adjustments when negotiated rates are found to be substantially less than those being paid to other non-FQHC/RHC providers for comparable services.

D. Network Management

The Plan must have policies and procedures in place to manage the provider network. The requirements for network management must include at least the following:

- Provide a system for ongoing communication with the providers regarding patterns of medical care, new clinical evidence, patterns of services, etc.
- Provide a determination of the degree and quality of coordination of services with other providers including specialty, tertiary, and HCBS Waiver services.
- Monitor the adequacy, accessibility and availability of the provider network to meet the special health care needs of persons with developmental disabilities, including care to persons with limited verbal abilities and/or physical disabilities.

- Monitor the training that providers have received and determine the need for additional training and skill development.
- Evaluate the quality of the services provided to the members in accordance with adherence to the practice guidelines and special prevention programs.
- Provide and manage out-of-network providers if the network is temporarily unable to meet the needs of the members in any geographic area.

E. Credentialing and Re-credentialing

The Plan is responsible for the credentialing and re-credentialing of its provider network. Hospital ancillary providers are not required to be independently credentialed if those providers serve the Plan enrollees only through the hospital. The Plan shall establish and verify credentialing and re-credentialing criteria for all professional providers that, at a minimum, include all the Agency's requirements for participation in the Medicaid program as outlined in the Health Plan Contract Attachment II- Core Contract provisions, May 1, 2011. In addition to the Agency's requirements, the credentialing and re-credentialing shall:

- ensure that all practitioners providing services within the Plan have either the required experience serving persons with developmental disabilities or have received the required training in serving persons with developmental disabilities;
- measure compliance with physical and time standards for access to care;
- review the operation of medical homes including accessing specialty care, provision of health care coordination, and operation of multi-disciplinary teams to provide services to persons with developmental disabilities with multiple needs;
- review the operation of medical homes to determine the degree to which they follow the expectations of medical homes as outlined in the SHPDD contract; and assess the network's and individual practitioner's capacity to provide services to persons with severe disabilities including physical, behavioral, intellectual and/or functional challenges.

F. Operation of University Affiliated Medical Resource Center for Persons with Developmental Disabilities

The Plan must establish at least one University Affiliated Medical Resource Center for Persons with Developmental Disabilities to provide the following:

- develop or locate resource materials to assist individuals with developmental disabilities in managing their medical care;
- be actively involved in work force development planning and implementation.
- locate or arrange educational materials and programs for primary care providers and specialty care providers in providing medical care to persons with developmental disabilities;
- coordinate training programs among the Florida medical schools and other educational entities that train primary care physicians, nurses, therapists and other medical practitioners;
- coordinate with university systems and other academic centers for training of residents and students (medical and allied health);
- provide technical support to local health practitioners; and

- provide outreach to rural areas by arranging consultations with traveling teams.

The Plan has the option of contracting with a University Center of Excellence for Persons with Developmental Disabilities to provide for the University Affiliated Medical Resource Center for Persons with Developmental Disabilities if a Center for Excellence has the necessary medical expertise and abilities to complete the work described above.

G. PCP Standards

The plan shall include in its provider network a sufficient number of PCPs to meet the requirements of this contract. The PCPs must be licensed in Florida as allopathic or osteopathic physicians who generally specialize in family practice, internal medicine, obstetrics, or gynecology; certified nurse practitioners or physician's assistants. The SHPDD shall determine the PCP's ability to meet the Plan's required appointment availability and other standards when determining the appropriate number of its members to assign to a PCP. The Plan shall have a system in place to monitor and ensure that each member is assigned to an individual PCP and that the Plan's data regarding PCP assignments is current. Whenever possible, the network will assign persons with medically complex conditions to physicians with experience in serving persons with medically complex conditions.

PCPs must be willing to provide services within a medical home. The PCP must have provided services to persons with developmental disabilities for at least five years in their practice or must be willing to participate in special training in primary care requirements for persons with developmental disabilities. The Plan is responsible for establishing and rendering this training through the University Affiliated Medical Resource Center for Persons with Developmental Disabilities.

The Plan will hold the PCP responsible for the following activities:

- providing medical services in accordance with the medical home model,
- maintaining collegial working relationships with providers of the HCBS Waiver services,
- organizing multi-disciplinary teams to address the full range of needs of persons with multiple conditions,
- participating in the Individual Support Plan process when the PCP's expertise is required, and
- ensuring that the HCBS Waiver service providers and the support coordinators are familiar with the member/family needs and requirements.

H. Encounter Data Requirements

The Plan must have a system in place to report encounter data to the Agency according to the Agency-imposed schedule. The data must be provided in a manner that will allow analysis of patterns of service provision with the HCBS Waiver services.

I. Medical Records Requirements

The enrollee's medical record is the property of the provider who generates the record. Each member is entitled to one copy of his or her medical record free of charge. The Plan shall have written policies and procedures to maintain the confidentiality of all medical records. The Plan is responsible for ensuring that a medical record is established when

information is received about a member. If receiving services from the HCBS Waiver, the enrollee's Waiver support coordinator may access the member's medical record upon presentation of a release of information signed by the member or legal guardian. When an enrollee changes PCPs, his/her medical records or copies of medical records must be promptly transferred.

The Plan must have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information. The Plan must have incorporated into their quality improvement program written policies for providing training and evaluation of provider compliance with the Plan's medical records standards. Plan providers are encouraged to use electronic health records.

The Plan must be in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA).

J. Specialty Care services

In addition to the above requirements, the Plan shall ensure the availability of providers in the following specialty areas:

- Audiology
- Allergies
- Anesthesiology
- Cardiology
- Chiropractic
- Dental
- Dermatology
- Endocrinology
- Gastroenterology
- General Surgery
- Hematology
- Infectious Diseases
- Nephrology
- Neurology
- Neurosurgery
- Obstetrics/Gynecology (OB/GYN)
- Oncology
- Ophthalmology
- Optometry
- Oral Surgery
- Orthopedics
- Otolaryngology
- Pathology
- Podiatry
- Physiologist
- Psychiatrist
- Pulmonology

- Radiology
- Rheumatology
- Therapy (Physical, Respiratory, Speech and Occupational)
- Urology

K. Utilization Management

The prior authorization and referral management program shall have a process for requests for initial and continuing authorization of services that:

- applies practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals in the field of practice and with an understanding of the special needs of persons with developmental disabilities,
- has mechanisms to ensure consistent application of review criteria for authorization decisions that are based on the practice guidelines, and
- ensures that prior authorization services are appropriately applied and established to ensure access to care and not serve to delay medical care.

The practice guidelines will be reviewed and updated at least every two years to ensure that they still reflect the most up-to-date clinical evidence.

The Plan will have in place, as part of the quality improvement program, a system to review the use of prior authorization and concurrent use of services, consistent and appropriate application of the criteria, and to ensure that understanding the needs of persons with developmental disabilities is considered in the application of prior authorization requirements and concurrent review.

Section XI: Quality Management

The Plan shall provide quality medical care to members and promote improvement in the quality of care provided to enrolled members through an established quality management and performance improvement process. The quality improvement plan shall include, at a minimum, the following:

- a written Quality Assessment and Quality Improvement Plan (QA/QIP),
- an evaluation of the previous year's program,
- quarterly reports that address its strategies for performance improvement, and
- guidelines for conducting quality management activities.

The QA/QIP must include a Peer Review and Quality Management Committee. Both groups must include members of the Plan and family members.

A. Quality Improvement Plan Requirements:

The quality improvement plan must be based on sound design, addressing structure, process, outcomes, and satisfaction of services with the Plan. The quality improvement plan will measure the following system components:

1. Structure

Structure refers to the physical and administrative context in which health care is delivered. The quality improvement plan must measure the elements listed below.

- access to medical care, ensuring that services are available, match the persons' needs, and include access to specialty care;
- multi-disciplinary planning and treatment for persons with multiple needs;
- comprehensive care, including the availability of primary, secondary, and tertiary care for individuals;
- preventive care, health promotion, and wellness activities;
- policies and procedures of the medical homes to ensure that the interactions with persons with developmental disabilities are person/family centered and provide for self-direction; and
- consistent application of prior authorization and concurrent review.

2. Process

Process measures the way that the health care is delivered for the individual receiving services including measurement of the items listed below:

- appointment scheduling is easy and flexible and access is 24 hours a day, 7 days a week;
- medical records are well maintained and information is shared with other parties as necessary;
- care coordination is comprehensive and includes coordination with non-State Plan services (HCBS Waiver services);
- care includes appropriate screenings and laboratory work and is geared to the specific needs of the individual based on their syndrome (if known);
- medication and dosage reviews are conducted regularly and reflect the different reactions to medications that may be seen in persons with developmental disabilities (special attention must be given when psychotropic medications are prescribed); and
- the individual, family members, and caregivers are provided information on possible medication side effects and are given instruction as to how to respond.

3. Outcomes

Outcome measures must be developed to determine the impact or results of the health care. The measures will have the following characteristics:

- must be based on a standardized scale of appropriate health care outcomes for persons with developmental disabilities;
- are designed to measure the management of conditions, such as thyroid disease, seizure disorders, cardiac functions, and other conditions associated with developmental disabilities; and
- measure the overall health status of the individual.

4. Satisfaction of Services

The Plan shall obtain feedback from the individual, family and/or caregivers. If the person is served by the Developmental Disabilities HCBS Waiver, the support coordinator should also be asked to provide feedback. The following areas should be addressed:

- access to services,
- the way that care was provided by the medical home,
- personal assessment of the status of the individual's physical health,
- personal assessment of the individual's mental and emotional functioning,
- level of communication with the primary care and specialty providers, and
- care coordination and involvement in health care decisions.

The Quality Improvement Plan must be coordinated with APD to ensure a comprehensive understanding of the quality of the services. Data must also be shared between the Plan and APD on at least the following issues:

- mental health emergency encounters, including crisis mobile services, short-term facility services, and/or inpatient stays; and
- pharmacy and laboratory utilization.

B. Referral Management Procedures and Standards

The Plan shall have written procedures regarding referrals to specialists that include at least the following:

- The PCP is responsible for coordinating services with specialty providers.
- The Plan must ensure that members with special health care needs that require a specialized course of treatment on a regular basis are allowed direct access to the specialty provider. However, the specialty provider must provide the PCP with regular reports regarding the individual's care.
- There is a process that ensures that the member's PCP receives all specialist and consulting reports and a process to ensure PCP follow-up of all referrals including procedures for behavioral health care services.
- The Plan must allow for a second opinion from a qualified health care professional within the network, or if one is not available in network, arrange for the member to obtain one outside the network, at no cost to the member.
- The PCP must make referrals to, and coordinate services with, all specialty providers.

C. Appointment Standards

The plan must monitor appointment availability as follows:

- Wait Time for Appointment
 - For Primary Care Appointments, the Plan shall provide:
 - Emergency PCP appointments- the same day of request
 - Urgent Care PCP appointments- within 2 days of request
 - Routine care PCP appointments- within 21 days of request
 - For specialty referrals, the Plan shall provide for:
 - Emergency appointments- within 24 hours of referrals
 - Urgent care appointments- within the 3 days of referral
 - Routine care appointments – within 45 days of referral
 - For dental appointments, the Plan shall provide for:
 - Emergency appointments- within 24 hours of request
 - Urgent care appointments- within 3 days of request
 - Routine care appointments- within 45 days of request

- For maternity care, the Plan shall provide initial prenatal care appointments for enrolled pregnant members as follows:
 - First trimester- within 14 days of request
 - Second trimester – within 7 days of request
 - Third trimester – within 3 days of request
 - High risk pregnancies – within 3 days of identification of high risk by the Plan or maternity care provider, or immediately if an emergency exists.
- Wait time in Office
 - The Plan must monitor to ensure that an enrollee’s wait time for a scheduled appointment at the PCP’s or specialist’s office is no more than 45 minutes, except when the provider is unavailable due to an emergency. If the person’s disability prevents them from waiting 45 minutes, the PCP’s office must make special accommodations.
 - The Plan shall establish processes to monitor and reduce the appointment “no show” rate by provider and service type. The Plan shall have written policies and procedures regarding the education of providers regarding appointment time requirements. The Plan must assign a staff member within the quality improvement unit to monitor compliance with standards. The Plan and the PCP must develop a corrective action plan when appointment standards are not met.

Section XII: Grievance System

A. Compliance with Federal and State Laws

Federal law requires that Medicaid managed care plans have internal grievance procedures under which Medicaid enrollees, or providers acting as authorized representatives, may challenge denial of coverage of, or payment for, medical assistance. The Plan’s grievance system must comply with the requirements set forth in s. 641.511, F. S. and with all applicable federal and state laws.

The SHPDD must meet the requirements for the Grievance System as described in the AHCA Health Plan Attachment II core contract. All grievance materials must be prepared in a manner that is understandable for persons with intellectual disabilities. The Plan must have staff available to assist persons with developmental disabilities to file grievances and to have the entire process explained to them or their support persons in a manner that is understandable at the time that they wish to file the Grievance.



Florida
Developmental
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Council, Inc.

Reneé Valletutti, Chair
Debra Dowds, Executive Director

Recommended Standards to Assess Managed Care Plans that serve Individuals with Disabilities

The Florida Developmental Disabilities Council has developed a Specialty Health Care Plan for Persons with Developmental Disabilities (SHPDD). The guidelines contained in this plan are valuable to individuals with all types of disabilities and should be considered for all disability populations who are or would be recipients of managed health care.

Currently, the Agency does not require individuals with developmental disabilities to be enrolled in managed health care plans. If the Agency is mandated to implement managed health care for individuals with developmental disabilities, The Florida Developmental Disabilities requests strong consideration that the SHPDD be utilized for individuals with developmental disabilities who would be recipients of managed health care. If that is not possible, these provisions within the plan should be used as a means to assess the quality and delivery of services provided to individuals with disabilities by other managed health care plans.

These provisions include:

1. The organization operating the plan should be knowledgeable about providing medical services to persons with disabilities.
2. The statewide managed care program should deliver services through a network of medical homes, specialty providers, and an array of other health care practitioners.
3. All practitioners providing services should have experience or receive training in providing services to persons with disabilities.
4. Services should be provided through a multi-disciplinary team approach with the medical home, led by the primary care physician, providing the coordination. Persons with disabilities need more support to ensure they are getting the medical care and/or medications they need. Participating primary care practices will deliver intensive health care coordination for patients with high needs. By engaging patients, other allied medical providers and/or HCBS Waiver providers, the primary care providers should create a plan of care that uniquely fits each patient's individual circumstances and values. A multi-disciplinary team approach will be used when the individual has multiple health care needs.
5. The prior authorization and referral management program should have a process for requests for initial and continuing authorization of services that applies practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals in the field of practice and with an understanding of the special needs of persons with disabilities.
6. The primary care providers should operate within a person- and family-centered medical home model.
7. Whenever possible, the etiologies of the disabilities should be identified. There are numerous co-morbid conditions associated with the various syndromes that impact the overall health of persons with disabilities.



8. The level of adaptive functioning should be documented and understood as it relates to the person's special needs for assistance in participating in their medical care and maintaining good health. Persons may need special assistance during health care visits and in maintaining appropriate health care regimes.
9. The plan should include dental and therapy services, which are not currently in the State Plan for adults.
10. Providers should receive enhanced rates for providing services to persons with disabilities. If providers render services through a prepaid mechanism, then their payment should be risk-adjusted based upon the complexity of the patients that they are seeing.
11. Provider medical necessity guidelines, clinical protocols, and provider requirements should be developed in accordance with the needs of this special population and should be developed to be complementary to current Waivers.
12. Each member should be assigned a health care coordinator who is responsible for providing coordination of all primary, specialty, and tertiary care and coordination with HCBS Waiver services.
13. The plan should have a written coordination of services agreement with APD.
14. The plan should ensure that services are provided by appropriately credentialed providers that have special training to serve persons with disabilities.
15. The plan should have a mechanism in place to ensure consistent application of medical necessity authorization of service in an amount, duration and scope that is appropriate to the needs of persons with disabilities. The determination should be made by a professional who has appropriate clinical expertise in treating the person with disabilities and the service under consideration.
16. Choice counseling should be provided in a manner appropriate for this population and will include information on the qualifications of the PCP in the plan, the range of services, the number of providers with expertise in serving persons with disabilities, and any enhancements addressing the special needs of persons with disabilities.
17. The plan should not be using any of the following conditions as reasons for disenrollment: an adverse change in an enrollee's health status, utilization rate of medical services, uncooperative or disruptive behavior, need for special accommodations to access services, failure to keep scheduled appointments, failure to adhere to the recommended treatment, the need for out-of-plan or out-of-area services, or interaction problems with the member, family, guardians, or other care givers.
18. For persons enrolled in a Developmental Disabilities HCBS Waiver, the plan must coordinate services with the provider of HCBS Waiver services when providing nursing services in a residential program and in the provision of all home health care services.
19. When the recipient is receiving inpatient hospital services, the plan must ensure that there is an established process to determine the ability to give informed consent and, if the individual with disabilities is not able to give consent, there must be a person given that responsibility. This person must have the authority to make decisions for the individual with disabilities if he/she is determined not to be able to make health care decisions.
20. The plan should provide an appropriate mode of transportation so enrollees can receive services covered by the plan. If necessary, the plan should provide for an attendant to assist with the transportation. Transportation time should not exceed a typical amount of time to travel to the



appointment and back. Persons with disabilities must not be in the transport vehicle for an extended period of time.

21. For persons taking medications for behavioral health disorders, the provider should use clinical guidelines for medications that take into consideration the possible different reactions to medication by persons with disabilities. The same physician should review all medications taken by the enrollee to ensure that there are no contraindications in taking these medications.
22. Because many medications, especially psychotropic medications, may have a different effect on persons with disabilities, the plan should have developed a clinical protocol system that alerts the pharmacy when medications may be inappropriate for the individual, in too high of a dose or in combination with other medications that could present problems with persons with disabilities.
23. Occupational, Physical, and Speech Therapy services should be included in the plan even though not currently provided by the Medicaid State Plan. Therapy intervention plans must include education and involvement of family members and primary caregivers.
24. The plan should not deny claims for emergency services and care received at a hospital due to lack of guardian's consent.
25. The plan should be responsible for providing all behavioral health care emergency services when associated with a diagnosed mental health or substance abuse condition.
26. Family Planning Services for persons with disabilities must be individualized based on their specific condition. If conducting examinations, the facility should have appropriate equipment and trained staff to examine individuals with physical and intellectual disabilities. Counseling should be offered to the enrollee, and those providing counseling should take into consideration the enrollee's physical condition and the impact that giving birth could have on her physical health and the health of the baby. Also, the counseling must be geared to the functional level of the enrollee and involve, at the enrollee's consent, family members' or other support persons' participation.
27. When an eligible individual turns 18 years of age, and if enrolled in a HCBS for persons with developmental disabilities waiver or on the waiting list for such a waiver, the youth should be given the choice of transitioning to the plan or remaining with CMS. If the youth remains with the CMS Network and wishes to eventually transition to the plan, the CMS Network should begin to plan to transfer the youth at age 20. The plan should begin immediately to plan for the health care transition of the youth to the plan.
28. Behavioral services covered through the State Plan and included in the plan's covered services should be provided through multi-disciplinary health care teams. The plan should ensure that either the medical home has qualified behavioral health care professionals on staff (psychiatrist, licensed psychologist, licensed clinical social worker, or psychiatric nurse) or that there is a written agreement with a locally available behavioral health care provider to render the services to persons with disabilities. Practitioners should have special training in providing behavioral health care services to persons with disabilities.
29. The plan should have a network that is geographically convenient for the members and reflects the special needs and service requirements of persons with disabilities. The provider network should use medical homes as the means to provide primary care services and locate these medical homes in community-based primary practices or university-affiliated sites. Specialty services should also be community-based or affiliated with a university and convenient to the



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members. If some services cannot be provided locally due to the special needs of the member, the plan should provide reasonable alternatives for members to access care. These alternatives should be in writing and approved by AHCA.