1915(i) State plan Home and Community-Based Services

Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for delinquent youth with serious emotional disturbances and their families as set forth below.

1. Services. *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Redirection services:

- Redirection Therapy services
  - Individual therapy
  - Family therapy
  - Group therapy
- Redirection Therapeutic Support services
- Redirection 24 Hour Crisis Therapeutic Support services
- Redirection services Case Coordination

2. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

○	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	○	The Medical Assistance Unit *(name of unit)*:	
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit *(name of division/unit)* *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*	
⊙	The State plan HCBS benefit is operated by *(name of agency)*		
	The Department of Juvenile Justice		
	A separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

3. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the State assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not

substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☑	☐	☐
2 State plan HCBS enrollment managed against approved limits, if any	☑	☑	☐	☐
3 Eligibility evaluation	☑	☑	☐	☐
4 Review of participant service plans	☑	☑	☐	☐
5 Prior authorization of State plan HCBS	☑	☑	☐	☐
6 Utilization management	☑	☑	☐	☐
7 Qualified provider enrollment	☑	☑	☐	☐
8 Execution of Medicaid provider agreement	☑	☐	☐	☐
9 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
11 Quality assurance and quality improvement activities	☑	☑	☐	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

1. Department of Juvenile Justice (DJJ).
2. Department of Juvenile Justice (DJJ).
3. Department of Juvenile Justice (DJJ).
4. Department of Juvenile Justice (DJJ).
5. Department of Juvenile Justice (DJJ).
6. Department of Juvenile Justice (DJJ).
7. Department of Juvenile Justice (DJJ).
11. Department of Juvenile Justice (DJJ).

(By checking the following boxes the State assures that):

4. ☑ **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual

- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

Assessments for Redirection services will be conducted by certified Redirection service providers. These are the only providers in the state that are qualified to conduct these assessments.

The Department of Juvenile Justice will screen recipients using the Positive Achievement Change Tool Assessment (PACT) to determine if they meet target criteria. The PACT is an assessment tool that is utilized in conjunction with a case management process that addresses both criminogenic needs and protective factors from the moment a recipient enters the Florida juvenile justice system until he or she exits. A recipient's Juvenile Probation Officer (JPO) will follow the recipient through the assessment process and will be one of the members of the recipient's multidisciplinary team (MDT).

The evaluations and reevaluations for eligibility will be performed by the Department of Juvenile Justice.

Assessments to determine the service needs of recipients will be performed by the certified Redirection services provider that will make treatment recommendations.

Person-centered recipient treatment plans will be developed and approved by a multidisciplinary team (MDT). The MDT should include the recipient, the recipient's parents, caregivers, or guardians, the recipient's Redirection services therapist, the Redirection services staff supervisor, a representative from the Department of Juvenile Justice, as well as representation from any other community supports applicable. Recipient treatment plans must be approved by the Department of Juvenile Justice.

The Department of Juvenile Justice will develop and implement a person-centered Youth Empowerment Success (YES) supervision plan with input from the youth and his or her family. The YES plan identifies supervision needs to help the youth successfully meet the conditions stipulated by the court; the provision of services that address the youth's offending behavior, strengths, protective factors and needs; and the coordination of services to assist the youth in choosing positive alternatives to offending behavior and becoming a productive member of his or her community. The YES plan will incorporate the Redirection services treatment recommendations and serves as a case management tool throughout the course of the youth's supervision and treatment. The YES plan will be monitored at required intervals through a case staffing process and includes the participation of the youth, family and Redirection services provider in the process. The youth driven, family-focused YES plan will be updated as needed, and Redirection services are revised or terminated based on youth's and family's needs and progress.

5. ☑ **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

Fair Hearing Policy	
Process	Roles and Responsibilities
The Medicaid Fair Hearing policy and process is detailed in Rule 65-2.042, Florida Administrative Code. Recipients have the right to a Fair Hearing when action has been taken regarding their Medicaid services or eligibility. Actions related to decisions regarding Medicaid eligibility include determinations that an applicant does or does not meet Medicaid financial, clinical, or technical criteria or failure to act in a timely manner for eligibility determination. If services are decreased or re-authorization is not provided, the entity that initiates the action must send notice to the recipient, the recipient's guardian, the recipient's attorney (if one exists), and the recipient's guardian ad litem (if one exists) at least 10 days prior to the service reduction or termination. If a recipient does not agree with this decision, the recipient or his or her authorized representative may ask for a hearing within 21 days of the date of this notice. If this action is a termination, reduction, or suspension of your services, those services may continue until your hearing is held, but the recipient must request a Fair Hearing within 10 days of the date of this notice in order to receive continued benefits. Recipients may be requested to repay that portion of the benefits that the hearing decision determines to be invalid. Recipients have the right to be represented by an authorized representative, to review his or her file at a reasonable time before and during the hearing, to review all documents and records to be used by the State at the hearing and to receive copies of all such documents. Recipients may request an interpreter. Fair Hearings may be requested verbally or in writing. No specific form is required. To request a Fair Hearing for financial or clinical eligibility determinations, individuals are directed to contact their local Department of Children and Families' office or to send Fair Hearing requests to: DCF, Office of Hearing Appeals 1317 Winewood Boulevard, Building 5, Room 205 Tallahassee, Florida 32399.	Certified Redirection services providers and the Department of Juvenile Justice will be required to inform recipients of Florida Medicaid's Fair Hearing policy. The Department of Juvenile Justice will verify during annual monitorings that recipients are notified of Florida Medicaid's Fair Hearing policy. The Florida Department of Children and Families will process appeals and Fair Hearing requests and will facilitate Fair Hearings on the behalf of recipients.

6. ☑ **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

7. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the

Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	1/1/13	1/1/14	403
Year 2	1/1/14	1/1/15	
Year 3	1/1/15	1/1/16	
Year 4	1/1/16	1/1/17	
Year 5	1/1/17	1/1/18	

2. ☑ **Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

2. Medically Needy. *(Select one):*

⊙	The State does not provide State plan HCBS to the medically needy.	
○	The State provides State plan HCBS to the medically needy *(select one):*	
	○	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
	○	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*select one*):

○	Directly by the Medicaid agency
⊙	By Other (*specify State agency or entity with contract with the State Medicaid agency*):
	The Department of Juvenile Justice.

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The Department of Juvenile Justice's management evaluation/reevaluation team will have a licensed psychiatrist with competence in diagnosis, and treatment of children and adolescents with serious emotional disturbances and behavioral disorders.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The Department of Juvenile Justice (DJJ) will screen recipients using the Positive Achievement Change Tool Assessment (PACT) to determine if they meet both the target criteria and the needs based eligibility criteria. Recipients within the defined target population will be notified by the Department of Juvenile Justice that they may be eligible for services following their initial and follow-up PACT assessments.

Recommendations for Redirection services will require an evaluation for prior authorization by the Department of Juvenile justice and reevaluations for continued service authorization will have to be completed no less that every six months.

4. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The following criteria are to be used for the authorization of Redirection services on behalf of eligible Medicaid recipients:

1) All admissions are voluntary.
2) The child or adolescent has age appropriate cognitive ability to benefit from treatment; recipient does not have an organic brain disorder (dementia or delirium) or other psychiatric or neurological conditions that would produce a cognitive deficit severe enough to prohibit benefit.

3) Home and community based resources do not meet the treatment needs of the recipient or are not available.
   a) To meet this requirement, one of the following shall be established.
      i) A lower level of care will not meet the recipient's treatment needs. Examples of lower levels of care include
         a. Individual and family outpatient therapy
         b. Group therapy
         c. Therapeutic behavioral onsite services
         d. Psychosocial rehabilitation
         e. Behavioral health day treatment
      ii) An appropriate lower level of care is unavailable or inaccessible and a reasonable course of traditional outpatient treatment is unlikely to resolve significant symptoms to permit a safe functioning in the community.
   b) Proper treatment of the recipient's psychiatric condition requires intensive community-based services. To meet this requirement all of the following criteria must be met:
      i) The child or adolescent has a serious impairment of functioning compared to others of the same age due to the psychiatric diagnosis, in one or more major life roles (school, family, interpersonal relations, self-care, etc.) as evidenced by documented presence of
         (a) Deficits in cognition, control, or judgment due to diagnosis(es)
         (b) Circumstances resulting from those deficits in self-care, personal safety, social/family functioning, academic or occupational performance, and
         (c) Prognostic indicators which predict the effectiveness of treatment;
   c) The services can reasonably be expected to improve the recipient's condition within a reasonable timeframe or prevent further regression so that the services will no longer be needed.
      i) The Redirection services provider shall develop with the recipient a treatment plan prescribing the services.
      ii) The treating Redirection services provider shall develop with the recipient a formal aftercare plan.
      iii) Redirection services are expected to result in maintaining or improving the recipient's level of functioning.

Target Group(s). ***(If applicable, specify the target population(s) who will be eligible to receive this State plan HCBS benefit):***

- Under 18 years of age; and
- Who meet the following diagnostic criteria

  - Has an ICD-9-CM diagnosis of 295.0 through 298.9 (psychotic disorder, major depression or bipolar disorder).
    OR
  - Has an ICD-9-CM diagnosis in the following range: 294.8, 294.9, 300 through 301.9, 307.1, 307.23, 307.5 through 307.7, 308.0 through 312.4, 312.81 through 314.9; and 303.0 through 305.9; and

In order to continue 1915(i) services the Agency for Health Care Administration will need to renew the SPA every five (5) years.

5. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	**NF (& NF LOC waivers)**	**ICF/MR (& ICF/MR LOC waivers)**	**Applicable Hospital* LOC (& Hospital LOC waivers)**
The needs based eligibility criteria are described in #4.	Not applicable as this institutional setting would not be considered for the population served by Redirection services.	Not applicable as this institutional setting would not be considered for the population served by Redirection services.	The following criteria are to be used for admission to a SIPP facility when reimbursement is to be made on behalf of eligible Medicaid recipients: 1. All admissions are non-emergency and voluntary. 2. Medical clearance must be given by a physician prior to admission. 3. The child or adolescent has age appropriate cognitive ability to benefit from treatment. 4. The child or adolescent has the cognitive and developmental ability to benefit from treatment and group setting. 5. CFR 441.152 Federal requirements A, B, and C shall be met for admission to a SIPP. A. Ambulatory care resources available in the community do not meet the treatment needs of the recipient (42 CFR 441.152(a)). A reasonable course of acute inpatient treatment and/or intensive outpatient services has failed to bring about adequate resolution of significant symptoms to permit placement in a less restrictive setting in the community. To meet this requirement, one of the following shall be established. 1) A lower level of care will not meet the recipient's treatment needs. Examples of lower levels of care include a) Family or relative

placement with outpatient therapy
b) Day or after-school treatment
c) Foster care with outpatient therapy
d) Therapeutic foster care
e) Group childcare supported by outpatient therapy
f) Therapeutic group childcare
g) Partial hospitalization
h) Custodial care

2) An appropriate lower level of care is unavailable or inaccessible and a reasonable course of acute inpatient treatment has failed to resolve significant symptoms to permit a safe return to the community.

B. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician (42 CFR 441.152(a)).

To meet this requirement all of the following criteria must be met:

1) An ICD-9 diagnosis is present and has been established through a documented comprehensive bio-psychosocial diagnostic assessment. The diagnosis must indicate the presence of a psychiatric disorder that is severe in nature and requires more intensive treatment than can be provided on an outpatient basis. As an example, the following diagnoses may indicate the need for SIPP care when acute inpatient treatment has not adequately resolved significant symptoms and behaviors: Major Depressive Disorder, active Post Traumatic Stress Syndrome with continued fragility, and newly

diagnosed psychotic disorders. A concurrent Axis I substance abuse disorder may be present.

2) The rating on DSM IV Axis V at admission is less than 70.

3) The recipient is currently experiencing problems related to the mental disorder diagnosed in B.1 above in one of the following categories designated as a, b, c, or d:

a) Self-care Deficit (not Age Related): Basic impairment of needs or nutrition, sleep, hygiene, rest, or stimulation related to the recipient's mental disorder and severe and long-standing enough to prohibit participation in an available alternative setting in the community, including refusal to comply with treatment (e.g., refuse medications)

OR

b) Impaired Safety (Threat to Self or Others): Evidence of intent to harm self or others caused by the recipient's mental disorder; and unable to function in community setting, provided that such intent does not constitute a clinically emergent situation. Threats to harm self or others accompanied by one of the following:

i. Severely depressed mood
ii. Recent loss
iii. Recent suicide

attempt or gesture or past history of multiple attempts or gestures

iv. Concomitant substance abuse

v. Recent suicide or history of multiple suicides in family or peer group

OR

c) Impaired Thought and/or Perceptual Processes (Reality Testing): Inability to perceive and validate reality to the extent that the patient cannot negotiate his/her basic environment, nor participate in family or school (paranoia, hallucinations, delusions) and it is likely that the recipient will suffer serious harm.

Indicators:

i. Disruption of safety of self, family, peer, or community group

ii. Impaired reality testing sufficient to prohibit participation in any community educational alternative

iii. Not responsive to outpatient trial of medication or supportive care

iv. Requires sub-acute diagnostic evaluation to determine treatment needs

OR

d) Severely Dysfunctional

Patterns: Family, environmental, or behavioral processes, which place the recipient at risk

Indicators (one of the following):

i. Family environment is causing escalation of recipient's symptoms or places recipient at risk.
ii. The family situation is not responsive to available outpatient or community resources and intervention.
iii. Instability or disruption is escalating.
iv. The situation does not improve with the provision of economic or social resources.
v. Severe behavior or established pattern of behavior prohibits any participation in a lower level of care; e.g., habitual runaway, prostitution, repeated substance abuse.

4) The child or adolescent has a serious impairment of functioning compared to others of the same age due to the psychiatric diagnosis, in one or more major life roles (school, family, interpersonal relations, self-care, etc.) as evidenced by documented presence of

a) Deficits in cognition, control, or judgment due to diagnosis(es)
b) Circumstances resulting from those deficits in self-care,

personal safety, social/family functioning, academic or occupational performance

c) Prognostic indicators which predict the effectiveness of treatment

5) The facility requesting prior authorization describes a proposed plan of active treatment based on comprehensive assessment that addresses medical, psychiatric, neurological, psychological, social, educational, and substance abuse needs. Specifically:

a) Services shall be under the supervision of a physician advisor.

b) Intervention of qualified professionals shall be available 24 hours a day.

c) Multiple therapies (group counseling, individual counseling, pre-vocational therapy, family therapy, recreational therapy, expressive therapies, etc.) shall be actively provided to the recipient. Families or surrogates must be involved in the treatment. Family therapy with families or surrogates must be included unless clinically contraindicated, with an expectation of at least one family session per week.

A. The services can reasonably be expected to improve the recipient's condition within a reasonable timeframe of three to six months or prevent further regression so that the services will no longer be needed (42 CFR 441.152(a)).

1) The treating facility shall provide a

			description of the plan for treatment illustrating the required services available at SIPP level of care. 2) The treating SIPP facility shall provide a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan shall include discrete, behavioral, measurable, and time framed discharge criteria. 3) The benefits of SIPP care are expected to result in maintaining or improving the recipient's level of functioning.

*Long Term Care/Chronic Care Hospital

(By checking the following boxes the State assures that):

6. ☑ **Reevaluation Schedule**. Needs-based eligibility reevaluations are conducted at least every twelve months.

7. ☑ **Adjustment Authority**. The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

8. ☑ **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

Services are provided in a family home placement, which may include relative and non-relative homes and licensed foster homes, excluding Specialized Therapeutic Foster Care homes and group settings. Treatment includes provision of clinical services which are psychological, behavioral and psychosocial in orientation and designed to maintain children in their homes and communities. Foster care placements must be licensed in accordance to 65C-13. There should be no more than five children in a licensed home, including the family's own children, without prior approval.

Services are highly supportive, individualized, and flexible and require a "whole family" approach to dealing with all problems affecting the recipient's functioning within the community. The participation of family and/or caretaker, and involvement in the community and school are considered essential to the recipient's successful discharge from this program.

Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:

- An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
- Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
- An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
- An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
- If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
- A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

2. ☑ Based on the independent assessment, the individualized plan of care:

- Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
- Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
- Prevents the provision of unnecessary or inappropriate care;
- Identifies the State plan HCBS that the individual is assessed to need;
- Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

3. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

Face-to-face assessments will be completed by Redirections services practitioners. These practitioners may be a physician or a licensed practitioner of the healing arts.

Licensed practitioners of the healing arts include:

- Clinical social workers licensed in accordance with Chapter 491 F.S.
- Mental health counselors licensed in accordance with Chapter 491 F.S.
- Marriage and family therapists, licensed in accordance with Chapter 491 F.S.
- Psychologists licensed in accordance with Chapter 490 F.S.
- Clinical Nurse Specialist (CNS) with a sub-specialty in Child/Adolescent Psychiatric and Mental Health or Psychiatric and Mental Health licensed in accordance with Chapter 464 F.S.
- Psychiatric ARNP licensed in accordance with Chapter 464 F.S.
- Psychiatric physician assistant licensed in accordance with Chapters 458 and 459, F.S.

Treating practitioners must have a minimum of two years of direct experience working with emotionally disturbed children with criminogenic factors and their families. Practitioners must be employed or under contract with a certified Redirection services provider agency.

4. Responsibility for Plan of Care Development. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

Clinical staff with at least a Master's degree in a human services field, with a minimum of two years of direct experience working with emotionally disturbed children with criminogenic factors, will work with the recipient and the recipient's family to develop an individualized treatment plan. Treatment plans must be authorized by a Medicaid enrolled treating practitioner linked to the certified Redirection services provider agency. A human services field is one in which major course work includes the study of human behavior and development. Non-licensed clinical staff will work under the clinical supervision of a licensed practitioner of the healing arts.

The multidisciplinary team must review the recipient's treatment plan monthly.

5. Supporting the Participant in Plan of Care Development. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The provider will make verbal and written information available to the participant about the person-centered planning process, the opportunity to include others to participate in the planning, and about available services through the program at admission. The participant will be encouraged to participate in the development of individualized treatment plan goals and objectives. The provider will ensure that the participant and identified supports are fully involved in the treatment plan development. Treatment plan meetings are conducted at times and places that are convenient

for the participant and the participant's family. Treatment plans must be developed by one of the following qualified practitioners:

- Physician;
- Psychiatrist;
- Psychiatric physician assistant;
- Psychiatric advanced registered nurse practitioner;
- Licensed Practitioner of the healing arts (LPHA);
- Master's level practitioner; or
- Bachelor's level practitioner.

Practitioners must have a minimum of two years of direct experience working with emotionally disturbed children with criminogenic factors and their families. Practitioners must be employed or under contract with a certified Redirection services provider agency.

Treatment plans must be authorized by a Medicaid enrolled treating practitioners, who must be a physician or a licensed practitioner of the healing arts.

6. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

Redirection services will be available statewide. The Department of Juvenile Justice will publish on its website a list of all certified Redirection services providers that are Medicaid enrolled in each Agency for Health Care Administration (AHCA) area. This list will be made available to participants and their families or legal representatives upon referral to Redirection services. Participants and their families or legal representatives will be afforded the opportunity to choose from certified Redirection services providers.

7. Process for Making Plan of Care Subject to the Approval of the Medicaid Agency. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

The multidisciplinary team with develop the recipient treatment plan. Treatment plans must be authorized by a Medicaid enrolled treating practitioners, who must be a physician or a licensed practitioner of the healing arts. The Department of Juvenile Justice must authorize all individualized treatment plans.

1. Maintenance of Plan of Care Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☐	Operating agency	☐	Case manager
☑	Other (*specify):*	The certified Redirection services provider agency.			

Services

1. 1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Redirection Services
Service Definition (Scope)*:*	

The goal of these services is to "redirect" recipients from juvenile justice facilities to more effective, family-focused, evidence-based treatment options. Redirection services are time-limited intensive community-based services that address the multiple determinants of behavioral disorders in juvenile offenders. Redirection services address the factors associated with delinquency across a recipient's life systems through case management and evidence-based treatment and interventions. Services are designed to address the following criminogenic risk factors:

- Records of referrals;
- Family history;
- Mental Health;
- Alcohol and drug use;
- Aggression;
- Relationships;
- Attitudes, behaviors, and skills;
- Current living arrangements;
- Use of free time;
- School performance; and
- Lack of employment.

Certified Redirection services providers are required to demonstrate expertise with the delinquent youth and must utilize specialized treatment approaches including the use of a multidisciplinary team (MDT). The MDT should include the recipient's parents, caregivers, or guardians, the recipient's Redirection Services case manager, the recipient's Redirection services therapist, the Redirection services staff supervisor, a representative from the Department of Juvenile Justice, as well as representation from any other community supports applicable.

Redirection services are provided in a home, school, or other community setting. Redirection services utilize an individualized combination of therapy and therapeutic support services.

Redirection Therapy Services:

Individual therapy services include the provision of insight oriented, cognitive behavioral or supportive therapy interventions to an individual recipient, to address criminogenic risk factors.

Family therapy services include the provision of insight oriented, cognitive behavioral or supportive

therapy interventions to a recipient's family, with or without the recipient present, to address criminogenic risk factors. The focus or primary beneficiary of family therapy services must always be the recipient.

Group therapy services include the provision of cognitive behavioral, supportive therapy or counseling interventions to recipients or their families to address criminogenic risk factors. The focus or primary beneficiary of group therapy services must always be the recipient.

A combination of therapy services, aside from Redirection 24 hour crisis therapeutic support services, must be provided at least two times weekly by one of the following qualified practitioners:

- Physician;
- Psychiatrist;
- Psychiatric physician assistant;
- Psychiatric advanced registered nurse practitioner;
- Licensed Practitioner of the healing arts (LPHA); or
- Master's level practitioner.

Practitioners must have a minimum of two years of direct experience working with emotionally disturbed children with criminogenic factors and their families. Practitioners must be employed or under contract with a certified Redirection services provider agency.

Redirection Therapeutic Support Services:

Redirection therapeutic support services combine living and social skills training, support to recipients and their families, housing, pre-vocational and transitional employment rehabilitation training, social support and network enhancement, structured activities to diminish tendencies towards antisocial and criminal behavior, and teaching the recipient and family about symptom management.

Redirection therapeutic support services shall not be available to individuals who are eligible to receive vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Education Act (IDEA).

Redirection therapeutic support services must be rendered at least one time weekly, in addition to therapy services, by one of the following qualified practitioners:

- Physician;
- Psychiatrist;
- Psychiatric physician assistant;
- Psychiatric advanced registered nurse practitioner;
- Licensed Practitioner of the healing arts (LPHA);
- Master's level practitioner; or
- Bachelor's level practitioner.

Practitioners must have a minimum of two years of direct experience working with emotionally disturbed children with criminogenic factors and their families. Practitioners must be employed or under contract with a certified Redirection services provider agency.

Redirection 24 Hour Crisis Therapeutic Support Services:

24 hour therapeutic support services are intended to assist recipients and their families to manage crisis situations. These services must be available 24 hours a day seven (7) days a week. 24 hour therapeutic support services cannot be counted toward weekly therapy and therapeutic support service requirements.

Redirection 24 hour therapeutic support services must be rendered by one of the following qualified practitioners:

- Physician;
- Psychiatrist;
- Psychiatric physician assistant;
- Psychiatric advanced registered nurse practitioner;
- Licensed Practitioner of the healing arts (LPHA);
- Master's level practitioner; or
- Bachelor's level practitioner.

Practitioners must have a minimum of two years of direct experience working with emotionally disturbed children with criminogenic factors and their families. Practitioners must be employed or under contract with a certified Redirection services provider agency.

Redirection Services Care Coordination:

The primary goal of Redirection services care coordination is to optimize the functioning of recipients who have complex needs by coordinating the provision of Redirection treatment and support services in the most efficient and effective manner. Services and service frequency should accurately reflect the individual needs, goals, and abilities of each recipient.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Specify whether the service may be provided by a *(check each that applies):*	☐	Relative
	☐	Legal Guardian
	☐	Legally Responsible Person

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Community Behavioral Health Services group provider (05)		Department of Juvenile Justice Certified Redirection Services Programs	Redirection services are governed by Title 42, Code of Federal Regulations (CFR), Part 440.130 and through the authority of Chapter 409.906, Florida Statutes (F.S.). The Florida Administrative Code, Chapter 59G, authorizes implementation of Medicaid

			policy for Redirection services.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Community Behavioral Health Services group provider (05)	Agency for Health Care Administration- Bureau of Medicaid Services or designee, and Department of Juvenile Justice.	Annually

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

2. ☐ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the State assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS ; (b) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (*Select one):*

⊙	The State does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. *(Specify criteria):*

2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the State affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. Financial Management. (*Select one):*

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

6. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). (*Select one):*

○	The State does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget). (*Select one):*

○	The State does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):*

Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes,and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of Analysis and Aggregation*
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	**Numerator:** Files reviewed that have evidence that an assessment of the recipient's needs was completed by qualified clinical staff prior to the development of the treatment plan. Denominator: All Redirection services recipient files reviewed.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with a 95% confidence level with a 5% margin of error. This will be required for each program monitoring.	The Department of Juvenile Justice (DJJ) will report monitoring results to Florida Medicaid quarterly.	Annually	The DJJ will ensure the development of a performance improvement plan within 15 calendar days of the compliance monitoring. The DJJ will approve or disapprove the plan within 7 calendar days. The performance improvement plan must be fully implemented within 30 calendar days of approval of the performance improvement plan. The DJJ will conduct a monitoring within 6 months of implementation to ensure performance	The DJJ will report monitoring results to Florida Medicaid quarterly. The DJJ will monitor provider adherence to performance improvement plans no less than annually.

					improvement plan compliance.	
	Numerator: Files reviewed for recipients eligible for services, who participated in services beyond the first 30 days that have evidence that an individualized service plan was completed and authorized by qualified clinical staff. Denominator: All Redirection services recipient files reviewed for recipients who participated in services beyond the first 30 days.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with a 95% confidence level with a 5% margin of error. This will be required for each program monitoring.	The DJJ will report monitoring results to Florida Medicaid quarterly.	Annually	The DJJ will ensure the development of a performance improvement plan within 15 calendar days of the compliance monitoring. The DJJ will approve or disapprove the plan within 7 calendar days. The performance improvement plan must be fully implemented within 30 calendar days of approval of the performance improvement plan. The DJJ will conduct a monitoring within 6 months of implementation to ensure performance improvement plan compliance.	The DJJ will report monitoring results to Florida Medicaid quarterly. The DJJ will monitor provider adherence to performance improvement plans no less than annually.

	Numerator: Files reviewed that contain informed consent, signed by the recipient and his or her parent or guardian, which informs the recipient of other available services and providers. Denominator: All Redirection services recipient files reviewed.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with a 95% confidence level with a 5% margin of error. This will be required for each program monitoring.	The DJJ will report monitoring results to Florida Medicaid quarterly.	Annually	The DJJ will ensure the development of a performance improvement plan within 15 calendar days of the compliance monitoring. The DJJ will approve or disapprove the plan within 7 calendar days. The performance improvement plan must be fully implemented within 30 calendar days of approval of the performance improvement plan. The DJJ will conduct a monitoring within 6 months of implementation to ensure performance improvement plan compliance.	The DJJ will report monitoring results to Florida Medicaid quarterly. The DJJ will monitor provider adherence to performance improvement plans no less than annually.

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes,and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of Analysis and Aggregation*
The SMA retains authority and responsibility for program operations and oversight.	Numerator: Number of individual provider compliance monitoring reports and quarterly reports completed by the Department of Juvenile Justice that have been approved by Florida Medicaid. Denominator: Individual provider compliance monitoring reports and quarterly reports completed by the Department of Juvenile Justice that were submitted to Florida Medicaid.	Bureau of Medicaid Services Redirection services contract manager will review all quarterly results.	Florida Medicaid	Ongoing	Florida Medicaid will ensure the development of a corrective action plan within 15 calendar days of notification of non-compliance. Medicaid will approve or disapprove the corrective action plan within 7 calendar days Florida. The corrective action plan must be fully implemented within 30 calendar days of Florida Medicaid's approval of the corrective action plan. Florida Medicaid will conduct a monitoring within 3 months of implementation to ensure corrective action plan compliance.	Florida Medicaid will monitor adherence with a corrective action plan on no less than a quarterly basis.

	Numerator: Number of corrective action plans that Florida Medicaid approved within 7 days. Denominator: All corrective action plans that were submitted to Florida Medicaid for approval.					
Providers meet required qualifications.	Numerator: Files reviewed that contain evidence that services were provided by a qualified professional. Denominator: All Redirection services recipient files reviewed.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with a 95% confidence level with a 5% margin of error. This will be required for each program monitoring.	The DJJ will report monitoring results to Florida Medicaid quarterly.	Annually	The DJJ will ensure the development of a performance improvement plan within 15 calendar days of the compliance monitoring. The DJJ will approve or disapprove the plan within 7 calendar days. The performance improvement plan must be fully implemented within 30 calendar days of approval of the performance improvement plan. The DJJ will conduct a monitoring within 6	The DJJ will report monitoring results to Florida Medicaid quarterly. The DJJ will monitor provider adherence to performance improvement plans no less than annually.

	Numerator: Redirection services providers with a valid certification from the Department of Juvenile Justice. Denominator: All Redirection services providers.				months of implementation to ensure performance improvement plan compliance.	

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes,and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of Analysis and Aggregation*
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	The Department of Juvenile Justice agrees to: • Maintain an ongoing management information system to ensure accountability of paid and reimbursed claims; • Maintain accurate records of payment and monitor services delivery; • Maintain, and require providers to maintain, records relevant to these services; • Provide any records to the Centers for Medicare and Medicaid Services (CMS) and to	Quarterly certification by the Department of Juvenile Justice of each provider and service.	Florida Medicaid	Quarterly	Florida Medicaid will ensure the development of a corrective action plan within 15 calendar days of notification of non-compliance. Florida Medicaid will approve or disapprove the corrective action plan within 7 calendar days. The corrective action plan must be fully implemented within 30 calendar days of Florida Medicaid's approval of the corrective action plan. Florida Medicaid will conduct a monitoring within 3 months of implementation to ensure corrective action plan compliance.	Florida Medicaid will monitor adherence with a corrective action plan on no less than a quarterly basis.

	Florida Medicaid, when requested for audit purposes; • Void or otherwise pay back any claims that are found to be ineligible for match due to an audit, deferral of denial as deemed appropriate; • Designate an employee to act as liaison with Florida Medicaid for issues related to this agreement. The DJJ will provide certification of claims to Florida Medicaid on a quarterly basis. Numerator: The number of claims submitted using the correct rate. Denominator:					

	The number of claims submitted. Numerator: The Number of claims submitted without error. Denominator: The number of claims submitted.					

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes,and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of Analysis and Aggregation*
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	The DJJ will require providers to report all incidents within 2 hours of the incident occurring or program staff learning of the incident.	The DJJ will provide notification of incidents to Florida Medicaid within 48 hours of receipt; and A contract compliance monitoring will be completed for each Redirection Service provider using a sample with a 95% confidence level with a 5% margin of error. This will be required for each program monitoring.	The DJJ will monitor providers with oversight from Florida Medicaid.	Annually	Certified Redirection Services providers will be required to report all incidents within 2 hours of the incident occurring or program staff learning of the incident, to the Central Communications Center. Providers are required to immediately respond to critical incidents. The DJJ will ensure the development of a performance improvement plan within 15 calendar days of the compliance monitoring. The DJJ will approve or disapprove the plan within 7 calendar days. The performance improvement plan must be fully implemented within 30 calendar days	The DJJ will report monitoring results to Florida Medicaid quarterly. The DJJ will monitor provider adherence to performance improvement plans no less than annually.

					of approval of the performance improvement plan. The DJJ will conduct a monitoring within 6 months of implementation to ensure performance improvement plan compliance.	
	Numerator: Files that contain informed consent, signed by the recipient and his or her parent or guardian, which informs the recipient of the provider's role as a mandated reporter in addition to providing the recipient with contact information for the Florida Abuse Hotline. Denominator: All Redirection	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with a 95% confidence level with a 5% margin of error. This will be required for each program monitoring.	The DJJ will monitor providers with oversight from Florida Medicaid.	Annually	Florida Medicaid will ensure the development of a corrective action plan within 15 calendar days of notification of non-compliance. Medicaid will approve or disapprove the corrective action plan within 7 calendar days Florida. The corrective action plan must be fully implemented within 30 calendar days of Florida Medicaid's approval of the corrective action plan. Florida Medicaid will conduct a monitoring within 3 months of implementation to	The DJJ report monitoring results to Florida Medicaid quarterly. The DJJ will monitor provider adherence to performance improvement plans no less than annually.

	services recipient files reviewed.				ensure corrective action plan compliance.	
	Numerator: Files reviewed that have evidence that any assessed history of trauma, (including abuse, neglect, and exploitation) was considered in the development of the recipient's service plan. Denominator: All Redirection services recipient files reviewed.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with a 95% confidence level with a 5% margin of error. This will be required for each program monitoring.	The DJJ will monitor providers with oversight from Florida Medicaid.	Annually	Florida Medicaid will ensure the development of a corrective action plan within 15 calendar days of notification of non-compliance. Medicaid will approve or disapprove the corrective action plan within 7 calendar days Florida. The corrective action plan must be fully implemented within 30 calendar days of Florida Medicaid's approval of the corrective action plan. Florida Medicaid will conduct a monitoring within 3 months of implementation to ensure corrective action plan compliance.	The DJJ will report monitoring results to Florida Medicaid quarterly. The DJJ will monitor provider adherence to performance improvement plans no less than annually.
	Numerator: Files reviewed that have evidence that reported incidents	A contract compliance monitoring will be completed for each Redirection Service provider	The DJJ will monitor providers with oversight from Florida Medicaid.	Annually	Florida Medicaid will ensure the development of a corrective action plan within 15 calendar days of notification of non-compliance.	The DJJ will report monitoring results to Florida Medicaid quarterly. The DJJ will monitor

	of recipient abuse, neglect, or exploitation were processed in accordance with reporting guidelines. Denominator: All Redirection services recipient files reviewed that have evidence that an incident of recipient abuse, neglect, or exploitation was reported.	using a sample with a 95% confidence level with a 5% margin of error. This will be required for each program monitoring.			Medicaid will approve or disapprove the corrective action plan within 7 calendar days Florida. The corrective action plan must be fully implemented within 30 calendar days of Florida Medicaid's approval of the corrective action plan. Florida Medicaid will conduct a monitoring within 3 months of implementation to ensure corrective action plan compliance.	provider adherence to performance improvement plans no less than annually

This page is intentionally blank.

System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
Contract adherence and the results of compliance monitoring results will be utilized to identify and address area of programmatic concern. The DJJ will collect program success data from each certified Redirection Provider and will report these results quarterly to Florida Medicaid. The DJJ will collect data on whether or not reportable incidents of recipient abuse, neglect, or exploitation were reported to Florida Abuse Hotline within 24 hours and to the Central Communications Center within 2 hours of the incident occurring or program staff learning of the incident.	The DJJ will address quarterly compliance monitoring results and areas of contract noncompliance when developing a corrective plan of action for areas requiring improvement. The corrective action plan must be approved by Florida Medicaid. Florida Medicaid will report compliance monitoring results to the Center for Medicare and Medicaid Services (CMS) annually.	Ongoing	Florida Medicaid will monitor quarterly reports by the Department of Juvenile Justice for data trends to identify performance concerns or areas of noncompliance. When Florida Medicaid identifies performance issues or areas of noncompliance, the DJJ will be required to complete a corrective action plan within 15 days. Florida Medicaid will approve or disapprove the corrective action plan within 7 calendar days. If there is not sufficient improvement in performance after the next quarterly report, Florida Medicaid will complete a compliance monitoring and will meet with the administration of DJJ to discuss how to address corrective action plan noncompliance from the operating agency itself. Strategies for increasing compliance may include recoupments and provider terminations in addition to referrals to the Fraud Prevention and Compliance Unit or to Medicaid Program Integrity. If there are instances of noncompliance by the operating agency that could not be resolved through corrective action activities, the Florida Medicaid will consult with the CMS when developing a strategy to ensure performance measures are met.

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:

	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

☑	Other Services (specify below) – Redirection Services
	Providers of Redirection services are reimbursed an all-inclusive weekly rate based on a state-developed fee schedule. Redirection services consist of four separate components: Redirection therapy, Redirection therapeutic support, Redirection 24 hour crisis therapeutic support, and Redirection services case coordination. The weekly rate will be paid only if both the Redirection therapy and the Redirection therapeutic support component services are rendered. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Redirection services. The agency's fee schedule rate was set as of 2/18/12 and is effective for services provided on and after that date. All rates are published on the Florida Medicaid web portal, www.mymedicaid-florida.com, under public information for providers, then provider support, then fee schedules.

The Redirection Service rate is based on rates currently set for state plan services. The rates for each Redirection service are multiplied by the anticipated service frequency per week, and are then multiplied by 26 (the number of weeks in an authorization period). The rate results are then averaged and divided by 26 (the number of weeks in an authorization period).

In order to receive reimbursement of the full weekly rate both the Redirection therapy and the Redirection therapeutic support services must be rendered. When both services cannot be provided in the same week, providers can bill for the Redirection therapy service or the Redirection therapeutic support service at an individual service rate. Billing for these services individually should only occur in exceptional situations and providers must verify that recipients remained eligible for this level of service in instances when the weekly service rate is not qualified.