

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):*

Redirections Services: <ul style="list-style-type: none"> Parenting with Love and Limits (PLL); Brief Strategic Family Therapy (BSFT); Functional Family Therapy (FFT); and Multisystemic Therapy (MST).
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2. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one):*

<input type="radio"/>	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 <i>(select one)</i> :
<input type="radio"/>	The Medical Assistance Unit <i>(name of unit)</i> :
<input type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit <i>(name of division/unit)</i> <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i> <div style="border: 1px solid black; width: 100%; height: 80px; margin-top: 5px;"></div>
<input checked="" type="radio"/>	The State plan HCBS benefit is operated by <i>(name of agency)</i> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;">The Department of Juvenile Justice</div> 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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 State plan HCBS enrollment managed against approved limits, if any	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Eligibility evaluation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Review of participant service plans	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Prior authorization of State plan HCBS	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Utilization management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- | |
|---|
| <ol style="list-style-type: none"> 1. Department of Juvenile Justice (DJJ) or their designee 2. Department of Juvenile Justice (DJJ) or their designee 3. Department of Juvenile Justice (DJJ) or their designee 4. Department of Juvenile Justice (DJJ) or their designee 5. Department of Juvenile Justice (DJJ) 6. Department of Juvenile Justice (DJJ) or their designee 7. Department of Juvenile Justice (DJJ) or their designee 11. Department of Juvenile Justice (DJJ) or their designee |
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(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):*

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.
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	1/1/12	1/1/13	597
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

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

<input checked="" type="radio"/>	The State does not provide State plan HCBS to the medically needy.
<input type="radio"/>	The State provides State plan HCBS to the medically needy <i>(select one):</i>
<input type="radio"/>	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.
<input type="radio"/>	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

- 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):*

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="radio"/>	By Other <i>(specify State agency or entity with contract with the State Medicaid agency):</i> Florida Department of Juvenile Justice or designee

- 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):*

Medicaid enrolled treating practitioners linked to a certified Redirection Services provider agency will provide evaluation/reevaluation for program eligibility. Redirection Services require prior authorization from the Department of Juvenile Justice or its designee. Services must be reauthorized every six months.

- 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 youth for a serious emotional disturbance if they are: age 18 or under; under the supervision of DJJ; have been adjudicated delinquent; and, are at imminent risk of out-of-home care. DJJ will refer Medicaid enrolled

youth who meet the screening criteria to a Certified Redirection Services program where a minimum of a bachelor’s level counselor will complete a biopsychosocial evaluation that includes a Children’s Functional Assessment Rating Scale (CFARS) evaluation.

Recommendations for Redirection services will require prior authorization by the Department of Juvenile Justice. A Medicaid enrolled treating practitioner must confirm an appropriate diagnosis and must determine that services are medically necessary, before a request for prior authorization is forwarded to DJJ or their designee for approval.

A treating practitioner must review the participant’s treatment plan every six months and will be required to seek reauthorization for services if it is determined Redirection Services are medically necessary for the participant.

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):*

To receive redirection services, a recipient must meet the following criteria:

- Under 18 years of age;
- Experiencing a serious emotional disturbance;
- Are “disposed by the court” to probation, post commitment, or conditional release services; and
- At imminent risk of out-of-home care.

Services must be medically necessary.

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)

*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):*

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 Medicaid enrolled individual treating providers linked to a certified Redirection Services provider agency. Medicaid enrolled treating providers must be a physician or a licensed practitioner of the healing arts.

- 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 Bachelor's degree in a human services field will work with the recipient and the recipient's family to develop an individualized treatment plan that must be authorized by a Medicaid enrolled treating provider linked to the certified Redirection Services provider agency. Non-licensed clinical staff will work under the clinical supervision of a licensed practitioner of the healing arts.

- 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. 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 will be based upon the recipient's individualized treatment plan, and will be provided by clinical staff, with at least a Bachelor's degree in a human services field, working under the clinical supervision of 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):*

The Department of Juvenile Justice will publish on its website a list of all certified Redirection Services providers in the State of Florida by DJJ area. This list will be made available to participants and their families or legal representatives upon referral to Redirection Services. To the extent possible, participants and their families or legal representatives will be afforded the opportunity to choose from certified Redirection Services providers available in their DJJ area.

- 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 Agency for Health Care Administration (AHCA) retains the right to review all service documentation, including individualized treatment plans to determine the necessary and appropriate provision of services. The Department of Juvenile Justice or its designee will review individualized treatment plan development and the implementation of services by certified Redirection Services programs during annual quality assurance reviews.

- 8. 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):*

<input type="checkbox"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other <i>(specify):</i>	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- Parenting with Love and Limits ® (PLL)	
Service Definition (Scope):			
<p>PLL consistently employs one highly effective, research-based treatment model throughout both parent group and family therapy, with each session building upon the preceding sessions. Parents/caregivers and adolescents attend group together to receive a new skill once each week, and that same week they receive individual family therapy "coaching" to practice this new skill.</p> <p>PLL shall be conducted with six group therapy sessions concurrent with a minimum of six or more family therapy sessions over 8-10 weeks, depending on the severity of the problems. Benchmark meetings with the provider, the probation officer, the family and other key stakeholders will take place immediately following the sixth family therapy session to determine progress on treatment goals and if additional sessions are needed.</p>			
Additional needs-based criteria for receiving the service, if applicable (specify):			
PLL is designed for youth between ages 10-18 with extreme emotional or behavioral problems (running away, extreme disrespect, chronic truancy, depression, drug or alcohol abuse, etc.).			
Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):			
<input type="checkbox"/>		Categorically needy (specify limits):	
<input type="checkbox"/>		Medically needy (specify limits):	
Specify whether the service may be provided by a (check each that applies):		<input type="checkbox"/>	Relative
		<input type="checkbox"/>	Legal Guardian
		<input type="checkbox"/>	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 or designee	Annually
Service Delivery Method. (Check each that applies):		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed	

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- Brief Strategic Family Therapy® (BSFT™)
Service Definition (Scope):	
<p>BSFT™ targets children and adolescents between the ages 6-17 who are displaying behavior problems including; substance abuse, conduct problems and delinquency. The focus of BSFT treatment is to shift the family from maladaptive patterns of interaction to adaptive ones. The goals of BSFT are to:</p> <ol style="list-style-type: none"> a. Organize a counselor-family therapeutic team. Develop a therapeutic alliance with each family member and with the entire family unit. b. Diagnose family strengths and problem relationships. c. Emphasize family relationships that are supportive as well as the problematic interactions that are the most closely linked to the youths' problem behaviors or interfere with parental figures' ability to correct those behaviors. d. Develop a change strategy that is practical, problem-focused, and planned, which will capitalize on strengths and correct problematic family interactions, thereby increasing family competence e. Implement change strategies and reinforce family behaviors that sustain new levels of family competence. <p>Brief Strategic Family Therapy® (BSFT™) provides families with tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill-building strategies that strengthen families. It targets:</p> <ol style="list-style-type: none"> a. Conduct problems b. Associations with antisocial peers c. Early substance use d. Problematic family relations 	

The program fosters parental leadership, appropriate parental involvement, mutual support among parenting figures, family communication, problem solving, clear rules and consequences, nurturing, and shared responsibility for family problems. In addition, the program provides specialized outreach strategies to bring families into therapy:

- a. BSFT program is available to clients 24 hour/day, 7 day/week via an on-call system staffed by BSFT team members
- b. Duration of treatment is an average of 4 months with an expected range of 3 to 5 months
- c. BSFT caseloads do not exceed 6 families per therapist

BSFT™ can be implemented in a variety of settings, including community social services agencies, mental health clinics, health agencies, and family clinics. BSFT™ is delivered in 12 to 16 weekly sessions. The family and BSFT™ therapist meet either in the program office or the family’s home. There are four important BSFT™ steps:

Step 1: Development of a therapeutic alliance with each family member and with the family as a whole is essential for BSFT™. This requires therapists to accept and demonstrate respect for each individual family member and the family as a whole.

Step 2: Diagnose family strengths and problem relations. Emphasis is on family relations that are supportive and problem relations that affect youths’ behaviors or interfere with parental figures’ ability to correct those behaviors.

Step 3: Develop a change strategy to capitalize on strengths and correct problematic family relations, thereby increasing family competence. In BSFT™, the therapist is plan- and problem-focused, direction-oriented (i.e., moving from problematic to competent interactions), and practical.

Step 4: Implement change strategies and reinforce family behaviors that sustain new levels of family competence. Important change strategies include reframing to change the meaning of interactions; changing alliances and shifting interpersonal boundaries; building conflict resolution skills; and providing parenting guidance and coaching.

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

BSFT™ is designed for youth between 6 and 17 who exhibit rebelliousness, truancy, delinquency, early substance use, and association with problem peers.

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

<input type="checkbox"/>	Categorically needy (<i>specify limits</i>):
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):

Specify whether the service may be provided by a (<i>check each that applies</i>):	<input type="checkbox"/>	Relative
	<input type="checkbox"/>	Legal Guardian
	<input type="checkbox"/>	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 or designee		Annually
Service Delivery Method. (Check each that applies):			
<input type="checkbox"/>	Participant-directed		<input checked="" type="checkbox"/> Provider managed

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- Functional Family Therapy (FFT)
Service Definition (Scope):	
<p>Functional Family Therapy (FFT) is a family based approach to providing treatment to recipients who are between the ages of 10 and 18 and are exhibiting significant behavioral or substance abuse problems. It is a systems based model of intervention and prevention which incorporates various levels of the recipient’s interpersonal experiences to include cognitive, emotional and behavioral experiences, as well as intrapersonal perspectives, which focus on the family and other systems (within the environment) and impact the recipient and his or her family system. FFT is a strengths-based model of intervention, which emphasizes the capitalization of the resources of the recipient, their family, and those of the multi-system involved. Its purpose is to foster resilience and ultimately decrease incidents of disruptive behavior for the child or adolescent. More specifically, some of the goals of the service are to reduce intense/negativistic behavioral patterns; improve family communication, parenting practices, and problem-solving skills; and increase the family’s ability to access community resources. The FFT model of intervention is based on three core principles:</p> <p>Core Principle One- Understanding recipients- this is a process whereby the therapist comes to understand the child or adolescent and family in terms of their strengths on the individual, family system and multi-systemic level.</p>	

Core Principle Two- Understanding the client systemically- This is a process whereby the therapist conceptualizes the recipient's behaviors in terms of their biological, relational, family, socioeconomic, and environmental etiology. Subsequently, the therapist assesses the recipient's relationships with family, parents, peers, their school, and their environment and these roles/relationships contribute to the maintenance and change of problematic behaviors.

Core Principle Three- Understanding therapy and the role of the therapist as a fundamentally relational process- This is a process where the therapist achieves a collaborative alliance with the recipient and their family. Subsequently, the therapist ensures that the therapy is systematic and purposeful, while maintaining clinical integrity. More specifically, the therapist follows the model, but also responds to the emotional processes (needs/feelings/behaviors) that occur in the immediacy during clinical practice.

On average, a recipient receives FFT for approximately 3 to 4 months. Over the course of this three-month period, the therapist works with the family in 9 to 14 one to two-hour sessions for less severe cases and up to 26 to 32 one to two-hour sessions for child or adolescent with more substantial acting-out behaviors. The frequency of the sessions varies on a case by case basis and over the course of the treatment; sessions could occur daily to weekly as needed. Services occur in the family's home or community and at times that are convenient for the family. FFT is carried out in the context of three distinct phases. Each phase consists of an assessment, goal-setting and an intervention component; all services rendered are carried-out based upon the theoretical framework of the three core principles.

The three phases of treatment are:

Phase One: Engagement and Motivation. During these initial phases, FFT applies reattribution/reframing and other model specific techniques to meet the following goals:

- a. Building a collaborative alliance, to include the therapist with each family member and within the family members themselves
- b. Reduce negativity and blame within the family system
- c. Secure buy-in by the family and ensure that each member is focused on the presenting problem
- d. Fostering the expectation that positive change will occur for the family

Phase Two: Behavior Change. Based upon the collaborative alliance from phase one, in this phase, concrete skills are utilized. Thus, the therapist applies individualized and developmentally appropriate techniques to interventions. These could include tools such as communication training, specific tasks and technical aides, basic parenting skills, and contracting responses-cost techniques. The goals of this phase are to reduce risk patterns on both the individual and family level using the tools in session and in vivo. These interventions should be designed to match the relational patterns of the family system, and be manageable in the context of the family and the multi-systems.

Phase Three: Generalization. In this phase, the focus changes from learning of the changes that needed to be made in phase two to their mastery in phase three. Generalization of change occurs when families are able to use newly acquired skills and apply them to new problems within the family system and within the greater multi-systems.

Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):			
Functional Family Therapy (FFT) is a family based approach to providing treatment to recipients who are between the ages of 10 and 18 and are exhibiting significant behavioral or substance abuse problems.			
Specify limits (if any) on the amount, duration, or scope of this service for (<i>chose each that applies</i>):			
<input type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Specify whether the service may be provided by a (<i>check each that applies</i>):		<input type="checkbox"/>	Relative
		<input type="checkbox"/>	Legal Guardian
		<input type="checkbox"/>	Legally Responsible Person
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Community Behavioral Health Service 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 (<i>For each provider type listed above. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):		Frequency of Verification (<i>Specify</i>):
Community Behavioral Health Services group provider (05)	Agency for Health Care Administration- Bureau of Medicaid Services or designee, and Department of Juvenile Justice or Designee		Annually
Service Delivery Method. (<i>Check each that applies</i>):			
<input type="checkbox"/>	Participant-directed		<input checked="" type="checkbox"/> Provider managed

Service Specifications (<i>Specify a service title from the options for REDIRECTIONS State plan services in Attachment 4.19-B</i>):	
Service Title:	Redirection Services- Multisystemic Therapy (MST)
Service Definition (Scope):	
<p>Multisystemic Therapy (MST) is a program designed for youth generally between the ages 7 through 17 who have aggressive behaviors, serious emotional disturbances, or who abuse substances.</p> <p>MST provides an intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. The purpose of this program is to keep youth in the home by delivering an intensive therapy to the family within the home. Services are provided through a team approach to youth and their families. Services include: an initial assessment to identify the focus of the MST intervention; individual therapeutic interventions with the youth and family; peer intervention; case management; and crisis intervention. Services are available in-home, at school, and in other community settings. The duration of MST intervention is three to five (3 to 5) months.</p> <p>MST involves families and other systems such as the school, probation officers, extended families, and community supports. MST services are delivered in a team approach designed to address the identified needs of children and adolescents with significant behavioral problems who are at risk of out-of-home placement and need intensive interventions to remain stable in the community. This population has access to a variety of interventions twenty four (24/7) hours a day by staff that will maintain contact and intervene as one organizational unit. This team approach is structured face-to-face therapeutic interventions to provide support and guidance in the following functional domains: adaptive; communication; psychosocial; problem solving; and behavior management.</p> <p>This model shall strive to overcome barriers to service access, increase family retention in treatment, allow for the provision of intensive services (i.e., therapists have low caseloads), and enhance the maintenance of treatment gains.</p> <ol style="list-style-type: none"> 1. MST therapists meet with youth and their families and other people in their lives more than once a week. 2. MST program is available to clients 24 hour/day, 7 day/week via an on-call system staffed by MST team members. 3. Duration of treatment is an average of 4 months with an expected range of 3 to 5 months. 	
Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):	
Multisystemic Therapy (MST) is a program designed for youth generally between the ages 7 through 17 who have aggressive/violent behaviors, serious emotional disturbances, or who abuse substances.	
Specify limits (if any) on the amount, duration, or scope of this service for (<i>chose each that applies</i>):	
<input type="checkbox"/>	Categorically needy (<i>specify limits</i>):
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):
Specify whether the service may be provided by a	<input type="checkbox"/> Relative

<i>(check each that applies):</i>		<input type="checkbox"/>	Legal Guardian
		<input type="checkbox"/>	Legally Responsible Person
Provider Qualifications <i>(For each type of provider. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	License <i>(Specify):</i>	Certification <i>(Specify):</i>	Other Standard <i>(Specify):</i>
Community Behavioral Health Service 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 <i>(For each provider type listed above. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>		Frequency of Verification <i>(Specify):</i>
Community Behavioral Health Services group provider (05)	Agency for Health Care Administration- Bureau of Medicaid Services or designee, and Department of Juvenile Justice or Designee		Annually
Service Delivery Method. <i>(Check each that applies):</i>			
<input type="checkbox"/>	Participant-directed		<input checked="" type="checkbox"/> 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):*

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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):*

<input checked="" type="radio"/>	The State does not offer opportunity for participant-direction of State plan HCBS.
<input type="radio"/>	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.
<input type="radio"/>	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. <i>(Specify criteria):</i>

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):*

<input type="radio"/>	Participant direction is available in all geographic areas in which State plan HCBS are available.
<input type="radio"/>	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. <i>(Specify the areas of the State affected by this option):</i>

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
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

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

<input type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	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):*

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7. Opportunities for Participant-Direction

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

<input type="radio"/>	The State does not offer opportunity for participant-employer authority.
<input type="radio"/>	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input type="checkbox"/>	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.
<input type="checkbox"/>	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):*

<input type="radio"/>	The State does not offer opportunity for participants to direct a budget.
<input type="radio"/>	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. <i>(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):</i>
	Expenditure Safeguards. <i>(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):</i>

Quality Improvement Strategy

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

Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	Frequency of Analysis and Aggregation
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	100% of recipient files reviewed will have evidence that an assessment of the recipient's needs was completed by qualified clinical staff prior to the development of the service plan, and was updated no less than annually.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with 95% confidence interval with a 5% margin of error. This will be required for each program monitoring.	The Department of Juvenile Justice or their designee will report monitoring results to Florida Medicaid annually.	Annually	The Department of Juvenile Justice or their designee will ensure the development of a performance improvement plan within 60 days of the compliance monitoring.	<p>The Department of Juvenile Justice or their designee will report monitoring results to Florida Medicaid annually.</p> <p>The Department of Juvenile Justice or their designee monitor will monitor provider adherence to performance improvement plans no less than annually.</p>

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Continued from Page 21	100% of files for recipients eligible for services, who participated in services beyond the first 30 days, will have evidence that an individualized service plan was completed and authorized by qualified clinical staff.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with 95% confidence interval with a 5% margin of error. This will be required for each program monitoring.	The Department of Juvenile Justice or their designee will report monitoring results to Florida Medicaid annually.	Annually	The Department of Juvenile Justice or their designee will ensure the development of a performance improvement plan within 60 days of the compliance monitoring.	The Department of Juvenile Justice or their designee will report monitoring results to Florida Medicaid annually. The Department of Juvenile Justice or their designee monitor will monitor provider adherence to performance improvement plans no less than annually.
	100% of recipient files must contain informed consent, signed by the recipient and his or her parent or guardian, which informs the recipient of other available services and providers.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with 95% confidence interval with a 5% margin of error. This will be required for each program monitoring.	The Department of Juvenile Justice or their designee will report monitoring results to Florida Medicaid annually.	Annually	The Department of Juvenile Justice or their designee will ensure the development of a performance improvement plan within 60 days of the compliance monitoring.	The Department of Juvenile Justice or their designee will report monitoring results to Florida Medicaid annually. The Department of Juvenile Justice or their designee monitor will monitor provider adherence to performance improvement plans no less than annually.

Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	Frequency of Analysis and Aggregation
The SMA retains authority and responsibility for program operations and oversight.	Individual provider compliance monitoring reports and quarterly reports completed by the Department of Juvenile Justice.	Bureau of Medicaid Services Redirection Services contract manager will review all quarterly results.	Florida Medicaid	Quarterly	Florida Medicaid will ensure the development of a corrective action plan within 30 days of notification of non-compliance.	Florida Medicaid will monitor adherence with a corrective action plan on no less than a quarterly basis.
Providers meet required qualifications.	100% of recipient files reviewed will contain evidence that services were provided by a qualified professional.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with 95% confidence interval with a 5% margin of error. This will be required for each program monitoring.	The Department of Juvenile Justice or their designee will report monitoring results to Florida Medicaid annually.	Annually	The Department of Juvenile Justice or their designee will ensure the development of a performance improvement plan within 60 days of the compliance monitoring.	The Department of Juvenile Justice or their designee will report monitoring results to Florida Medicaid annually. The Department of Juvenile Justice or their designee monitor will monitor provider adherence to performance improvement plans no less than annually.

Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	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 and its designee agree to: <ul style="list-style-type: none"> • 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 Florida Medicaid, or their designees, 	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 30 days of notification of non-compliance.	Florida Medicaid will monitor adherence with a corrective action plan on no less than a quarterly basis.

Continued from Page 24	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 Department of Juvenile Justice or its designee will provide certification of claims to Florida Medicaid on a quarterly basis.					
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Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	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 Department of Juvenile Justice or their designee will require providers to report all incidents within 48 hours.	The Department of Juvenile Justice or their designee 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 95% confidence interval with a 5% margin of error. This will be required for each program monitoring.	The Department of Justice or their designee will monitor providers with oversight from Florida Medicaid.	Annually	The Department of Juvenile Justice or their designee will ensure the development of a performance improvement plan within 60 days of the compliance monitoring.	The Department of Juvenile Justice or their designee will report monitoring results to Florida Medicaid annually. The Department of Juvenile Justice or their designee will monitor provider adherence to performance improvement plans no less than annually.

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Continued from Page 26	100% of recipient files must 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.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with 95% confidence interval with a 5% margin of error. This will be required for each program monitoring.	The Department of Justice or their designee will monitor providers with oversight from Florida Medicaid.	Annually	The Department of Juvenile Justice or their designee will ensure the development of a performance improvement plan within 60 days of the compliance monitoring.	The Department of Juvenile Justice or their designee will report monitoring results to Florida Medicaid annually. The Department of Juvenile Justice or their designee monitor will monitor provider adherence to performance improvement plans no less than annually.
	100% of recipient files reviewed will have evidence that any assessed history of trauma, (including abuse, neglect, and exploitation) was considered in the development of the recipient's service plan.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with 95% confidence interval with a 5% margin of error. This will be required for each program monitoring.	The Department of Justice or their designee will monitor providers with oversight from Florida Medicaid.	Annually	The Department of Juvenile Justice or their designee will ensure the development of a performance improvement plan within 60 days of the compliance monitoring.	The Department of Juvenile Justice or their designee will report monitoring results to Florida Medicaid annually. The Department of Juvenile Justice or their designee monitor will monitor provider adherence to performance improvement plans no less than annually.

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Continued from Page 27	100% of recipient files reviewed will have evidence that any reportable incidents of recipient abuse, neglect, or exploitation were reported to Florida Abuse Hotline within 24 hours.	A contract compliance monitoring will be completed for each Redirection Service provider using a sample with 95% confidence interval with a 5% margin of error. This will be required for each program monitoring.	The Department of Justice or their designee will monitor providers with oversight from Florida Medicaid.	Annually	The Department of Juvenile Justice or their designee will ensure the development of a performance improvement plan within 60 days of the compliance monitoring.	The Department of Juvenile Justice or their designee will report monitoring results to Florida Medicaid annually. The Department of Juvenile Justice or their designee monitor will monitor provider adherence to performance improvement plans no less than annually.
		A contract compliance monitoring will be completed for each Redirection Service provider using a sample with 95% confidence interval with a 5% margin of error. This will be required for each program monitoring.	The Department of Justice or their designee will monitor providers with oversight from Florida Medicaid.	Annually	The Department of Juvenile Justice or their designee will ensure the development of a performance improvement plan within 60 days of the compliance monitoring.	The Department of Juvenile Justice or their designee will report monitoring results to Florida Medicaid annually. The Department of Juvenile Justice or their designee monitor will monitor provider adherence to performance improvement plans no less than annually.

System Improvement: <i>(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)</i>			
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 Department of Juvenile Justice or its designee will consider 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.	Quarterly	Florida Medicaid will monitor subsequent quarterly reports by the Department of Juvenile Justice to ensure improvement in areas of noncompliance addressed in any corrective action plan.

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):*

<input checked="" type="checkbox"/>	HCBS Case Management	Case management services are a component of comprehensive services provided by certified Redirection programs. The rates for Redirection Services are incorporated into an inclusive rate similar to those approved for other states.
<input type="checkbox"/>	HCBS Homemaker	
<input type="checkbox"/>	HCBS Home Health Aide	
<input type="checkbox"/>	HCBS Personal Care	
<input type="checkbox"/>	HCBS Adult Day Health	
<input type="checkbox"/>	HCBS Habilitation	
<input type="checkbox"/>	HCBS Respite Care	
For Individuals with Chronic Mental Illness, the following services:		
<input checked="" type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services	Day treatment services are a component of comprehensive services provided by certified Redirection programs. The rates for Redirection Services are incorporated into an inclusive rate similar to those approved for other states.
<input checked="" type="checkbox"/>	HCBS Psychosocial Rehabilitation	Psychosocial rehabilitation services are a component of comprehensive services provided by certified Redirection programs. The rates for Redirection Services are incorporated into an inclusive rate similar to those approved for other states.
<input checked="" type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)	Clinic services are a component of comprehensive services provided by certified Redirection programs. The rates for Redirection Services are incorporated into an inclusive rate similar to those approved for other states.