UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 10-23048-CIV-UNGARO/Simonton

LUIS CRUZ and NIGEL DE LA TORRE,

Plaintiffs,

vs.

ELIZABETH DUDEK, in her official capacity as Secretary, Florida Agency for Health Care Administration, and

DR. ANA VIAMONTE ROS, in her official capacity as Surgeon General, Florida Department of Health ,

Defendants.

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STATEMENT OF INTEREST OF THE UNITED STATES OF AMERICA

The United States respectfully submits this Statement of Interest, pursuant to 28 U.S.C. § 517, because this litigation implicates the proper interpretation and application of the integration mandate of title II of the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12101, *et. seq*. *See Olmstead v. L.C.*, 527 U.S. 581 (1999).[1] The Attorney General has authority to enforce title II of the ADA, and pursuant to Congressional mandate, to issue regulations setting forth the forms of discrimination prohibited by Title II. 42 U.S.C § 12134. Accordingly, the United States has a strong interest in the resolution of this matter.

[1] 28 U.S.C. § 517 states that "[t]he Solicitor General, or any officer of the Department of Justice, may be sent by the Attorney General to any State or district in the United States to attend to the interests of the United States in a suit pending in a court of the United States, or in a court of a State, or to attend to any other interest of the United States."
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INTRODUCTION

This lawsuit alleges that defendants, the Secretary of the Florida Agency for Health Care Administration (AHCA) and the State Surgeon General (collectively, "defendants" or "the State") fail to provide sufficient community-based services so that Medicaid-eligible individuals with spinal cord injuries who are at risk of institutionalization may be served in the "most integrated setting appropriate to their needs."[2]

Plaintiffs Luis Cruz and Nigel De La Torre are Medicaid-eligible individuals with quadriplegia resulting from spinal cord injuries. As a result of their disabilities, they require assistance with many activities of daily living. Both men are able to—and desire to continue to—live in their own homes with adequate support services, but the services they currently receive through the State's Medicaid program are far from adequate to meet their needs. As a result, Mr. Cruz and Mr. De La Torre are at risk of being needlessly institutionalized.

Providing services to the plaintiffs in the community is a reasonable modification of the State's Medicaid program. Defendants acknowledge that it is generally less costly to provide services to individuals with spinal cord injuries in the community rather than in a nursing home. Nonetheless, the State refuses to provide community-based, Medicaid-funded services to the plaintiffs, unless they first enter an institution.

The State's failure to provide adequate community-based services to qualified individuals

[2] This lawsuit is related to *Jones v. Arnold*, No. 09-cv-1170, a proposed class action pending in the Jacksonville Division of the U.S. District Court for the Middle District of Florida. On January 27, 2010, plaintiff filed a motion to add Mr. Cruz and Mr. De La Torre as named plaintiffs in the *Jones* action. On August 13, 2010, the motion to amend was denied without prejudice because of a pending motion to dismiss. In light of an order in the *Jones* action, holding that an unnamed class member in an uncertified class does not have standing to seek preliminary injunctive relief, a motion for preliminary injunctive relief was filed in a separate action in the Middle District on August 18, 2010 on behalf of Mr. Cruz and Mr. De La Torre. *Cruz, et al. v. Arnold, et al.*, No. 10-725 (M.D. Fla.). On August 23, that action was transferred to this Court.

who are at risk of institutionalization and its practice of conditioning such services on entrance into a nursing home violates the ADA and the Rehabilitation Act. The facts alleged in plaintiffs' complaint, as well as in their declarations in support of their motion for preliminary injunction, demonstrate a likelihood of success on the merits of their claims. Furthermore, their allegations meet the additional requirements for a preliminary injunction: plaintiffs' placements in an institutional setting will cause irreparable harm, the balance of equities weighs in their favor, and granting this injunction is in the public interest.

Statutory and Regulatory Background

Congress enacted the ADA "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1). It found that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2). For those reasons, Congress prohibited discrimination against individuals with disabilities by public entities:

> [N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132.[3]

One form of discrimination prohibited by the ADA is a violation of the "integration mandate." The integration mandate arises out of Congress's explicit findings in the ADA, the

[3] Section 504 of the Rehabilitation Act of 1973 similarly prohibits disability-based discrimination. 29 U.S.C. § 794(a) ("No otherwise qualified individual with a disability … shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance").

regulations of the Attorney General implementing title II,[4] and the Supreme Court decision *Olmstead v. L.C.*, 527 U.S. 581, 586 (1999). In *Olmstead*, the Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity. *Id*. at 607.

FACTUAL BACKGROUND

The Medicaid program is a medical assistance program cooperatively funded by the federal and state governments. State participation in Medicaid is voluntary, but once a state elects to participate in the Medicaid program, it is required to administer the Medicaid program in accordance with all federal laws, including the ADA and the Rehabilitation Act.

Pursuant to provisions of the Medicaid Act, Florida administers the Traumatic Brain Injury/Spinal Cord Injury ("TBI/SCI") waiver program, which reimburses participants' costs for a range of home-based services provided to Medicaid recipients. *See* 42 U.S.C. § 1396(c).[5] The TBI/SCI waiver, which was approved by the federal government's Centers for Medicare and Medicaid Services ("CMS") in 2002, caps the number of persons eligible to receive community-based services at 375 people through 2012. *See Brain and Spinal Cord Injury Program*, http://www.doh.state.fl.us/demo/BrainSC/Medicaid/providers.html (last visited 9/9/2010)

[4] The regulations provide that "a public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified persons with disabilities." 28 C.F.R. §§ 35.150(d), 41.51(d). The preamble discussion of the ADA "integration regulation" explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. § 35.130(d), App. A.

[5] Waiver programs allow states to provide home and community based services to individuals with disabilities who would otherwise require the level of care provided in institutions such as nursing homes.

(attached hereto as Exhibit 1). Despite the substantial waiting list for these services,[6] defendants have not sought to expand the program.[7] They have, however, recently submitted an amendment to CMS to set aside 45 slots in the program exclusively for persons in nursing homes. (*See* Letter from Florida Deputy Secretary for Medicaid to CMS, dated Feb. 23, 2010 (attached hereto as Exhibit 3).) If the amendment were approved, the waiver program would be capped at 330 slots for persons who, like plaintiffs, are at risk of institutionalization. Nonetheless, at the end of fiscal year 2008-2009, 66 slots in the waiver program were vacant.[8] (Affidavit of Susan Michele Morgan, dated Sept. 8, 2010, ECF No. 35-1 ("Morgan Aff.") ¶ 14.)

The State acknowledges that it is generally less costly to provide community-based services than it is to provide services in a nursing home. (Morgan Aff. ¶ 15 ("In most cases, when a Medicaid recipient is diverted or transitioned from a nursing facility to an HCBS waiver program, costs to Medicaid for providing care to that individual are reduced.").) The average per capita rate at which Medicaid reimburses nursing homes for Medicaid services is $209.20 per day, or roughly $6,276.00 per month. (*See* AHCA Nursing Home Rates, http://ahca.myflorida.com/medicaid/cost_reim/nh_rates.shtml (attached hereto as Exhibit 5).) In

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[6] A January 2010 report reflected that, as of December 2009, 605 individuals were on the wait list for the TBI/SCI Waiver Program. *See* "Profile of Florida's Medicaid Home and Community-Based Services Waivers, Florida Legislature Office of Program Policy Analysis & Government Accountability," Report No. 10-10, January 2010, at 11 (attached hereto as Exhibit 2).

[7] States can submit requests for approval to CMS to increase the number of individuals to be served under a particular waiver. 42 C.F.R. § 441.355. Such requests are regularly granted by CMS. *See Knowles v. Horn*, No. 08-CV-1492, 2010 WL 517591 at*4 (N.D. Tex., Feb. 10, 2010) (citing *Grooms v. Maram*, 563 F. Supp. 2d 840, 857 (N.D. Ill. 2008).

[8] Defendants also deliver personal care assistance services to Florida residents through the Assistive Care Services ("ACS") program, an optional service funded through Medicaid. Defendants, however, restrict eligibility for these services to Medicaid-eligible individuals who live in assisted living facilities, qualified residential treatment facilities, or adult family-care homes. (*See* AHCA, Assisted Care Services, *available at*: http://ahca.myflorida.com/medicaid/asc/index.shtml.) (attached hereto as Exhibit 4). This restriction in the ACS program effectively eliminates the personal care option as a service option for individuals like Mr. Cruz and Mr. De La Torre, who currently reside in the community.

contrast, the State reported that the average monthly per capita cost of services in the TBI/SCI waiver program during fiscal year 2008-2009 was $2,361.47. (*See Profile of Florida's HCBS Waivers*, Report No. 10-10, *supra* n. 6, at 11.)

Mr. Cruz, a 52 year-old man, has quadriplegia as a result of a car accident in 1992. (Declaration of Luis J. Cruz, ECF No. 3, ("Cruz Decl.") ¶¶ 2, 5.) For nearly five years after the accident, he lived in institutions, where he experienced severe clinical depression. (Id. ¶ 9.) However, for the past twelve years, Mr. Cruz has lived alone in an accessible apartment. (Id. ¶ 4.) He requires assistance with all of his activities of daily living, (id. ¶ 6), and defendants currently provide limited Medicaid-funded support services. (Id. ¶¶ 19-20.) Those services are, however, insufficient to meet his daily needs. (Id.)

Mr. Cruz applied for services in the TBI/SCI waiver program in January 2006, but was placed on a waiting list, and has not yet received any services through the program. (Id. ¶¶ 8, 30.) Without adequate services, Mr. Cruz has fallen out of his wheelchair and has had to lie on the floor for hours at a time. (Id. ¶¶ 22-23.) He has also urinated on himself, slept on the bathroom floor, and slept upright in his wheelchair when no one was available to assist him. (Id. ¶¶ 23-24.) If Mr. Cruz's needs continue to go unmet, he will have to enter a nursing home in order to receive necessary services. Indeed, he has been hospitalized several times since January 2010. (Id. ¶¶ 12-14.)

Despite his physical limitations, Mr. Cruz is active in his community, including volunteering for the local park and recreation program and socializing with friends. (Id. ¶ 25-29.) He wants to remain living in his community so that he can continue participating in these activities. (Id. ¶ 25.) If forced to enter a nursing home to receive necessary services, he will have to relinquish the benefits that accompany community living.

Mr. De La Torre is a 27 year-old man with quadriplegia resulting from a gunshot wound he incurred in 2007 while he was being robbed. (Declaration of Nigel De La Torre, ECF No. 4 ("De La Torre Decl.") ¶¶ 2, 3.) As a result of his disability, Mr. De La Torre requires help with his activities of daily living. (Id. ¶ 20.) He currently receives limited support services for one hour in the morning and one hour in the evening from a personal assistant provided through the State Medicaid plan. (Id. ¶ 26.) These limited services, however, are inadequate to meet his needs, and he has suffered toileting accidents or missed meals because no one is available to assist him. (Id. ¶¶ 27-29.) Mr. De La Torre applied for services in the TBI/SCI waiver program in October 2007, but he remains on the waiting list and has not yet received any services under the waiver. (Id. ¶¶ 5-6, 36-37.)

Since his injury, Mr. De La Torre's mother, who has a full-time job outside the home, has assisted with activities of daily living such as transferring Mr. De La Torre to and from his bed and wheelchair, turning him during the night, and catheterization. (Id. ¶ 13-5.) She has injured her back and elbow as a result of doing so, however, and she plans to move permanently to Spain in the near future.[9] (Id. ¶¶ 15, 17; Declaration of Alejandrina Padro, ECF No. 5 ¶ 7.) Because the services provided through the State's Medicaid program are insufficient to meet his needs, Mr. De La Torre will be forced to enter a nursing home upon the changes in his caregiver circumstances.

Mr. De La Torre enjoys the benefits of living in the community, such as going to the movies, mall, and visiting with friends. (De La Torre Decl. ¶¶ 30-31.) He wants to remain living in his community so that he can continue participating in these activities. (Id. ¶ 32.) If

[9] Mr. De La Torre's brother may be able to provide assistance temporarily, but he has enlisted in the U.S. Marine Corps and plans to leave the Miami area in the near future. (Padro Decl. ¶ 8.)

forced to enter a nursing home to receive necessary services, he will be forced to relinquish the benefits that accompany community living. (Id. ¶¶ 32-33, 35, 39.)

ARGUMENT

Plaintiffs satisfy the requirements for a preliminary injunction. To obtain a preliminary injunction, the moving party must show (1) substantial likelihood of success on the merits, (2) substantial likelihood of irreparable harm, (3) that the balance of equities favors granting the injunction and (4) that the public interest would not be harmed by the injunction. *Horton v. St. Augustine*, 272 F.3d 1318, 1326 (11th Cir. 2001) (citing *Siegel v. LePore*, 234 F.3d 1163, 1176 (11th Cir. 2000).

The decision whether or not to issue a preliminary injunction lies within the sound discretion of the trial court. *Charles H. Wesley Educ. Foundation, Inc.* v. *Cox*, 408 F.3d 1349, 1354 (11th Cir. 2005). The determination of whether preliminary injunctive relief is necessary hinges not on the specific nature of the relief, but on whether such relief is necessary to prevent irreparable harm so as to preserve the court's ability to render a meaningful decision. *Canal Authority v. Callaway*, 489 F. 2d 567, 573, 576 (5th Cir. (Fla.) 1974); *Cox*, 408 F.3d at 1351 (affirming preliminary injunction in a voting rights acts case requiring defendants to process voter registration applications).[10] Here, preliminary injunctive relief is necessary to prevent the

[10] *See also Haddad v. Arnold*, No. 3:10-cv-00414-MMH-TEM (M.D. Fla. June 23, 2010) (issuing preliminary injunction requiring defendants to provide community-based services to plaintiff); *Gresham* v. *Windrush Partners, Ltd.*, 730 F.2d 1417, 1425 (11th Cir. 1984) (issuing preliminary injunction requiring defendants to display notices and instruct employees and agents of nondiscrimination policies and finding that "when housing discrimination is shown it is reasonable to presume that irreparable injury flows from the discrimination"); *Rogers* v. *Windmill Point Vill. Club Assoc., Inc.*, 967 F.2d 525, 528 (11th Cir. 1992); *Long* v. *Benson*, No. 08cv26, 2008 WL 4571903 *2 (N.D. Fla. Oct. 14, 2008) (granting preliminary injunction requiring Florida to provide Medicaid coverage for nursing services because irreparable injury would result if plaintiff were forced to enter a nursing home); *Katie A.* v. *Bonta*, 433 F. Supp. 2d 1065 (C.D. Cal. 2006) (granting a mandatory preliminary injunction requiring the state to

irreparable harm of needless institutionalization caused by defendants' failure to provide services in the most integrated setting appropriate to the plaintiffs' needs.

A. Plaintiffs Are Likely to Succeed on the Merits of Their Claims

To establish a violation of Title II of the ADA, a plaintiff must prove that he or she (1) is a "qualified individual with a disability;" (2) was either excluded from participation in or denied the benefits of a public entity's services, programs, or activities or was otherwise discriminated against by the public entity; and (3) such exclusion, denial of benefits, or discrimination was by reason of his disability. *See Raines v. Florida*, 983 F. Supp. 1362, 1371 (N.D. Fla. 1997).[11]

A plaintiff need not wait until he is institutionalized to pursue a claim for violation of the integration mandate. The risk of institutionalization itself is sufficient to demonstrate a violation of Title II. *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175 (10th Cir. 2003). In *Fisher*, the Tenth Circuit rejected defendants' argument that plaintiffs could not make an integration mandate challenge until they were placed in the institutions. The Court reasoned that the protections of the integration mandate "would be meaningless if plaintiffs were required to segregate themselves by entering an institution before they could challenge an allegedly discriminatory law or policy that threatens to force them into segregated isolation." *Id*. at 1181. *See also Haddad v. Arnold*, No. 3:10-cv-00414-MMH-TEM (M.D. Fla. July 9, 2010), ECF No. 46 (attached as Exhibit B to Pls.' Notice of Filing Cited Authority, dated Sept. 9, 2010, ECF. No

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provide support services to class of children with mental health needs who faced irreparable injury due to unnecessary institutionalization) (rev'd and remanded, 481 F. 3d 1150 (9th Cir. 2007) (finding proper standard for a mandatory preliminary injunction was applied, but reversing and remanding on other grounds). *Community Services, Inc.* v. *Heidelberg*, 439 F. Supp. 2d 380, 400-401 (M.D. Pa. 2006) (entering preliminary injunction ordering defendants to issue permits for plaintiff to utilize property as long term structured residence for individuals with mental illness).

[11] Claims under the ADA and the Rehabilitation Act are treated identically unless one of the differences in the two statutes is pertinent to a claim. *Allmond v. Akal Sec., Inc.*, 558 F.3d 1312, 1316 n.3 (11th Cir. 2009); *Henrietta D. v. Bloomberg*, 331 F.3d 261, 272 (2d Cir. 2003).

29-2) (hereinafter "*Haddad* Op.") (granting preliminary injunction to plaintiff at risk of institutionalization); *Marlo M. v. Cansler*, 679 F. Supp. 2d 635, 637 (E.D.N.C. 2010) (granting preliminary injunction in case where plaintiffs were at risk of institutionalization).[12]

1. Plaintiffs Are Qualified Individuals with Disabilities Who Meet the Essential Eligibility Criteria of the State's Medicaid Program

Mr. Cruz and Mr. De La Torre are individuals with disabilities who are eligible to receive services in Florida's Medicaid program. They desire to and are able to live in their own homes with adequate support services, but because of the way the State administers its Medicaid program, they are at risk of institutionalization. Mr. De La Torre will soon lose the assistance of his caregiver, and without additional community-based services in the State's Medicaid program, he will have to enter a nursing home to receive the services he needs to survive. Similarly, Mr. Cruz is also at risk of institutionalization. Without adequate services in the State's Medicaid program, he has undergone repeated hospitalizations in recent months.

Defendants do not dispute that the plaintiffs are qualified persons with disabilities who want to and are able to receive community-based services through the State's Medicaid program. Nor do they dispute that plaintiffs are at risk of institutionalization. Indeed, defendants are

[12] *See also Ball v. Rogers*, No. 00-67 (D. Ariz. April 24, 2009) (holding that defendants' failure to provide adequate services to avoid unnecessary institutionalization was discriminatory); *Makin v. Hawaii*, 114 F. Supp. 2d 1017, 1034 (D. Haw. 1999) (holding that individuals in the community on the waiting list for community-based services offered through the State's Medicaid program, could challenge administration of the program as violating Title II's integration mandate because it "could potentially force Plaintiffs into institutions"); *M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1309 (D. Utah 2003) (ADA's integration mandate applies equally to those individuals already institutionalized and to those at risk of institutionalization); *Crabtree v. Goetz*, No. 3:08-0939, 2008 WL 5330506, at *30 (M.D. Tenn. Dec. 19, 2008) (unpublished decision) ("Plaintiffs have demonstrated a strong likelihood of success on the merits of their [ADA] claims that the Defendants' drastic cuts of their home health care services will force their institutionalization in nursing homes."); *see also Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161,1164 (N.D. Cal. 2009); *Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980, 985 (N.D. Cal. 2010); and *V.L. v. Wagner*, 669 F. Supp. 2d 1106, 1109 (N.D. Cal. 2009) (all granting preliminary injunctions where plaintiffs were at risk of institutionalization due to cuts in community-based services).

requiring plaintiffs to submit to institutionalization to receive the same services they are qualified to receive in the community. Thus, plaintiffs are likely to succeed on the merits of their prima facie claim of discrimination.

2. Defendants Cannot Establish a Fundamental Alteration Defense

A state's obligation to provide services in the most integrated setting may be excused only where it can prove that the relief sought would result in a "fundamental alteration" of its service system. *Olmstead*, 527 U.S. at 601-03. Further, to invoke the fundamental alteration defense, a public entity must demonstrate that it has a "comprehensive, effectively working plan" in place to address unnecessary institutionalization.[13] *Olmstead*, 527 U.S. at 605-06; *Pa. Prot. & Advocacy, Inc. v. Pa. Dep't of Pub. Welfare*, 402 F.3d 374, 381-82 (3d Cir. 2005).

Defendants cannot show that providing community-based services to the plaintiffs would be a fundamental alteration of their Medicaid program. First, they do not have a comprehensive, effectively working plan in place to address unnecessary institutionalization. Defendants' cite to the expansion of other waiver programs, (Defs.' Opp. at 24-25), but they fail to demonstrate any expansion or effectiveness of the TBI/SCI waiver program. *See Haddad* Op. at 34 (finding that evidence of expansion of other waiver programs does not address the effectiveness of the

[13] Defendants' argument that they need not have a plan to address unnecessary institutionalization because the "portion of the *Olmstead* opinion describing such plans is not part of the majority's opinion" is without merit. Defs.' Opp. to Pls.' Mot. for Prelim. Injun., ECF No. 36 ("Defs.' Opp."), at 23. While the portion of Justice Ginsburg's opinion addressing the state's fundamental alteration defense garnered only four votes, it controls because it relied on narrower grounds than did the concurrences of Justices Stevens and Kennedy. *Arc of Washington State, Inc. v. Braddock*, 427 F.3d 615, 617 (9th Cir. 2005) (quoting *Sanchez v. Johnson*, 416 F.3d 1051, 1064 n.7 (9th Cir. 2005). Indeed, defendants' argument was rejected by the U.S. District Court for the Middle District of Florida in the related case, *Haddad v. Arnold*. *See Haddad* Op. at 19 n.12 and 33 (finding that Justice Ginsburg's opinion controls and that defendants did not establish a fundamental alteration defense because they "failed to show that they have a comprehensive, effectively working plan in place to address unnecessary institutionalization."); *see also Frederick L. v. Dept. of Public Welfare*, 422 F.3d 151, 157 (3d Cir. 2005) (a comprehensive, effectively working plan is a necessary component of a successful fundamental alteration defense).

TBI/SCI Waiver program). Indeed, with respect to the TBI/SCI waiver program, defendants have sought to limit the number of slots available to persons at risk of institutionalization, and only 309 of the 375 approved slots are occupied. *See* Exhibit 1 hereto; Morgan Aff. ¶ 14. While defendants identify plaintiffs' "prioritization scores," they fail to provide any information concerning the average length of time on the waiting list, the rate of turnover, or when, if ever, plaintiffs and the many others on the wait list at risk of institutionalization can expect to move off the wait list. Instead, defendants' opposition papers confirm that no one else will be moved off the waiting list unless they first submit to institutionalization. Thus, the information provided by defendants only serves to underscore that they have no plan or commitment to avoid unnecessary institutionalization.

Second, defendants fail to show that the requested relief would fundamentally alter their program or affect their ability to provide services to others with disabilities. They provide no support for their argument that placing plaintiffs in the TBI/SCI waiver program would reduce the availability of services to others on the wait list with higher "prioritization scores" or others in the waiver program. Indeed, the evidence shows otherwise. As the State acknowledges, it generally saves money when a Medicaid recipient is served in a home and community-based services waiver program rather than a nursing home. *See* Morgan Aff. ¶ 15. While the average per capita rate at which Medicaid reimburses Florida nursing homes for Medicaid services is roughly $6,276.00 per month, the average monthly per capita cost of services in the TBI/SCI waiver program during fiscal year 2008-2009 was $2,361.47. *See* p. 6, *supra*. As the court noted in *Haddad*, "for budgeting purposes, Defendants assume a two-to-one savings for those diverted from nursing homes." *Haddad* Op. at 12; *see also* Morgan Aff. ¶ 16.

Defendants do not dispute that it costs less to provide community-based services. Instead, they argue that the costs of institutional and community-based services cannot be compared because they are independently funded by the legislature, and defendants have no authority themselves to transfer funds from one funding source to another. This argument is without merit. Defendants cannot carve out from the fundamental alteration analysis particular monies the State spends on services for persons with spinal cord injuries. The relevant resources for purposes of evaluating a fundamental alteration defense in this context consist of all money the State receives, allots or spends to provide services to persons with spinal cord injuries. *See Disability Advocates, Inc. v. Paterson*, 598 F. Supp. 2d 289, 350 (E.D.N.Y. 2009) (rejecting state's argument that relevant budget was solely the budget of one state agency, when other agencies and programs also spent money on services to persons with disabilities).

Nor can defendants hide behind state budgetary processes to avoid compliance with federal anti-discrimination law. *See, e.g., Assoc'n of Surrogates and Supreme Court Rep'trs v. State of New York*, 966 F.2d 75, 79 (2d Cir. 1992) ("[S]tate budgetary processes may not trump court-ordered measures necessary to undo a federal constitutional violation…."); *Haddad* Op. at 32-33 ("[T]o the extent Defendants' refusal to provide services is based on its financial structure, the Court notes that budgetary constraints, taken alone, are not enough to establish a fundamental alteration defense.") (quoting *Pa. Prot. & Advocacy, Inc. v. Pa. Dep't of Public Welfare*, 402 F.3d 374, 381 (3d Cir. 2005)).[14] In sum, defendants have provided no support for their assertion that providing services to the plaintiffs in the community instead of an institution would work a fundamental alteration.

[14] *Cf. Biggs v. Wilson*, 1 F.3d 1537, 1543 (9th Cir. 1993) (rejecting state's argument that Tenth Amendment preempts Fair Labor Standards Act ("FLSA") and finding that non-compliance with FLSA is not excused by state budgetary processes).

3. Defendants' Interpretation of Federal Law is Unfounded

Defendants argue that the relief requested pursuant to the ADA and the Rehabilitation Act is inconsistent with other federal laws. First, they assert that the ADA's Personal Devices and Services Regulation, 28 C.F.R. § 35.135, exempts Florida from having to provide "services of a personal nature." (Defs.' Opp. at 15-16.) This argument was explicitly rejected by the court in the *Haddad* action. *Haddad* Op. at 27 ("Defendants' argument misses the mark. The ADA does not require states to provide a level of care or specific services, but once states choose to provide certain services, they must do so in a nondiscriminatory fashion.").

The regulation merely establishes that Title II does not require a state to provide personal services where such services are *not "customarily provided." See* U.S. Dept. of Justice, ADA Title II Technical Assistance Manual § II-3.6200. Indeed, courts that have held that §35.135 imposes any limits on a state's duty to provide reasonable accommodations have only done so, as the Department's interpretation contemplates, where such devices or services are not "customarily provided." *See, e.g.*, *McCauley v. Winegarden*, 60 F.3d 766, 767 (11th Cir. 1995) ("environmental filtering" device in a courtroom); *Kerry M. v. Manhattan School Dist. #114*, 2006 WL 2862118, at *10 (N.D. Ill. 2006) (collapsible wheelchair in school district's bus service); *Blatch ex rel. Clay v. Hernandez*, 360 F. Supp. 2d 595, 630 (S.D.N.Y. 2005) (expert representatives in tenancy termination proceedings); *Rivera v. Delta Air Lines, Inc.*, 1997 WL 634500, at *1-2 (E.D. Pa. 1997) (wheelchair to board airplane); *Adelman v. Dunmire*, 1996 WL 107853, *3 (E.D. Pa. 1996) (wheelchair in courtroom).[15] Thus, where, as here, the services

[15] Other courts have interpreted § 35.135 narrowly. For example, in *A.P. ex rel. Peterson v. Anoka-Hennepin Indep. School Dist. No. 11*, 538 F. Supp. 2d 1125, 1152-53 (D. Minn. 2008), the court held that § 35.135 does not bar a diabetic child's parents from requesting that school district staff be trained and authorized to provide glucagon injections to the child. Similarly, in *Purcell v. Pennsylvania Department of Corrections*, 1998 WL 10236, at *9 (E.D. Pa. 1998), the court rejected the state's argument that it was not required under the ADA to provide a plastic

sought by plaintiffs are customarily provided in the institutional setting into which they will be relegated absent a reasonable modification of the defendants' waiver admission policies, the limitation expressed by 28 C.F.R. § 35.135 has no bearing.

Second, defendants argue that providing community-based services to the plaintiffs would require this Court "invalidate," "amend" or "repeal" the Medicaid Act. This argument was also explicitly rejected by the court in *Haddad* as "unavailing." *Haddad* Op. at 28. A determination that plaintiffs should be provided services to avoid institutionalization does not require a finding that states cannot cap enrollment in waiver programs or that they must provide personal care services as a mandatory (as opposed to optional) Medicaid service.[16] Instead, it entails a finding that because defendants have elected to provide personal care services, they must administer those services in accordance with the ADA.[17] As the court in *Haddad* correctly held:

> A state that chooses to provide optional services cannot defend against the discriminatory administration of those services simply because the state was not initially required to provide them. Indeed, Defendants have provided no authority for the proposition that a state that chooses to provide Medicaid services, even if otherwise optional, would not be required to comply with the ADA in the provision of those services, just as it would have to comply with the ADA for any other 'services, programs, or activities' provided by a public entity.

Haddad Op. at 28.

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chair for support in shower to accommodate plaintiff's joint disease.

[16] Defendants' argument is particularly nonsensical given that the TBI/SCI program is not operating at full capacity. Thus, they would not need to "uncap" the program to provide services to the plaintiffs.

[17] As CMS has indicated in technical assistance to the states, the mere fact that a state is permitted to "cap" the number of individuals it serves on a particular waiver under the Medicaid Act does not by itself determine whether a requested modification would result in a fundamental alteration under the ADA. See CMS, Olmstead Update No. 4, at 4 (Jan. 10, 2001), available at http://www.cms.hhs.gov/smdl/downloads/smd011001a.pdf ("If other laws (e.g., ADA) require the State to serve more people, the State may…request an increase in the number of people permitted under the HCBS Waiver.") (Attached hereto as Exhibit 6).

Finally, defendants argue that their practice of requiring individuals to undergo institutionalization prior to receiving community-based services for which they are qualified has been sanctioned by Congress, because Congress has authorized grants to states for programs designed to transition into the community individuals who have been institutionalized for more than 90 days. Defendants' argument mischaracterizes the purpose of the grant program. The program, called the Money Follows the Person Rebalancing Demonstration, was "designed to provide assistance to States to balance their long-term care systems and help Medicaid enrollees transition from institutions to the community" and "reflects a growing consensus that long-term supports must be transformed from being institutionally-based and provider-driven to 'person-centered' consumer directed and community-based." *See Money Follows the Person Rebalancing Grant Demonstration Program,* Initial Announcement and Invitation to Apply, July 26, 2010 at 5 (attached as Exhibit A to Affidavit of Elizabeth Y. Kidder, dated Sept. 9, 2010, ECF No. 33-1). It simply does not follow, as defendants argue, that Congress intended the program to be used to drive individuals *into* institutional settings. Defendants' interpretation of the program as "incentivizing" states to redirect individuals who already reside in the community to institutions for the purposes of increasing available community-based funds is contrary to Congress's express purpose in authorizing the program.[18]

B. Plaintiffs Will Suffer Irreparable Harm if an Injunction is not Issued

As many courts have held, requiring an individual to submit to unnecessary institutionalization in order to receive state services—even temporarily—results in irreparable

[18] Deficit Reduction Act Section 6071, Pub. L. No. 109-171 (purpose of the program is to "increase the use of home-and-community-based [services]" and "eliminate barriers or mechanisms that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals" to receive HCBS Services).)

harm. *See Marlo M.*, 679 F. Supp. 2d at 638 (finding irreparable harm even if institutionalization were only temporary and recognizing the "regressive consequences" that such placements would have on the individuals); *Crabtree v. Goetz*, No. 08-0939, 2008 WL 5330506 *25 (M.D. Tenn. Dec. 19, 2008) (finding that unnecessary institutionalization "would be detrimental to [plaintiffs'] care, causing, inter alia, mental depression, and for some Plaintiffs, a shorter life expectancy or death"); *Long v. Benson*, No. 08cv26, 2008 WL 4571903 *2 (N.D. Fla. Oct. 14, 2008) (finding irreparable harm where individual would be forced to leave his community placement and enter a nursing home and specifically recognizing the "enormous psychological blow" that such placements would cause due to the " very substantial difference in [plaintiff's] perceived quality of life in the apartment as compared to the nursing home, each day he is required to live in the nursing home").

The *Olmstead* Court itself recognized the harm that results from unnecessary institutionalization. Specifically, the Court recognized that needless institutionalization perpetuates "unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life" and that severing individuals from their communities "severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Olmstead*, 527 U.S. at 600-01. Should plaintiffs be required to enter a nursing home to receive services, they will sacrifice these exact benefits of community integration. They will be forced to sever ties to their communities and lose the independence and freedom they now enjoy in their daily lives.[19]

[19] Additionally, given Mr. Cruz's prior experiences in institutions, it is certain that he would become depressed if he was forced out of the community placement he has been living in for 12 years. (Cruz Decl. ¶9.). In addition to the physical and emotional harms of institutional

C. The Balance of Hardships Tips in Plaintiffs' Favor

The hardship to defendants of providing services to plaintiffs in a community setting under the waiver program is negligible and is clearly outweighed by the benefit of allowing plaintiffs to remain in their homes. *Long*, 2008 WL 4571903 at *3 (N.D. Fla. Oct. 14, 2008) ("If, as it ultimately turns out, treating individuals like [the plaintiff] in the community would require a fundamental alteration of the Medicaid program, so that the Secretary prevails in this litigation, little harm will have been done. To the contrary, [plaintiff's] life will have been better, at least for a time."). Allowing Messrs. Cruz and De La Torre to receive community-based services without first entering a nursing home will *save* defendants and its Medicaid program money because it will cost less than placing them in a nursing home. *See* pp. 12-14 *supra*. The lack of hardship to defendant stands in stark contrast to the significant hardship the plaintiffs face if no injunction is granted.

D. Granting a Preliminary Injunction is in the Public Interest

There is a strong public interest allowing plaintiffs to remain in their homes and in eliminating the discriminatory effects that arise from segregating persons with disabilities into institutions when they can be appropriately placed in community settings. As the *Olmstead* Court explained, the unjustified segregation of persons with disabilities stigmatizes them as incapable or unworthy of participating in community life. *Olmstead*, 527 U.S. at 600.

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placements, it is likely that Mr. Cruz would lose his current housing if he was forced to move into the nursing home. Affordable, accessible housing is scarce, and it is very likely that if he loses his apartment, he would have significant challenges in finding another apartment after the nursing home. *Marlo M.*, 679 F.Supp. 2d at 638 (recognizing that if plaintiff were "removed during the pendency of the lawsuit and prevail, there is no indication the [accessible] apartment or a similar one will be available for her.").

See also Haddad Opinion at 38("[T]he public interest favors preventing the discrimination that faces Plaintiff so that she may avoid unnecessary institutionalization … [and] upholding the law and having the mandates of the ADA and Rehabilitation Act enforced….").

The public also has an interest "in protecting its pocketbook." *Florida Wildlife Fed'n v. Goldschmidt*, 506 F.Supp. 350, 373 (C.D. Fla. 1981). As noted above, it is less costly to provide community-based services than it is to provide services in a nursing home. The public interest favors a preliminary injunction where such a fiscal loss would otherwise result.

Conclusion

The Court should grant Plaintiffs' Motion for Preliminary Injunction. Plaintiffs have demonstrated that the Complaint satisfies all the requirements for this Court to grant a preliminary injunction, and as such, the Court has authority to grant plaintiffs the relief that they seek in this matter.

Dated: September 14, 2010

Respectfully submitted,

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Certificate of Service

I hereby certify that on September 14, 2010, I electronically filed the foregoing document with the Clerk of Court using CM/ECF. I also certify that the foregoing document is being served this day on all counsel of record or pro se parties identified on the attached Service List in the manner specified, either via transmission of Notices of Electronic Filing generated by CM/ECF or in some other authorized manner for those counsel or parties who are not authorized to receive electronically Notices of Electronic Filing.

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Case No. 10-23048-Civ—Ungaro/Simonton
United States District Court, Southern District of Florida

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Exhibit 1

floridashealth.com

BRAIN AND SPINAL CORD INJURY PROGRAM

Medicaid Waiver Providers

This is a small waiver with Federal approval for 375 clients statewide. Provider services are rendered based upon client choice, taken from an approved list of Medicaid Waiver providers.

All Medicaid WAIVER providers are required to comply with specific enrollment and Waiver requirements unique to this Waiver. Some important facts to consider when applying for this Waiver:

- You are required to enter your information upon approval, into MyFlorida Marketplace the same way you were enrolled in Florida Medicaid.
- You are required to return your Medicaid Referral Agreement (pdf 54.79kb/6 pages) completed in full.
- This waiver does not direct bill. Your invoice and required service documentation is submitted to the BSCIP Billing Office. The Department of Health will pay the provider and then submit the claims to Medicaid for reimbursement.
- If you are already a Medicaid Waiver provider for another waiver, then you do NOT need a complete application. [See below for instructions on how to proceed].
- At the time of enrollment, all individual providers are required to hand write a note describing familiarity and experience in working with this population.
- At the time of enrollment, all providers must show proof of valid credentials as a requirement of the service(s) you believe you are qualified to provide.
- 59G-13.130 Traumatic Brain and Spinal Cord Injury Waiver Services

Core Services

All documents are PDF files less than 3mb and less than 20 pages. All open in a new window.

Prior to authorizing Medicaid Waiver services, community support coordinators and Medicaid Waiver Specialists are required to seek services through Medicaid, Medicare and all other resources. The Medicaid Waiver

must be the provider of last resort.

Adaptive Health and Wellness	Consumable Medical Supplies
Attendant Care	Environmental Accessibility Adaptations
Assistive Technologies and Equipment	Life Skills Training
Behavioral Programming	Personal Care Services
Companion Services	Personal Adjustment Counseling
Community Support Coordination	Rehabilitation Engineering Evaluation

How to Apply - Page 2

Exhibit 2

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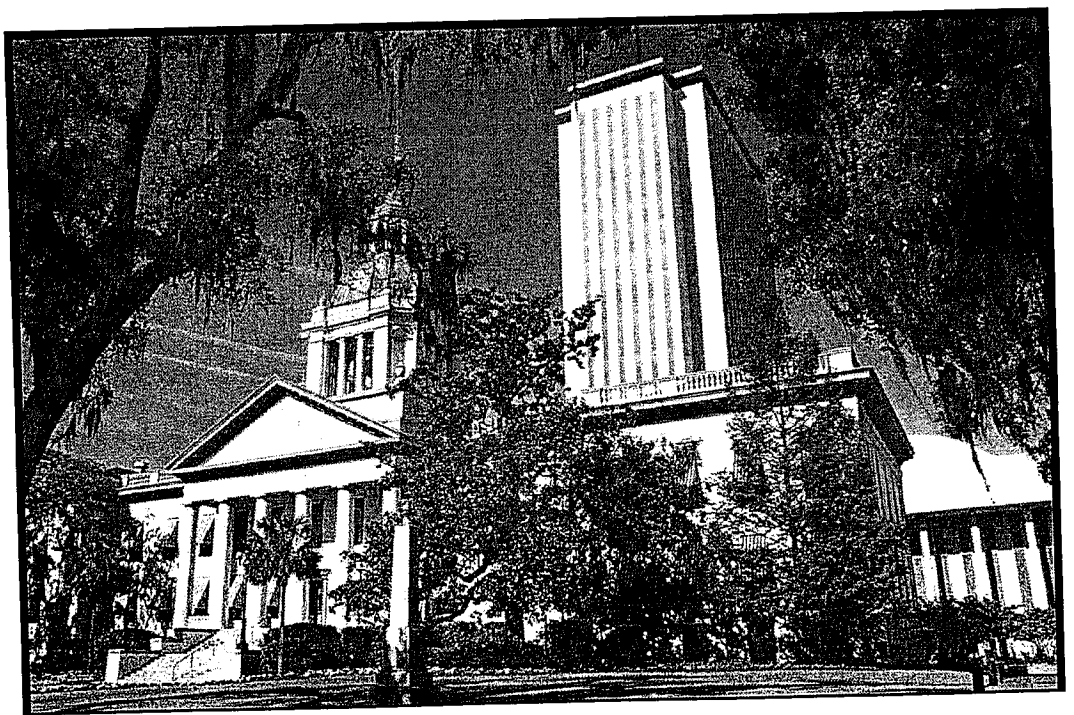
Profile of Florida's Medicaid Home and Community-Based Services Waivers

JANUARY 2010

Report No. 10-10



Office of Program Policy Analysis & Government Accountability
an office of the Florida Legislature

Profile of Florida's Medicaid Home and Community-Based Services Waivers

January 2010 Report No. 10-10

Introduction

OPPAGA produced this profile of Florida's Medicaid Home and Community-Based Services (HCBS) waivers as a resource for interested policy makers and stakeholders. The profile summarizes each of Florida's HCBS waivers by providing uniform information about each waiver (eligibility criteria, services provided, persons served, expenditures, etc.) that can help inform funding and policy. Each profile also identifies the state agency responsible for operating the waiver program; additional information about the waivers can be obtained from that agency.[1]

Medicaid HCBS waivers are authorized by Section 2176 of the Omnibus Budget Reconciliation Act of 1981 and incorporated into Title XIX of the Social Security Act as Section 1915(c). States can use this authority to offer a broad array of services not otherwise available through Medicaid that are intended to prevent or delay institutional placement. Florida's HCBS waivers vary on a number of dimensions. Some waivers are limited to persons with specific disease states or physical conditions (such as persons with traumatic brain and spinal cord injuries); others serve broader groups (such as persons who are elderly and/or have disabilities). Waivers also differ with respect to the number and types of services provided, payment method, and whether waiver services are available statewide or limited to a few counties.[2] In Fiscal Year 2009-10 the Legislature appropriated $1.45 billion to state agencies to serve beneficiaries in these 15 waivers.

Table of Contents

[1] Agencies with waiver responsibilities include the Agency for Health Care Administration, Agency for Persons with Disabilities, Department of Children and Families, Department of Elder Affairs, and the Department of Health.

[2] For example, 11 waivers can serve individuals in all 67 counties while the other 4 waivers serve beneficiaries in as few as two counties.

FLORIDA'S ELDER AND DISABLED MEDICAID HCBS WAIVERS

AGED AND DISABLED ADULT SERVICES

Counties Served
Statewide

Year Implemented
1982

Waiver Eligibility
Individual must
- be age 65 or older or age 18 to 64 and determined disabled by the Social Security Administration
- be Medicaid eligible
- meet Nursing Home Level of Care[1]
- reside in home

Services Provided
- adult companion
- adult day health care
- attendant care
- caregiver training
- case aide
- case management
- chore services
- consumable medical supplies
- counseling
- escort services
- financial assessment and risk reduction
- home-delivered meals
- home accessibility adaptations
- homemaker
- nutritional assessment and risk reduction
- personal care
- personal emergency response system
- pest control
- physical risk reduction
- rehabilitation engineering
- respite care
- skilled nursing
- specialized medical equipment and supplies
- therapies: occupational, physical, respiratory, speech

Operational Entity
Department of Elder Affairs (DOEA), ages 60 or older
Department of Children and Families (DCF), ages 18 to 59
Agency for Health Care Administration (AHCA), Aging Out program[2]

Enrollment and Waitlist[3]

	Total	DOEA	DCF	AHCA
Enrollment	9,656	8,712	904	40
Waitlist	10,986	7,254	3,732	None

Total Waiver Approved Enrollment
12,087

2009-10 Funding

DOEA	Total Appropriation $87,197,330.00	Federal Funds $58,980,274.01	State Funds $28,217,055.99
DCF	Total Appropriation $12,492,014.00	Federal Funds $8,449,599.00	State Funds $4,042,415.00
AHCA	Total Appropriation $13,799,141.00	Federal Funds $9,333,740.00	State Funds $4,465,401.00

2008-09 Average Monthly Cost per Beneficiary[4]

DOEA	Average Monthly Cost $757.54	FY 2008-09 Expenditures $70,416,322.67	FY 2008-09 Enrollee Months 92,954
DCF	Average Monthly Cost $1,053.19	FY 2008-09 Expenditures $9,170,097.08	FY 2008-09 Enrollee Months 8,707
AHCA	Average Monthly Cost $18,830.50	FY 2008-09 Expenditures $8,417,231.36	FY 2008-09 Enrollee Months 447

Type of Reimbursement
Fee-for-Service: Florida Medicaid approved rate or the provider's customary fee, whichever is lower.

[1] The Department of Elder Affairs determines that a beneficiary meets the medical and functional eligibility for Medicaid nursing home care.

[2] The Aging Out Program is for beneficiaries age 21 or older who no longer qualify to receive home-based medical services through the Department of Health's Children's Medical Services program and thus "age out" of Children's Medical Services.

[3] All enrollment and waitlist information is provided for Department of Children and Families and Agency for Healthcare Administration as of December 2009. All enrollment information is provided for Department of Elder Affairs as of September 2009 and waitlist information as of December 2009. Delays in moving beneficiaries from the waitlist to enrolled status are due to attrition, the availability and amount of services a beneficiary may need, and funding limits.

[4] Average monthly cost per beneficiary was calculated by dividing total Fiscal Year 2008-09 expenditures by total number of enrollee months.

ADULT DAY HEALTH CARE

Counties Served	Lee and Palm Beach counties		
Year Implemented	2004		
Waiver Eligibility	Individual must • be age 75 or older and live with a caregiver • be Medicaid eligible • meet Nursing Home Level of Care[1] • not reside in an institutional setting		
Services Provided	All services are provided within an Adult Day Health Care facility and include • assistance with daily living activities • case management • counseling • health care monitoring • intake and assessment • medical direction • medication management • nutritionally balanced meals/snacks • personal care assistance • therapeutic social and recreational activities • therapies: occupational, physical, speech • transportation		
Operational Entity	Department of Elder Affairs		
Enrollment and Waitlist[2]	Enrollment: 33 Waitlist: None		
Total Waiver-Approved Enrollment	150		
2009-10 Funding	Total Appropriation $1,946,858	Federal Funds $1,316,855	State Funds $630,003
2008-09 Average Monthly Cost per Beneficiary[3]	Average Monthly Cost $1,390.85	FY 2008-09 Expenditures $538,259.00	FY 2008-09 Enrollee Months 387
Type of Reimbursement	Contracted Negotiated Rate based on either a half-day or full-day stay.		

[1] The Department of Elder Affairs determines that a beneficiary meets the medical and functional eligibility for Medicaid nursing home care.

[2] All enrollment and waitlist information is provided as of December 2009.

[3] Average monthly cost per beneficiary was calculated by dividing total Fiscal Year 2008-09 expenditures by total number of enrollee months.

ASSISTED LIVING FOR THE ELDERLY

Counties Served	Statewide
Year Implemented	1995
Waiver Eligibility	Individual must • be age 65 or older or age 60 to 64 and be determined disabled by the Social Security Administration • be Medicaid eligible • meet Nursing Home Level of Care[1] • reside in an Assisted Living Facility • meet one or more of the following: a. require assistance with four or more activities of daily living (ADLs), three ADLs plus supervision or administration of medication, or total help with one or more ADLs[2] b. have a diagnosis of Alzheimer's or other dementia and need assistance with two or more ADLs c. have a diagnosed degenerative or chronic medical condition requiring nursing services that cannot be provided in a standard assisted living facility, but are available in an assisted living facility that is licensed for limited nursing or extended congregate care d. be a Medicaid-eligible beneficiary who meets assisted living facility criteria e. be awaiting discharge from a nursing facility and unable to return to a private residence because of a need for supervision, personal care, and/or periodic nursing services
Services Provided [3]	All services are provided within an Assisted Living Facility and include • case management • incontinence supplies • expanded Assisted Living services which may include the following: o attendant call system o attendant care o behavior management o chore services o companion services o homemaker o intermittent nursing o medication administration (within the assisted living facility license) o personal care o specialized medical equipment and supplies o therapeutic social and recreational activities o therapies: occupational, physical, speech
Operational Entity	Department of Elder Affairs
Enrollment and Waitlist [4]	Enrollment: 2,650 Waitlist: 329
Total Waiver-Approved Enrollment	5,630
2009-10 Funding	Total Appropriation: $35,165,608 Federal Funds: $23,786,017 State Funds: $11,379,591
2008-09 Average Monthly Cost per Beneficiary [5]	Average Monthly Cost: $838.54 FY 2008-09 Expenditures: $22,845,186.70 FY 2008-09 Enrollee Months: 27,244
Type of Reimbursement	Mixed: Medicaid reimburses for assisted living services at a daily rate and case management services at a monthly rate. Medicaid reimburses incontinence supplies separately, on a monthly basis, based on use.

[1] The Department of Elder Affairs determines that a beneficiary meets the medical and functional eligibility for Medicaid nursing home care.

[2] Examples of activities of daily living are cooking, cleaning, grooming, and bathing.

[3] This waiver is designed to provide extra support to frail elders residing in assisted living facilities in an effort to delay or prevent nursing facility admission.

[4] All enrollment information is provided as of September 2009 and waitlist information as of December 2009. Delays in moving beneficiaries from the waitlist to enrolled status are due to attrition, availability and amount of services a beneficiary may need, and funding limits.

[5] Average monthly cost per beneficiary was calculated by dividing total Fiscal Year 2008-09 expenditures by total number of enrollee months.

CHANNELING FOR THE FRAIL ELDER

Counties Served	Miami-Dade and Broward counties
Year Implemented	1985
Waiver Eligibility	Individual must • be age 65 or older • be Medicaid eligible • meet Nursing Home Level of Care[1] • have two or more unmet long-term care services needs • reside in home or with a caregiver in Miami-Dade or Broward counties • have a cost of care that does not exceed 85% of the Medicaid nursing home payment in Broward or Miami-Dade counties
Services Provided	• adult day health care • adult companion • case management • chore services • counseling (in-home) • environmental accessibility adaptations • family training • financial assessment and risk reduction • home health aide • personal care • personal emergency response system • respite care • skilled nursing • special drug and nutritional assessment services • special home delivered meals • special medical equipment and supplies • therapies: occupational, physical, speech
Operational Entity	Department of Elder Affairs
Enrollment and Waitlist[2]	Enrollment: 1,489 Waitlist: 67
Total Waiver-Approved Enrollment	1,825
2009-10 Funding	Total Appropriation: $14,700,762 Federal Funds: $9,943,596 State Funds: $4,757,166
2008-09 Average Monthly Cost per Beneficiary[3]	Average Monthly Cost: $1,039.22 FY 2008-09 Expenditures: $15,370,048.33 FY 2008-09 Enrollee Months: 14,790
Type of Reimbursement	Contracted negotiated per person daily rate with the Miami Jewish Home and Hospital in Miami-Dade and Broward counties.

[1] The Department of Elder Affairs determines that a beneficiary meets the medical and functional eligibility for Medicaid nursing home care.

[2] All enrollment and waitlist information is provided as of December 2009. Delays in moving beneficiaries from the waitlist to enrolled status are due to attrition, the availability and amount of services a beneficiary may need, and funding limits.

[3] Average monthly cost per beneficiary was calculated by dividing total Fiscal Year 2008-09 expenditures by total number of enrollee months.

NURSING HOME DIVERSION

Counties Served [1]	37 counties: Alachua, Brevard, Broward, Charlotte, Citrus, Clay, Collier, Duval, Escambia, Flagler, Hendry, Hernando, Highlands, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Miami-Dade, Nassau, Okaloosa, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Santa Rosa, Sarasota, Seminole, St. Johns, St. Lucie, Sumter, Volusia
Year Implemented	1998
Waiver Eligibility	Individual must • be age 65 or older • be Medicaid eligible • be Medicare Parts A and B eligible • meet Nursing Home Level of Care[2] • have two or more unmet long-term care services needs • reside in own home, in their caregiver's home, or in an Assisted Living Facility
Services Provided	*Acute Medical Services* • community mental health services • dental • hearing and visual services (optional) • independent laboratory and x ray • inpatient hospital • outpatient hospital/emergency • physicians • prescribed drugs *Long-Term Care Community Services* • adult companion • adult day health care • assisted living • case management • chore services • consumable medical supplies • environmental accessibility adaptations • escort services • family training *Long-Term Care Community Services (continued)* • financial assessment and risk reduction • home-delivered meals • home health care • homemaker • nutritional assessment and risk reduction • personal care • personal emergency response system • respite care • therapies: occupational, physical and speech • nursing facility services/long-term care • transportation (optional) Some plans offer additional **optional services** listed at: http://204.156.255.8/welcome/newsite/scbs/nhd_benefit_grid.html
Operational Entity	Department of Elder Affairs
Enrollment and Waitlist [3]	Enrollment: 16,500 Waitlist: None
Total Waiver-Approved Enrollment	14,925
2009-10 Funding[4]	Total Appropriation: $338,177,729 — Federal Funds: $228,743,416 — State Funds: $109,434,313
2008-09 Average Monthly Cost per Beneficiary [5]	Average Monthly Cost: $1,601.49 — FY 2008-09 Expenditures: $245,300,865.59 — FY 2008-09 Enrollee Months: 153,170
Type of Reimbursement	Capitated risk-adjusted monthly rate that varies by plan and county.[6]

[1] Nursing Home Diversion is authorized to expand to an additional 23 counties; however the waiver is not yet operational because no providers have contracted to provide services in those counties. The Department of Elder Affairs has requested approval from the Centers for Medicare and Medicaid Services to expand to the remaining seven counties.

[2] The Department of Elder Affairs determines that a beneficiary meets the medical and functional eligibility for Medicaid nursing home care.

[3] All enrollment and waitlist information is provided as of December 2009. In the absence of legislative authority to seek federal approval to increase waiver enrollment, the Department of Elder Affairs will reduce program enrollment to the approved level through natural attrition.

[4] The Nursing Home Diversion appropriation includes $10,278,683 for the Program of All-Inclusive Care for the Elderly.

[5] Average monthly cost per beneficiary was calculated by dividing total Fiscal Year 2008-09 expenditures by total number of enrollee months.

[6] The Department of Elder Affairs risk adjusts base rates using several factors including level of assistance needed with activities of daily living, instrumental activities of daily living, the presence of specific chronic conditions, and level of cognitive impairment.

FLORIDA'S DISEASE-SPECIFIC MEDICAID HCBS WAIVERS

ALZHEIMER'S DISEASE

Counties Served	Broward, Miami-Dade, Palm Beach, and Pinellas counties
Year Implemented	2005
Waiver Eligibility	Individual must • be age 60 or older • be Medicaid eligible • have a diagnosis of Alzheimer's Disease made or confirmed by a memory disorder clinic, a board certified neurologist, or a physician with experience in neurology[1] • meet Nursing Home Level of Care[2] • live with a caregiver in a private residence
Services Provided	• adult day health care • behavioral assessment and intervention • case management • caregiver training • environmental accessibility adaptations • incontinence supplies • personal care • pharmacy/medication review • respite care • wanderer alarm systems • wanderer identification and location programs A case manager authorizes services based on the beneficiaries' documented need.
Operational Entity	Department of Elder Affairs
Enrollment and Waitlist[3]	Enrollment: 273 Waitlist: 85
Total Waiver-Approved Enrollment	350
2009-10 Funding	Total Appropriation: $5,020,209 Federal Funds: $3,395,669 State Funds: $1,624,540
2008-09 Average Monthly Cost per Beneficiary[4]	Average Monthly Cost: $1,417.17 FY 2008-09 Expenditures: $5,962,050.06 FY 2008-09 Enrollee Months: 4,207
Type of Reimbursement	Fee-for-Service: Medicaid reimburses case management at a monthly fixed rate per beneficiary and all other services based on the Florida Medicaid approved rate or the provider's customary fee, whichever is lower.

[1] Alzheimer's, the most common form of dementia, is a progressive and fatal brain disease for which there is no cure.

[2] The Department of Elder Affairs determines that a beneficiary meets the medical and functional eligibility for Medicaid nursing home care.

[3] All enrollment and waitlist information is provided as of December 2009. Delays in moving beneficiaries from the waitlist to enrolled status are due to attrition, the availability and amount of services a beneficiary may need, and funding limits. In February 2009 the department suspended all new enrollments into this waiver.

[4] Average monthly cost per beneficiary was calculated by dividing total Fiscal Year 2008-09 expenditures by total number of enrollee months.

ADULT CYSTIC FIBROSIS

Counties Served	Statewide		
Year Implemented	2005		
Waiver Eligibility	Individual must • be age 18 or older • be Medicaid eligible • have a diagnosis of Cystic Fibrosis[1] • meet Inpatient Hospital Level of Care[2]		
Services Provided	• acupuncture • case management • chore services • counseling (individual and family) • dental • homemaker • nutritional assessment and risk reduction • personal care • personal emergency response service • prescribed drugs • respite care • skilled nursing • specialized medical equipment and supplies • therapies: exercise, massage, physical, and respiratory • transportation • vitamins and nutritional supplements		
Operational Entity	Department of Health		
Enrollment and Waitlist[3]	Enrollment: 97 Waitlist: 23		
Total Waiver-Approved Enrollment	100		
2009-10 Funding	Total Appropriation $386,632	Federal Funds $230,632	State Funds $156,000
2008-09 Average Monthly Cost per Beneficiary[4]	Average Monthly Cost $414.70	FY 2008-09 Expenditures $463,631.51	FY 2008-09 Enrollee Months 1,118
Type of Reimbursement	Fee-for-Service: Florida Medicaid approved rate or the provider's customary fee, whichever is lower.		

[1] Cystic fibrosis is a genetic disease that primarily affects a person's lungs and digestive system and is chronic, progressive, and terminal.

[2] The Department of Elder Affairs determines that a beneficiary meets the medical and functional eligibility for inpatient hospitalization.

[3] All enrollment and waitlist information is provided as of December 2009.

[4] Average monthly cost per beneficiary was calculated by dividing total Fiscal Year 2008-09 expenditures by total number of enrollee months.

FAMILIAL DYSAUTONOMIA

Counties Served	Statewide		
Year Implemented	2007		
Waiver Eligibility	Individual must • be age 3 or older • be Medicaid eligible • have a diagnosis of Familial Dysautonomia[1] • meet Inpatient Hospital Level of Care[2]		
Services Provided	• behavioral services • consumable medical supplies • dental • durable medical equipment • non-residential support • respite care • support coordination		
Operational Entity	Agency for Health Care Administration		
Enrollment and Waitlist[3]	Enrollment: 8 Waitlist: None		
Total Waiver-Approved Enrollment	20		
2009-10 Funding	Total Appropriation $418,000	Federal Funds $246,160	State Funds $171,840
2008-09 Average Monthly Cost per Beneficiary[4]	Average Monthly Cost $463.87	FY 2008-09 Expenditures $25,049.07	FY 2008-09 Enrollee Months 54
Type of Reimbursement	Fee-for-Service: Florida Medicaid approved rate or the provider's customary fee, whichever is lower.		

[1] Also known as Riley-Day Syndrome, this is a genetic disease that results in incomplete development of the nervous system.

[2] The Department of Elder Affairs determines that a beneficiary meets the medical and functional eligibility for inpatient hospitalization.

[3] All enrollment and waitlist information is provided as of December 2009.

[4] Average monthly cost per beneficiary was calculated by dividing total Fiscal Year 2008-09 expenditures by total number of enrollee months.

PROJECT AIDS CARE

Counties Served	Statewide
Year Implemented	1991
Waiver Eligibility	Individual must • be Medicaid eligible • have a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) documented by a physician • have an AIDS related opportunistic infection • be at-risk of hospitalization or institutionalization in a skilled nursing facility • be determined disabled according to the Social Security Administration • not be enrolled in a Medicaid Health Maintenance Organization unless residing in the Medicaid Reform areas
Services Provided	• case management • chore services • day health care • education and support • environmental accessibility adaptations • home-delivered meals • homemaker • personal care • restorative massage • skilled nursing • specialized medical equipment and supplies • specialized personal care services for children in foster care • therapeutic management of substance abuse The Project AIDS Care case manager, in consultation with the beneficiary and a registered nurse care manager, develops a plan of care and authorize services
Operational Entity	Agency for Health Care Administration
Enrollment and Waitlist [1]	Enrollment: 4,609 Waitlist: None
Total Waiver-Approved Enrollment	5,900
2009-10 Funding	Total Appropriation: $8,722,138.00 Federal Funds: $4,971,618.66 State Funds: $3,750,519.34
2008-09 Average Monthly Cost per Beneficiary [2]	Average Monthly Cost: $141.65 FY 2008-09 Expenditures: $7,737,275.93 FY 2008-09 Enrollee Months: 54,623
Type of Reimbursement	Fee-for-Service: Medicaid reimburses case management at a monthly fixed rate per beneficiary and all other services based on the Florida Medicaid approved rate or the provider's customary fee, whichever is lower.

[1] All enrollment and waitlist information is provided as of December 2009.

[2] Average monthly cost per beneficiary was calculated by dividing total Fiscal Year 2008-09 expenditures by total number of enrollee months.

TRAUMATIC BRAIN AND SPINAL CORD INJURY

Counties Served	Statewide
Year Implemented	1999

Waiver Eligibility	Individual must
	• be age 18 or older
	• be Medicaid eligible
	• have one of the injuries described below
	  o traumatic brain Injury, defined as an insult to the skull, brain, or its covering from external trauma, which produces an altered state of consciousness or anatomic, motor, sensory, or cognitive/behavioral deficits
	  o spinal cord Injury, defined as a lesion to the spinal cord or cauda equine resulting from external trauma with evidence of significant involvement of two of the following: motor deficit, sensory deficit, or bowel and bladder dysfunction.
	• meet Nursing Home Level of Care[1]
	• be referred to the state's Brain and Spinal Cord Injury Program Central Registry in accordance with s. 381.75, *Florida Statutes*.

Services Provided	• adaptive health and wellness • assistive technologies • attendant care • behavioral programming • adult companion • consumable medical supplies • counseling (personal adjustment) • environmental accessibility adaptations • life skills training • personal care • rehabilitation engineering evaluation • support coordination
Operational Entity	Department of Health
Enrollment and Waitlist[2]	Enrollment: 327 Waitlist: 605
Total Waiver-Approved Enrollment	375
2009-10 Funding	Total Appropriation: $9,000,000 — Federal Funds: $6,087,600 — State Funds: $2,912,400
2008-09 Average Monthly Cost per Beneficiary[3]	Average Monthly Cost: $2,361.47 — FY 2008-09 Expenditures: $2,472,462.11 — FY 2008-09 Enrollee Months: 1,047
Type of Reimbursement	Fee-for-Service: Florida Medicaid approved rate or the provider's customary fee, whichever is lower.

[1] The Department of Elder Affairs determines that a beneficiary meets the medical and functional eligibility for Medicaid nursing home care.
[2] All enrollment and waitlist information is provided as of December 2009. Delays in moving beneficiaries from the waitlist to enrolled status are due to attrition, the availability and amount of services a beneficiary may need, and funding limits.
[3] Average monthly cost per beneficiary was calculated by dividing total Fiscal Year 2008-09 expenditures by total number of enrollee months.

MODEL WAIVER PROGRAM			
Counties Served	Statewide		
Year Implemented	1991		
Waiver Eligibility	Individual must • be age 20 or younger • be Medicaid eligible • be determined disabled according to the Social Security Administration • diagnosed with a degenerative spinocerebellar disease[1] • meet Inpatient Hospital Level of Care[2]		
Services Provided	• assistive technology • environmental accessibility adaptations • respite care • service evaluation		
Operational Entity	Agency for Health Care Administration		
Enrollment and Waitlist[3]	Enrollment: 5 Waitlist: 1		
Total Waiver-Approved Enrollment	5		
2009-10 Funding	Total Appropriation $24,514.80	Federal Funds $16,581.81	State Funds $7,932.99
2008-09 Average Monthly Cost per Beneficiary[4]	Average Monthly Cost $721.02	FY 2008-09 Expenditures $24,514.80	FY 2008-09 Enrollee Months 34
Type of Reimbursement	Fee-for-Service: Florida Medicaid approved rate or the provider's customary fee, whichever is lower.		

[1] This is a group of rare genetic disorders which affect the brain and nervous system.

[2] The Department of Elder Affairs determines that a beneficiary meets the medical and functional eligibility for inpatient hospitalization.

[3] All enrollment and waitlist information is provided as of December 2009.

[4] Average monthly cost per beneficiary was calculated by dividing total Fiscal Year 2008-09 expenditures by total number of enrollee months.

FLORIDA'S DEVELOPMENTAL DISABILITIES MEDICAID HCBS WAIVERS

DEVELOPMENTAL DISABILITIES TIER 1, 2, 3, and 4[1]

Counties Served

Statewide

Year Implemented

Tier 1	Tier 2	Tier 3	Tier 4
1985	2008	2008	1998

To implement Ch. 2007-64, *Laws of Florida,* the Agency for Persons with Disabilities created a four-tier waiver system in 2008. This system comprises four waivers: two new waivers that define Tiers 2 and 3 with the existing Developmental Disabilities and Family and Supported Living waivers, implemented in 1985 and 1998, respectively. Each tier has specific need criteria that determine the tier under which beneficiaries will be served. In addition, with the exception of Tier 1, each tier has an annual per-client spending limit.

Waiver Eligibility [2]

All Individuals must

- be age 3 or older
- be Medicaid eligible
- be registered as an eligible beneficiary with the Agency for Persons with Disabilities or its contractor
- meet level of care criteria for intermediate care facilities for the developmentally disabled
- meet specific criteria for assignment to a tier
  - Tier 1, must have intensive medical, behavioral, or adaptive needs.
  - Tier 2, must live in a licensed residential facility and require greater than five hours a day of residential habilitation or reside in supported living arrangements and receive more than six hours of in-home support.
  - Tier 3, must not meet criteria for tiers 1 or 2.
  - Tier 4, must live in their family home, foster home, or own home.

Services Provided

Tier 1, 2, and 3

- adult day training
- adult dental
- behavior analysis
- behavior assistant
- companion
- dietician services
- environmental accessibility adaptations
- in-home support
- medication review
- personal care
- personal emergency response system
- private duty nursing
- residential habilitation
- residential nursing
- respite care
- skilled nursing
- special medical home care
- specialized medical equipment and supplies
- specialized mental health services
- support coordination
- supported employment
- supported living coaching
- therapies: occupational, physical, respiratory, speech
- transportation

Tier 4

- adult day training
- behavior analysis
- behavior assistant
- environmental accessibility adaptations
- in-home support
- personal emergency response system
- respite care
- specialized medical equipment and supplies
- support coordination
- supported living coaching
- supported employment
- transportation

[1] The Agency for Persons with Disabilities assigns a beneficiary to a tier based on a needs assessment which determines the beneficiary's service needs, risk level, and the spending needed per year to address the beneficiary's needs.

[2] For information on additional requirements based on age, living arrangements, exceptional behavioral problems, and authorization for certain services see *Florida Administrative Code,* 65G-4.0021-0025.

DEVELOPMENTAL DISABILITIES TIER 1, 2, 3, and 4 (continued)

Operational Entity: Agency for Persons with Disabilities

Enrollment and Waitlist [3]

	Tier 1	Tier 2	Tier 3	Tier 4	Beneficiaries Pending Tier Assignment[4]	Total
Enrollment	3,901	3,530	5,329	12,526	4,500	29,786
Waitlist						18,961

Annual Maximum Allowable Spending Per Beneficiary

Tier 1	Tier 2	Tier 3	Tier 4
No maximum	$55,000	$35,000	$14,792

2009-10 Funding Tier 1, 2, and 3

Total Appropriation	Federal Funds	State Funds
$849,699,685	$574,736,867	$274,962,818

Funding Tier 4

Total Appropriation	Federal Funds	State Funds
$74,557,478	$41,349,577	$33,207,901

2008-09 TIER 1, 2, and 3 Average Monthly Cost Per Beneficiary [5]

Average Monthly Cost Per Beneficiary	FY 2008-09 Expenditures	FY 2008-09 Enrollee Months
$3,341.90	$767,150,206.73	229,555

2008-09 TIER 4 Average Monthly Cost Per Beneficiary [6]

Average Monthly Cost Per Beneficiary	FY 2008-09 Expenditures	FY 2008-09 Enrollee Months
$645.59	$75,189,668.78	116,467

Type of Reimbursement: Fee-for-Service: Based on rates approved by the Agency for Persons with Disabilities and the Agency for Health Care Administration and incorporated into rule.

[3] All enrollment and waitlist information provided as of September 2009. All tiers share one waitlist and beneficiaries are placed in the appropriate tier based on a needs assessment which determines the individual's needs, risk level, and the spending needed per year to address the beneficiary's needs.

[4] These beneficiaries are receiving services and are awaiting a tier placement based on a needs assessment which determines the individual's needs, risk level, and the spending needed per year to address the beneficiary's needs.

[5] Average monthly cost per beneficiary was calculated by dividing total Fiscal Year 2008-09 expenditures of Tiers 1, 2, and 3 by total number of enrollee months.

[6] Average monthly cost per beneficiary was calculated by dividing total Fiscal Year 2008-09 expenditures of Tier 4 by total number of enrollee months.

The Florida Legislature

Office of Program Policy Analysis and Government Accountability

OPPAGA provides performance and accountability information about Florida government in several ways.

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Exhibit 3

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration
Better Health Care for all Floridians

CHARLIE CRIST
GOVERNOR

THOMAS W. ARNOLD
SECRETARY

February 23, 2010

Jackie Glaze, Acting Associate Regional Administrator
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health
61 Forsyth St. S.W., Suite 4T20
Atlanta, GA 30303-8909

Re: Traumatic Brain Injury and Spinal Cord Injury Waiver – #342.90R02.02

Dear Ms. Glaze:

Florida's Agency for Health Care Administration, in collaboration with several of the state's agencies involved in waiver operations, has established a formal process to assist and support eligible Medicaid nursing home residents who want to transition from the nursing home to a community setting.

Florida Medicaid would like to ensure that waiver capacity is available when nursing home residents are ready for community transition and enrollment in the TBI/SCI waiver. To this end, we are submitting an amendment designating forty-five (45) of the currently approved waiver slots on the TBI/SCI waiver as reserved capacity for individuals with a qualifying brain or spinal cord injury who will transition from nursing home placements to community settings.

Revised replacement pages for Appendix B-3: 2-3 are enclosed. Florida Medicaid is requesting an effective date of January 1, 2010 for this waiver amendment.

If you have any questions regarding this request, please contact Arlene Walker of my staff at (850) 412-4270.

Sincerely,

Roberta K. Bradford
Deputy Secretary for Medicaid

RKB/aw
Enclosures
cc: Kenni Howard, CMS RO

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○	**Not applicable.** The state does not reserve capacity.
✓	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	Florida will reserve capacity in the TBI/SCI waiver for community transition of individuals residing in nursing homes. The operating agency for the waiver, the Department of Health's Brain and Spinal Cord Injury Program, conducted an analysis and determined that approximately 12% of those presently waiting for enrollment in the waiver are residing in nursing homes. The same percentage was used in determining the number of slots to be reserved for the purpose of assisting eligible individuals to transition to a community setting. Twelve percent (12%) of the waiver's approved capacity or forty-five (45) slots are being reserved.
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose: Capacity Reserved	Purpose: Capacity Reserved
Year 1	N/A	
Year 2	N/A	
Year 3	45	
Year 4 (renewal only)	45	
Year 5 (renewal only)	45	

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

✓	The waiver is not subject to a phase-in or a phase-out schedule.
○	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity. *Select one:*

✓	Waiver capacity is allocated/managed on a statewide basis.
○	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Participants must apply for Traumatic Brian Injury and Spinal Cord Injury Waiver (TBI/SCI) services, be determined eligible for the waiver and be determined Medicaid eligible. The Physician Diagnosis Confirmation and Referral to Determine Level of Care form must indicate that the participant may require nursing home level of care in the absence of home and community-based services.

Appendix A of the Traumatic Brain and Spinal Cord Injury Waiver Services Handbook includes a six page policy describing the prioritization screening to be conducted annually on individuals whose names appear on the Waiting List Log for the TBI/SCI Waiver (Attachment 1). The purpose of the policy is to provide a valid process for ranking individuals and to ensure that consistency in ranking is maintained statewide. A TBI/SCI Prioritization Screening Instrument (Attachment 2) is used to record demographic information about the individual whose name appears on the Waiting List Log and to determine functional abilities, formal and informal support available, services provided from other programs, needs and risk of institutionalization of the individual. The policy specifies how the screening instrument is to be scored and how the determination of which individual from the Waiting List Log to be offered an opportunity to enter the TBI/SCI Waiver will be made. The policy became part of Florida Administrative Rule in May, 2006 (59G-13.130, Florida Administrative Code)

www.flrules.org

The Agency for Health Care Administration in collaboration with the Department of Health Brain and Spinal Cord Injury Program has implemented a process to transition Medicaid eligible nursing home residents eighteen (18) years of age and older into community settings and enroll them in the waiver. Individuals with a qualifying brain or spinal cord injury residing in a nursing home who express an interest in moving to a community setting will be provided an assessment by a trained specialist to determine whether they could successfully transition to a community setting with services available from the TBI/SCI waiver. Forty-five (45) slots have been designated as reserved capacity for nursing home transition and will be available to individuals approved for transition to a community setting. Waiver services will minimize the barriers to transition and insure that the health and safety of waiver participants is maintained following transition.

Exhibit 4

Assistive Care Services Home | Providers | Recipient

Local Navigation

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Beneficiary Services
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Deputy Secretary
Disease Management
Durable Medical Equipment (DME)
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HCBS Waivers
HIPAA
Intergovernmental Transfer (IGT) Workgroup
Long-Term Care Partnership
Medicaid Encounter Data System (MEDS)
Medicaid HMOs
Medicaid Privacy Notice
Medicaid Procurements
Medicaid Reform
Medicaid Research Contracts and Evaluations
Medicaid State Plan
MediKids
MediPass
Newborn Eligibility
Nursing Facility Provider Information
Nursing Home Transition
Organ Transplant Advisory Council
Payment Error Rate Measurement (PERM)
Pharmacy Services
Preferred Drug List
Provider Service Network (PSN)
Quality in Managed Care
Recent Presentations
Reimbursement Workgroups
Meetings
Report Medicaid Fraud
Substance Abuse Services
Utilization Review

Assistive Care Services

This service is for low-income residents of enrolled assisted living facilities (ALFs), qualified residential treatment facilities (RTFs) and adult family-care homes (AFCHs). The purpose of the Medicaid Assistive Care Services Program is to increase state payments for recipients requiring an integrated set of services on a 24-hour per day basis. These services, provided by the residential care facilities, promote and maintain the health of eligible recipients in order to delay or prevent institutionalization. To accomplish this goal, funds are transferred from the Department of Children and Families (http://www.state.fl.us) to Medicaid to draw down federal Title XIX matching funds.

What is assistive care?

This Medicaid optional state plan service is provided to low-income people who live in ALFs, AFCHs, and RTFs. Services are provided to individuals who demonstrate functional limitations and must be based on need as confirmed by an assessment and provided in accordance with an individual service plan for each resident.

What kinds of services are provided?

Assistive care services are similar to services typically provided in residential care facilities to residents who require an integrated set of services on a 24-hour basis. They include assistance with activities of daily living, assistance with instrumental activities of daily living, medication assistance, and health support. The services will be specified in a resident care plan developed from an annual assessment.

Who will provide Medicaid Assistive Care Services?

Three types of residences may qualify as Medicaid Assistive Care Service providers: ssisted living facilities, mental health residential treatment facilities, and adult family-care homes.

When did services begin?

Assistive Care Services were implemented in ALFs September 1, 2001, in qualified RTFs November 1, 2001, and in AFCHs January 1, 2002.

What are the regulations governing the ACS Program?

The Agency adopted a new rule governing Assistive Care Services, Rule 59G-4.025, Florida Administrative Code (F.A.C.), with a Provider Handbook incorporated by reference. The handbook is available on the Medicaid fiscal agent's Provider Web Portal at no charge.

What other regulations are applicable?

ACS providers must comply with the requirements of the Florida Medicaid Provider Reimbursement Handbook, which is incorporated by reference in Rule 59G-5.020, F.A.C., and which is posted on the Medicaid fiscal agent's web site. ACS providers must also comply with the licensure requirements applicable to the facility type.

How is eligibility determined and who can receive ACS services?

The Department of Children and Families is responsible for determining the individual's Optional State Supplementation (OSS) and Medicaid eligibility. To receive assistive care services, recipients must be 18 years of age or older and meet these requirements:

- Be Medicaid eligible;
- Have a health assessment completed by a physician or other licensed health practitioner which indicates the medical necessity of two of the four assistive care services; and
- Reside in a Medicaid enrolled assisted living facility, qualified residential treatment facility or adult family-care home.

How can I learn more about this program?

Please contact the Bureau of Medicaid Services at (850) 487-2618 or write to us at:

Assistive Care Services
AHCA Bureau of Medicaid Services
2727 Mahan Drive, Mail Stop 20
Tallahassee, Florida 32308

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Assistive Care Services Home | Providers | Recipient

Exhibit 5

Florida Medicaid Nursing Homes July, 2010 Rate Semester Initial Per Diems

Sorted By Medicaid Number

Medicaid Number	Provider Name	Per Diem	
001135	Surrey Place Care Center	208.79	1
001136	Signature HealthCARE of Palm Beach	215.25	2
001281	Cross Pointe Care Center	231.52	3
001300	Cross Terrace Rehabilitation Center	212.31	4
001416	Florida Baptist Retirement Center	220.93	5
002400	Village Place Health and Rehabilitation Center	236.14	6
002419	West Broward Care Center	231.29	7
003521	Trinity Regional Rehab Center	221.23	8
005021	Braden River Convalescent Center	209.07	9
005219	Osceola Health Care Center	226.86	10
005372	Debary Manor	208.23	11
005374	Flagler Pines	212.80	12
005379	Longwood Health Care Center	212.23	13
005380	The Rehabilitation Center of Winter Park	229.46	14
005381	Brynwood Center	219.35	15
005383	Nursing Pavilion at Chipola Retirement Center	201.75	16
005384	Glencove Nursing Pavilion	222.10	17
005385	Panama City Nursing Center	211.10	18
005386	Riverchase Care Center	200.54	19
005387	Suwannee Health Care Center	218.73	20
005388	Berkshire Manor	230.00	21
005519	Carnegie Gardens Nursing Center	219.08	22
005523	Fountainhead Care Center	221.57	23
005524	North Campus Rehabilitation and Nursing Center	215.82	24
005543	Manor on the Green	221.35	25
005547	Oakwood Garden of Deland	211.40	26
005549	Oaks Of Kissimmee	221.87	27
005701	Avante at Ocala	204.03	28
005811	Palatka Health Care Center	220.91	29
005814	Boynton Health Care Center	242.04	30
005826	Health Care Center of Tampa	201.86	31
005849	Glen Oaks Health Care Center	243.80	32
005850	Heritage Park	212.94	33
005851	Lake Eustis Care Center	221.33	34
006339	Lake Placid Health Care Center	212.25	35
006340	Windsor Manor	213.95	36
006408	Rehabilitation Center of St. Pete	229.45	37
006483	Salerno Bay Manor	228.94	38
006489	Royal Manor	223.10	39
006767	Oakbrook of LaBelle	238.44	40
007012	Crosswinds Health & Rehab Center	219.40	41
007014	Cross Landings Health & Rehab Center	222.79	42
008793	Woods of Manatee Springs	227.23	43
009495	Okeechobee Health Care Facility	224.71	44
010082	Courtyard Gardens Rehabilitation Center, LLC	209.94	45
011997	Heartland Health & Rehab of Boca Raton	208.68	46

Medicaid Number	Provider Name	Per Diem	
011998	Royal Palm Healthcare & Rehabilitation Center	204.35	47
015613	St. James Health & Rehabilitation Center	223.01	48
016016	Whitehall Boca Raton	223.40	49
017221	Bayside Manor	195.85	50
017222	Margate Health Care Center	213.63	51
017223	Rosewood Manor	198.80	52
017225	Bay Breeze Nursing & Retirement Center	215.14	53
017230	Silvercrest Manor	210.83	54
017236	Specialty Center of Pensacola	216.36	55
017242	Health Care Center of Destin	219.21	56
018066	The Park Summit at Coral Springs	212.83	57
200107	Bon Secours Maria Manor	217.11	58
200409	Westminster Oaks	194.73	59
200425	Floridean Nursing & Rehab	237.02	60
200506	Miami Jewish Home & Hospital for the Aged, Inc.	226.59	61
200620	Pines Nursing Home	241.74	62
200735	All Saints Catholic Nursing Home & R.C. Inc.	209.39	63
200859	River Garden Hebrew Home	229.67	64
200913	AVANTE AT JACKSONVILLE BEACH	218.24	65
200956	COMPREHENSIVE HEALTHCARE OF CLEARWAT	234.63	66
201006	Memorial Manor Nursing Home	234.80	67
201120	Gulf Coast Village	209.71	68
201154	The Home Association, Inc	226.74	69
201545	Hobe Sound Geriatric Village, Inc.	214.95	70
201588	Mary Lee Depugh Nursing Center	190.32	71
201651	Guardian Care Nursing & Rehabilitation Center	216.35	72
202011	Westchester Gardens Rehabilitation & Care Center	213.23	73
202533	The Rohr Home	233.43	74
202606	SAMANTHA R. WILSON AT BAYVIEW	210.48	75
202681	JH FLOYD SUNSHINE MANOR, INC.	220.40	76
202703	Pines of Sarasota	245.52	77
202711	SUNNYSIDE NURSING HOME	254.60	78
202789	Alliance Nursing Center	177.79	79
202941	MIRACLE HILL NURSING AND CONVALESCENT C	203.71	80
203122	AVANTE AT LEESBURG	224.07	81
203165	Villa Maria Nursing & Rehabilitation	236.81	82
203203	Glades Health Care Center	215.27	83
203220	Avante At Inverness	219.10	84
203238	Avante At Lake Worth, Inc.	242.11	85
203327	The Palace at Kendall Nursing and Rehab Center	219.56	86
203335	TimberRidge Nursing & Rehab Center	213.82	87
203475	Marianna Health & Rehabilitation	199.69	88
203599	Manor at Carpenter's	218.18	89
203670	Jackson Memorial Perdue Medical Center	242.91	90
203769	John Knox Village Of Florida	216.78	91
203815	Westminster Asbury Towers	201.34	92
203823	Oak Bluffs Health Center	199.07	93
203980	Lisenby on Lake Caroline	178.44	94
204072	Mease Continuing Care	210.27	95
204161	Jackson Memorial Long Term Care Center	240.43	96
204170	Regents Park Of Boca Raton	234.92	97

Medicaid Number	Provider Name	Per Diem	
204391	Olds Hall Good Samaritan	214.27	98
204536	TAYLOR HOME FOR THE AGED, INC.	200.81	99
204625	Tri-County Nursing Home	183.59	100
204811	Health Central Park	217.80	101
205150	St. Catherine Laboure Manor	218.01	102
205303	KISSIMMEE GOOD SAMARITAN	200.90	103
205460	American Finnish Nursing Home	229.01	104
205745	Health Center at Abbey Delray	223.50	105
205796	The Commons at Orlando Lutheran Towers	197.74	106
205800	St. John's Nursing Home	236.98	107
205923	Lourdes-Noreen McKeen Residence	239.61	108
206300	Suwannee Valley Nursing Center	213.25	109
206431	Morton Plant Rehabilitation Center	218.77	110
206521	Saint Andrews Estates North	227.79	111
206610	The Waterford	245.10	112
206865	Abbey Delray South	240.96	113
207276	Riverside Care Center	220.93	114
207381	Joseph L. Morse Geriatric Center, Inc.	226.28	115
207446	TAYLOR CARE CENTER, INC.	214.01	116
207497	Sunrise Health & Rehabilitation Center	227.69	117
207527	AUBURNDALE OAKS HEALTHCARE CENTER	204.28	118
207683	Lakeside Health Center	212.98	119
207799	Ponce de Leon Care Center	222.60	120
207993	Florida Club Care Center	245.47	121
208442	BERNARD L. SAMSON NURSING CENTER	232.29	122
208485	Jupiter Medical Center Pavilion, Inc.	229.94	123
208507	Claridge House	194.30	124
208540	Westminster Towers	189.86	125
208809	Baptist Manor	194.16	126
208906	Plantation Key Convalescent Center	191.33	127
209325	Courtenay Springs Village	221.61	128
209422	Westminster Asbury Manor	200.04	129
209473	St. Anne's Nursing Center	224.72	130
209511	Bishop's Glen Health Care Center	227.84	131
209848	Winter Park Towers	183.52	132
209856	Sun Terrace Health Center	210.10	133
210137	Life Care Center of Altamonte Springs	198.76	134
210188	Covenant Village Care Center	232.62	135
210285	John Knox Village Medical Center	212.24	136
210374	Azalea Trace	212.06	137
210463	Village on the Isle	232.64	138
210587	HealthPark Care Center, Inc.	233.29	139
210617	Miami Gardens Care Centre	232.70	140
210676	AVANTE AT BOCA RATON, INC.	238.07	141
210684	The Edgewater at Waterman Village	218.87	142
210781	Brighton Gardens of Port St. Lucie	221.81	143
210889	Emory L. Bennett State Veteran's Nursing Home	217.87	144
210943	Stratford Court at Palm Harbor	227.96	145
210951	Sabal Palms Health Care Center	188.12	146
211010	Stratford Court at Boca Pointe	234.22	147
211052	W. FRANK WELLS NURSING FACILITY	232.25	148

Medicaid Number	Provider Name	Per Diem	
211281	Huntington Place Care & Rehabilitation Center	193.60	149
211435	Hardee Manor Health Care Center	187.69	150
211516	LAUREL POINTE HEALTH AND REHABILITATION	200.92	151
211532	Life Care Center of Citrus County	194.40	152
211885	Plaza West	203.18	153
211923	Lake Park of Madison	197.92	154
212032	E.J. Healey Rehabilitation and Nursing Center	245.90	155
212083	Westminster Woods on Julington Creek	197.05	156
212121	Homestead Manor	196.08	157
212164	Ybor City Healthcare and Rehabilitation Center	204.86	158
212393	The Fountains Nursing Home	211.10	159
212636	Woodland Terrace	170.11	160
212709	Suncoast Manor	185.65	161
212733	Oceanside Extended Care Center	162.70	162
212792	Florida Lutheran Retirement Church	196.72	163
212806	Palmetto Sub Acute Care Center	252.27	164
212831	University Center West	205.71	165
212849	Tarpon Bayou Center	197.33	166
212865	Lakeland Hills Center	186.21	167
212873	University Center East	204.33	168
212881	The Groves Center	179.55	169
212890	Egret Cove Center	184.91	170
212903	Emerald Coast Center	188.77	171
212911	Clearwater Center	205.83	172
212971	Florida Presbyterian Homes, Inc.	216.77	173
212989	Bay Center	201.10	174
212997	Bartow Center	190.93	175
213004	Boca Ciega Center	203.12	176
213098	Tamarac Rehabilitation and Health Center	217.25	177
213152	Water's Edge Extended Care	250.71	178
213161	Life Care Center of Wells Crossing	191.52	179
213322	Haborchase of Venice	212.09	180
213403	Life Care Center Of Orlando	198.78	181
213462	Madison Nursing Center	212.90	182
213837	Lakeside Village A Classic Residence by Hyatt	241.43	183
213900	Shady Rest Care Pavilion, Inc.	228.89	184
213934	TMH Skilled Nursing Facility	208.69	185
214027	Gramercy Park Nursing Center	205.60	186
214035	MIAMI SHORES NURSING AND REHAB CENTER	242.09	187
214043	Marion House Health Care Center	219.86	188
214060	Life Care Center of Hilliard	187.32	189
214914	Baldomero Lopez State Veteran's Nursing Home	223.99	190
215597	Osprey Point Nursing Center	197.33	191
216399	Harbour's Edge	240.14	192
217263	Crystal River Health & Rehabilitation Center	201.25	193
217395	Ocala Health & Rehabilitation Center	190.67	194
217727	West Melbourne Health & Rehabilitation Center	202.14	195
217735	St.Augustine Health & Rehabilitation Center	206.17	196
217743	Daytona Beach Health and Rehabilitation Center	202.15	197
217824	Life Care Center of Port St. Lucie	210.69	198
218057	Lakeshore Villas Health Care Center	211.53	199

Medicaid Number	Provider Name	Per Diem	
218171	W. JACKSONVILLE HEALTH AND REHAB CENTE	197.61	200
219380	Life Care Center of Winter Haven	195.93	201
220604	Century Care Center.	211.72	202
220612	Santa Rosa Health & Rehabilitation Center	202.28	203
220621	Sandy Ridge Care Center	215.86	204
221465	Westminster Care of Clermont	183.13	205
221473	Calusa Harbour	233.14	206
221589	Westminster Care of Delaney Park	197.43	207
223239	Regents Park at Aventura	219.96	208
223654	Westminster Care of Orlando	183.56	209
223786	Life Care Center of Sarasota	221.16	210
223808	Avante at Orlando, inc.	222.24	211
223883	Doctors Lake of Orange Park	199.98	212
223905	Horizon Healthcare Center at Daytona	230.34	213
224243	Pensacola Health Care Facility	199.18	214
224341	MK of Haines City LLC	194.05	215
224910	South Tampa Health and Rehabilitation Center	206.37	216
225053	MK of North Port LLC	211.33	217
225177	Victoria Nursing and Rehabilitation Center	218.93	218
225274	MK of Fernandina Beach LLC	197.10	219
225291	The Aristocrat	260.97	220
225410	MK of Winter Garden LLC	204.83	221
225631	Springtree Rehab & Health Care Center, LLC	213.23	222
225754	Pinecrest Convalescent Center	228.26	223
225991	Stuart Nursing & Restorative Care Center	201.49	224
226009	Port St. Lucie Nursing & Restorative Care Center	209.65	225
226017	Plantation Nursing & Rehab Center	226.94	226
226033	Martin Nursing and Restorative Care Center	210.08	227
226041	The Manor At Blue Water Bay	198.95	228
226068	Cathedral Gerontology Center	209.68	229
226076	Bayonet Point Health & Rehabilitation Center	216.19	230
226173	The Health Center of Lake City	199.44	231
226327	Charlotte Harbor Health Care	226.14	232
226335	Broward Nursing and Rehab Center	209.92	233
226343	The Health Center of Plant City	209.19	234
226351	Ocean View Nursing and Rehabilitation Center	203.10	235
226360	South Heritage Nursing Center	202.32	236
226378	Imperial Health Care Center	229.08	237
226581	Health Center of Coconut Creek	232.30	238
226602	Treasure Isle Care Center	201.96	239
226700	The Health Center of Merritt Island	216.62	240
227226	Fair Havens Center, LLC	151.34	241
227251	Alpine Health & Rehabilitation Center	215.51	242
227544	Unity Health & Rehab Center	202.68	243
227561	Lady Lake Specialty Care Center	214.46	244
227579	Wilton Manors Health & Rehab Center	221.14	245
227587	Rockledge Rehab & Nursing Center	208.53	246
227625	Greenbriar Rehab & Nursing Center	222.21	247
227633	Apollo Health & Rehab Center	219.78	248
227641	North Rehabilitation Center	216.28	249
227650	Lexington Health & Rehabilitation Center	220.42	250

Medicaid Number	Provider Name	Per Diem	
227676	Liberty Inn	232.66	251
227765	Park Meadows Health & Rehab Center	214.92	252
227773	New Horizon Health & Rehab Center	218.84	253
227838	First Coast Health and Rehab Center	203.35	254
227871	Ayers Health & Rehab Center	182.29	255
228001	North Beach Nursing & Rehabilitation Center	241.75	256
228320	The Gardens Court	224.54	257
228338	Life Care Center of Melbourne	202.30	258
228401	Park Ridge Nursing Center	189.98	259
228567	Bear Creek Nursing Center	181.87	260
228575	Royal Oak Nursing Center	188.65	261
228591	Heather Hill Nursing Home	191.39	262
228621	Inn at Sarasota Bay Club	262.53	263
228702	Winter Haven Health & Rehab Center	187.63	264
228711	Woodland Terrace of Citrus County	172.40	265
228788	East Ridge Retirement Village, Inc.	232.62	266
228877	The Healthcare Center Of Windermere	202.28	267
228885	Parkway Health & Rehab	218.99	268
228940	Cypress Cove Care Center	189.52	269
228958	Brooksville Healthcare Center	182.81	270
228966	Lake Harris Health Center	197.64	271
229091	The Health Center of Daytona Beach	211.85	272
229164	Sylvan Health Center	210.67	273
229202	Shell Point Village Retirement Community	209.22	274
229237	Parthenon Healthcare of Ft. Walton	198.88	275
229288	Gainesville Health Care Center	213.62	276
229571	The Health Center of Pensacola	199.64	277
229610	Lake View Care Center at Delray	208.54	278
229628	Menorah House	210.42	279
229849	Alexander Nininger State Veteran's Nursing Home	227.45	280
250988	HIALEAH SHORES NURSING AND REHAB CENTE	233.80	281
251097	Parthenon Healthcare of Blountstown	181.31	282
251101	Parthenon Healthcare of Crestview	184.84	283
251399	Brandywyne Health Care Center	203.66	284
251666	Concordia Manor	190.09	285
251721	Oakhurst Care & Rehabilitation Center	190.83	286
251739	Bradford Terrace, LLC	170.61	287
252018	Avante at Melbourne, Inc.	223.48	288
252034	AVANTE AT ORMOND BEACH	218.09	289
252042	Avante at Mt. Dora	216.19	290
252051	San Jose Health and Rehabilitation Center	195.82	291
252069	Bradenton Health Care	200.34	292
252077	Brandon Health and Rehab. Center	185.61	293
252093	Capital Healthcare Center	191.63	294
252107	Coral Trace Health Care	202.43	295
252115	Countryside Healthcare Center	200.82	296
252123	University Hills Health and Rehab.	201.26	297
252158	Deltona Health Care	193.30	298
252166	Destin Healthcare and Rehab. Center	192.76	299
252174	Heron Pointe Health and Rehab.	192.38	300
252182	Magnolia Health and Rehab. Center	205.62	301

Medicaid Number	Provider Name	Per Diem	
252191	Emerald Shores Health and Rehab.	195.75	302
252204	Englewood Healthcare & Rehab. Center	191.80	303
252212	Evans Health Care	199.89	304
252221	Fletcher Health and Rehab. Center	196.30	305
252239	Fort Pierce Health Care	204.49	306
252247	Sea Breeze Health Care	187.50	307
252255	Harbor Beach Nursing and Rehab. Center	214.77	308
252263	Health Center at Brentwood	198.77	309
252271	Heritage Health Care Center	207.86	310
252280	Heritage Healthcare and Rehab. Center	217.14	311
252298	Heritage Healthcare Center	182.67	312
252310	Lake Mary Health and Rehab.Center	190.62	313
252328	Wedgewood Healthcare Center	201.52	314
252336	Largo Health Care Center	209.08	315
252344	Heritage Park Rehab. and Healthcare	215.38	316
252352	Island Health and Rehab. Center	191.64	317
252361	North Florida Rehab. and Specialty Care	197.91	318
252379	Shoal Creek Rehabilitation Center	178.70	319
252387	Governor's Creek Health and Rehab.	198.91	320
252395	The Palms Rehab. and Healthcare Center	203.02	321
252409	Grand Oaks Health and Rehab. Center	190.11	322
252417	Harts Harbor Health Care Center	197.78	323
252425	Marshall Health and Rehab. Center	183.22	324
252433	SeaView Nursing and Rehab. Center	203.83	325
252441	Plantation Bay Rehabilitation Center	194.29	326
252450	Rio Pinar Health Care	200.79	327
252468	Rosewood Health and Rehab. Center	201.12	328
252476	OAKTREE HEALTHCARE	194.00	329
252484	Edinborough Healthcare Center	203.12	330
252492	Spring Hill Health and Rehab. Center	193.10	331
252506	Habana Health Care Center	195.82	332
252522	Vista Manor	200.56	333
252531	Hillcrest Nursing and Rehabilitation Center	198.15	334
252549	Azalea Court	219.62	335
252557	Colonial Lakes Health Care	197.63	336
252662	Pinebrook Care & Rehabilitation Center	212.58	337
252671	Palms of Sebring	215.47	338
252689	Orchard Ridge Care & Rehabilitation Center	201.75	339
252956	Leesburg Health & Rehab	216.30	340
253014	Springwood Care & Rehabilitation Center	223.13	341
253146	Southern Oaks Health Care	188.42	342
253421	The Palms At Park Place	185.31	343
253430	Sunset Point Care & Rehabilitation Center	193.06	344
253448	Bay Tree Care & Rehabilitation Center	204.91	345
253456	Surrey Place Health & Rehab Center	192.91	346
253464	West Bay Care & Rehabilitation Center	210.56	347
253472	WUESTHOFF PROGRESSIVE CARE CTR	219.58	348
253481	Forum at Deer Creek	239.16	349
253707	Eden Springs Nursing and Rehab Center	209.91	350
253723	Jackson Plaza Nursing & Rehab	233.56	351
254177	Manor Pines Convalescent Center, LLC	201.68	352

Medicaid Number	Provider Name	Per Diem	
254291	Arch Plaza Nursing & Rehabilitation Center	247.04	353
254762	Wrights Healthcare & Rehabilitation Center	208.93	354
254878	EdgeWood Nursing Center	187.69	355
255572	Woodlands Care Center of Alachua County	173.63	356
256269	Diamond Ridge Health & Rehabilitation Center	198.18	357
256277	Surrey Place Convalescent Center of Bradenton	228.39	358
256757	Lakeside Nursing & Rehabilitation Center	185.58	359
256846	Lakeside Pavillion Care & Rehabilitation Center	209.39	360
256935	Manor Oaks Nursing & Rehab Center	204.42	361
257249	PG of Port St Lucie	200.36	362
257257	PG of West Palm Beach	208.82	363
257265	PG of Gainesville	199.85	364
257273	PG of Jacksonville	209.16	365
257290	PG of Ocala	204.06	366
257303	PG of Orlando	210.89	367
257311	PG of Vero Beach	199.96	368
257320	PG of Winter Haven	196.49	369
257419	Citrus Health and Rehabilitation Center	218.81	370
257460	PG of Clearwater	209.21	371
257478	PG of Largo	221.98	372
257494	PG of North Miami	216.49	373
257508	PG of Pinellas	207.16	374
257516	PG of Sun City	200.53	375
257524	PG of Tampa	205.14	376
258342	Oak Manor Healthcare and Rehabilitation Center	198.35	377
258750	Indigo Manor	219.21	378
258831	Haven of Our Lady of Peace	208.99	379
259080	Life Care Center of Inverrary	213.77	380
259225	Lakeview Terrace Skilled Nursing Facility	205.23	381
259331	UniHealth Post-Acute Care - Santa Rosa	197.43	382
259357	Life Care Center of New Port Richey	194.96	383
259462	The Nursing Center at University Village	223.08	384
259586	Hamlin Place	239.90	385
259870	Avante at St. Cloud, Inc.	227.35	386
259896	Beneva Lakes Healthcare and Rehabilitation Center	202.92	387
259900	Central Park Healthcare and Rehabilitation Center	184.53	388
259918	Coral Bay Healthcare and Rehabilitation	201.53	389
259926	Oakbridge Healthcare Center	202.40	390
259934	The Parks Healthcare and Rehabilitation Center	194.43	391
259942	Riverfront Nursing and Rehab Center	214.63	392
260355	Sarasota Memorial Nursing & Rehabilitation Facilit	208.94	393
260371	Bridgeview Center, LLC	216.52	394
260444	Bayview Center, LLC	215.77	395
260452	Ruleme Center, LLC	220.99	396
260568	Tierra Pines Center, LLC	214.66	397
260576	Highlands Lake Center, LLC	221.02	398
260649	Coquina Center, LLC	218.24	399
260657	Island Lake Center, LLC	213.24	400
260665	Indian River Center LLC	219.05	401
260673	Riverwood Center, LLC	208.56	402
260690	Fairway Oaks Center, LLC	215.70	403

Medicaid Number	Provider Name	Per Diem	
260771	Sinai Plaza Nursing & Rehab	238.46	404
261254	Alhambra Health & Rehab Center	212.12	405
261599	Wood Lake Nursing & Rehabilitation Center	219.09	406
261611	Terra Vista Rehabilitation and Health Center	203.98	407
261629	Avalon Health Care Center	183.97	408
261637	Emerald Healthcare Center	204.08	409
261670	Hawthorne Health & Rehab Center	184.42	410
262064	Golfcrest Healthcare Center	188.85	411
262706	Southern Pines Healthcare Center	181.24	412
262714	Cedar Hills Healthcare Center	182.93	413
262722	Golfview Healthcare Center	204.79	414
263389	Atlantic Shores Nursing and Rehab	209.53	415
263443	Bonifay Nursing and Rehab	177.19	416
263451	Riviera Palms Nursing and Rehab	209.26	417
263460	Boynton Beach Nursing and Rehab	216.91	418
263478	Arbor Trail Nursing and Rehab	197.73	419
263486	Pinellas Point Nursing and Rehab	227.18	420
263494	Jacksonville Nursing and Rehab	207.33	421
263508	Port Orange Nursing and Rehab	213.09	422
263516	Macclenny Nursing and Rehab	192.20	423
263524	Medicana Nursing and Rehab	213.57	424
263532	Tiffany Hall Nursing and Rehab	208.93	425
263541	Metrowest Nursing and Rehab	213.59	426
263559	Moultrie Creek Nursing and Rehab	200.19	427
263567	Orange City Nursing and Rehab	202.31	428
263575	Bayshore Pointe Nursing and Rehab	200.86	429
263583	Royal Oaks Nursing and Rehab	203.35	430
263591	Tuskawilla Nursing and Rehab	203.03	431
263605	Hunter's Creek Nursing and Rehab	223.84	432
263613	Boulevard Manor Nursing and Rehab	202.40	433
263621	Palm City Nursing and Rehab	205.04	434
263834	Bay Pointe Nursing Pavillion	195.69	435
263842	Boca Raton Rehabilitation Center	189.30	436
263851	Rehabilitation and Nursing Center of Broward	216.31	437
263869	Rehabilitation and Healthcare Center of Cape Coral	193.93	438
263877	Carrollwood Care Center	188.03	439
263885	Casa Mora Rehabilitation and Extended Care	195.31	440
263893	Evergreen Woods	195.90	441
263907	Highland Pines Rehabilitation Center	194.45	442
263915	Rehabilitation Center of Palm Beaches	204.61	443
263923	Pompano Rehabilitation and Nursing Center	202.80	444
263931	Healthcare and Rehabilitation Center of Sanford	179.93	445
263940	Rehabilitation and Healthcare of Tampa	186.42	446
263958	The Abbey Rehabilitation and Nursing Center	199.64	447
263966	The Oaks at Avon	196.05	448
263974	Titusville Rehabilitation and Nursing Center	196.72	449
263982	Sarasota Health and Rehabilitation Center	199.09	450
263991	Windsor Woods Rehabilitation and Healthcare Cente	182.54	451
264008	Winkler Court	198.35	452
264067	Blountstown Health and Rehabilitation Center	204.90	453
264351	Crystal Oaks of Pinellas	211.14	454

Medicaid Number	Provider Name	Per Diem	
264482	Lafayette Healthcare Center	202.32	455
264491	Clifford Chester Sims State Veteran's Nursing Home	212.33	456
264512	Conway Lakes Nursing Center	214.46	457
264521	Belleair East Health Care Center	208.27	458
264539	East Bay Nursing Center	210.78	459
264547	MELBOURNE TERRACE RESTORATIVE CARE CE	215.36	460
264563	Centre Point Health and Rehab Center	205.23	461
264571	SPRING LAKE NURSING CENTER	216.74	462
265381	Life Care Center of Estero	207.95	463
265560	Valencia Hills Health and Rehabilitation Center	191.19	464
265721	Summer Brook Health Care Center	175.72	465
265730	Hialeah Convalescent Center	181.62	466
266108	Life Care Center of Ocala	208.90	467
266124	Lake Worth Manor	223.56	468
266281	Southpoint Terrace	181.68	469
266612	Whispering Oaks	159.75	470
267724	The Springs At Boca Ciega Bay	214.09	471
267902	The Nursing Center At Mercy	192.59	472
268003	Lanier Manor	194.54	473
268062	Susanna Wesley Health Center	218.16	474
268186	Life Care Center of Palm Bay	205.14	475
268585	HarborChase of Naples	210.80	476
268755	Abbiejean Russell Care Center	223.37	477
268763	Good Samaritan Center	191.86	478
268780	The Springs at Lake Pointe Woods	223.41	479
269000	John Knox Village Medical Center	187.29	480
269107	Harmony Health Center	186.79	481
269395	The Crossings	200.86	482
269409	The Crossroads	191.33	483
269492	Douglas Jacobson State Veteran's Nursing Home	228.40	484
269697	Regents Park of Sunrise	207.16	485
269719	Regents Park of Winter Park	200.18	486
269727	Regents Park of Jacksonville	193.47	487
281743	Jacaranda Manor	170.91	488
281891	Pasadena Manor	192.57	489
281913	Community Care Center	182.82	490
282359	West Gables Health Care Center	227.96	491
282464	Ridgecrest Nursing & Rehabilitation Center	205.84	492
282529	Coral Reef Nursing and Rehabilitation Center	234.10	493
282537	Palm Terrace of St. Petersburg	230.31	494
282553	The Terrace at Daytona Beach	175.70	495
282618	Palm Terrace of Clewiston	213.94	496
282626	Palm Terrace of Lakeland	215.09	497
283134	Catalina Health Care Center	192.32	498
283193	Life Care Center of Jacksonville	210.47	499
284289	Life Care Center of Orange Park	172.48	500
284785	The Terrace at Flemming Island	179.04	501
284793	Brighton Gardens of Tampa	214.78	502
284823	Aventura Plaza Rehabilitation & Nursing Center	247.14	503
307998	Cypress Village	210.61	504
308005	Palms of Lauderdale Lakes	217.02	505

Medicaid Number	Provider Name	Per Diem	
308111	Baya Pointe Nursing and Rehabilitation Center	196.86	506
308242	Hebrew Home of South Beach	224.05	507
308251	Ponce Plaza Nursing & Rehab Center	227.96	508
308501	Sunset Lake Health & Rehab Center	230.33	509
309800	The Allegro at College Harbor	228.13	510
310409	Watercrest Care Center	209.17	511
310581	ATLANTIC HEALTHCARE CENTER	204.78	512
310841	St. Mark Village	200.97	513
311065	Eagle Lake Rehabilitation and Care Center	215.76	514
311308	South Pointe Plaza	220.83	515
311685	Life Care Center of Punta Gorda	215.25	516
312045	SandalWood Nursing Center	193.09	517
312142	LakeWood Nursing Center	186.28	518
312151	Cross City Rehabilitation and Health Center	199.98	519
312274	CrestWood Nursing Center	181.97	520
312312	Savannah Cove of the Palm Beaches	221.02	521
312371	Southlake Nursing and Rehabilitation Center	224.96	522
312550	Savannah Cove of Maitland	173.55	523
312789	Children's Comprehensive Care Center	247.82	524
313424	Hollywood Hills Rehabilitation Center, LLC	211.40	525
313718	Lutheran Haven Nursing Home	202.96	526
315524	Carrington Place Care Center	207.56	527
315664	Life Care Center of Pensacola	216.42	528
316075	Westwood Health Care Center	212.08	529
316229	Desoto Health & Rehab	240.10	530
316601	San Marco Terrace Rehabilitation and Care	171.60	531
316628	Laurellwood Nursing Center, Inc.	197.95	532
316636	HarbourWood Nursing Center, Inc.	192.84	533
316644	GraceWood Nursing Center, Inc.	187.55	534
316652	BayWood Nursing Center, Inc	180.73	535
317136	Harmony Healthcare & Rehabilitation Center	239.36	536
317195	The Nursing Center at Freedom Village	215.25	537
317349	Darcy Hall of Life Care	207.34	538
317560	Keystone Rehab. and Health Center	205.97	539
317578	Parklands Rehabilitation and Nursing Center	228.67	540
317586	Williston Rehabilitation and Nursing Center	229.03	541
318761	Lake Bennett Health & Rehabilitation Center	204.04	542
318779	Community Health and Rehab Center	198.40	543
318787	Citrus Gardens of Fort Myers	197.89	544
318795	The Court at Palm-Aire	231.41	545
319244	Palmer Ranch Healthcare and Rehabilitation	247.96	546
319325	Deep Creek Rehab & Nursing Center	220.09	547
319333	Harbour Health Center	212.98	548
319341	Dove Healthcare at Lake Wales	209.86	549
319376	Atrium Healthcare Center	185.90	550
319503	Consulate Health Care of Jacksonville	219.89	551
319511	Consulate Health Care of Kissimmee	209.91	552
319520	Consulate Health Care of Melbourne	210.81	553
319538	Consulate Health Care of Orange Park	220.09	554
319546	Consulate Health Care of West Altamonte	218.79	555
319554	Franco Nursing and Rehabilitation Center	199.06	556

Medicaid Number	Provider Name	Per Diem	
319651	Consulate Health Care of Bayonet Point	207.14	557
319660	Consulate Health Care of Brandon	214.57	558
319678	Consulate Health Care of Lake Parker	215.38	559
319686	Consulate Health Care of Pensacola	205.34	560
319694	Consulate Health Care of Safety Harbor	217.17	561
319708	Consulate Health Care of St. Petersburg	215.64	562
319716	Consulate Health Care of Tallahassee	218.33	563
319724	Consulate Health Care of Winter Haven	204.77	564
319953	Consulate Health Care of Lakeland	202.31	565
319970	Consulate Health Care Of New Port Richey	209.20	566
320111	Consulate Health Care of North Fort Myers	202.22	567
320129	Consulate Health Care of Port Charlotte	203.17	568
320137	Consulate Health Care of Sarasota	237.81	569
320145	Consulate Health Care of Vero Beach	208.00	570
320153	Consulate Health Care of West Palm Beach	215.29	571
320391	Zephyr Haven Health & Rehab Center, Inc.	203.31	572
320404	Zephyrhills Health & Rehab Center, Inc.	211.51	573
320412	Sunbelt Health & Rehab Center - Apopka, Inc.	200.28	574
320421	East Orlando Health & Rehab Center, Inc.	225.67	575
320439	Adventist Care Centers - Courtland, Inc.	217.02	576
320463	Florida Living Nursing Center	224.20	577
320528	Health & Rehab. Centre at Dolphins View	226.88	578
320978	Lehigh Acres Health & Rehabilitation Center	235.29	579
321303	Ft. Lauderdale Health & Rehab Center	223.36	580
323772	Coral Gables Nursing and Rehabilitation	212.40	581
323781	Tarpon Point Nursing & Rehabilitation Center	228.79	582
323799	St. Andrews Bay Skilled Nursing & Rehab Center	220.59	583
324027	Hampton Court Nursing Center	229.85	584
324094	Advanced Rehabilitation & Health Center	237.95	585
324108	Bayside Rehabilitation & Health Center	254.31	586
324116	Excel Rehabilitation & Health Center	227.98	587
324124	Madison Pointe Rehabilitation & Health Center	226.29	588
324132	Shore Acres Rehabilitation & Health Center	229.19	589
324141	Woodbridge Rehabilitation & Health Center	227.46	590
324159	Ocoee Health Care Facility	220.50	591
324167	Palmetto Rehabilitation and Health Center	247.55	592
324175	Courtyards of Orlando	229.55	593
324213	Royal Care of Avon Park	188.50	594
324230	Seminole Nursing Pavilion	210.28	595
324248	Freedom Square Nursing Center	188.84	596
324345	Heritage Park Care and Rehabilitation Center	207.06	597
324353	Washington Rehabilitation and Nursing Center	201.20	598
324361	Chautauqua Rehabilitation and Nursing Center	193.19	599
324370	Signature HealthCARE of College Park	206.92	600
324388	Signature HealthCARE of Gainesville	193.45	601
324396	Signature Healthcare of North Florida	190.40	602
324400	Signature HealthCARE Center of Waterford	188.74	603
324418	Signature Healthcare of Brookwood Gardens	219.30	604
324426	Signature Healthcare at the Courtyard	183.29	605
324434	Signature Healthcare of Orange Park	201.10	606
324442	Signature Healthcare of Ormond	208.77	607

Medicaid Number	Provider Name	Per Diem	
324451	Anchor Care & Rehabilitation Center	201.18	608
324469	Pinellas Park Care and Rehabilitation Center	192.35	609
324477	Signature Healthcare of Port Charlotte	214.50	610
324485	The Bridge at Bay St. Joe	193.07	611
324493	Kenilworth Care and Rehabilitation Center	200.12	612
324507	Peninsula Care and Rehabilitation Center	213.64	613
324515	Winter Park Care and Rehabilitation Center	200.82	614
324566	Southern Oaks Rehabilitation and Nursing Center	214.06	615
324612	RiverWood Nursing Center	163.82	616
325031	Terraces of Lake Worth Rehab and Health Center	256.74	617
325040	Arbor Village Nursing Center	203.14	618
325163	North Lake Rehabilitation and Health Center	254.77	619
325236	Heartland Health Care Center - Jacksonville	194.96	620
325244	Heartland of Kendall	190.63	621
325252	Heartland of Miami Lakes	209.37	622
325261	Heartland of Orange Park	197.87	623
325279	MCHS - Winter Park	200.67	624
325287	South Jacksonville	195.41	625
325295	Heartland of Brooksville	202.11	626
325309	Heartland of Boynton Beach	180.94	627
325325	Heartland of Ft. Myers	203.52	628
325333	Heartland of Lauderhill	194.93	629
325341	Heartland of Prosperity Oaks	205.37	630
325350	Heartland of Tamarac	200.88	631
325368	MCHS- Boca Raton	212.89	632
325376	MCHS- Boynton Beach	205.20	633
325384	MCHS - Ft. Myers	208.04	634
325422	MCHS-Lely Palms	216.98	635
325449	MCHS - Naples	203.87	636
325457	MCHS- Plantation	211.74	637
325465	MCHS - Sarasota	207.24	638
325473	MCHS Venice	198.32	639
325481	MCHS West Palm Beach	210.49	640
325490	North Sarasota	213.01	641
325520	MCHS- Delray	192.65	642
325678	MCHS - Carrollwood	214.45	643
325686	MCHS - Dunedin	203.45	644
325694	MCHS - Palm Harbor	193.99	645
325708	Heartland of Zephyrhills	195.29	646
326011	Moosehaven	209.34	647
	Statewide Average:	209.20	

Exhibit 6

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

SMDL #01-006

Olmstead Update No: 4
Subject: HCFA Update
Date: January 10, 2001

Dear State Medicaid Director:

This is the fourth in a series of letters designed to provide guidance and support to States in their efforts to enable individuals with disabilities to live in the most integrated setting appropriate to their needs, consistent with the Americans with Disabilities Act (ADA). In attachments to this letter, we address certain issues related to allowable limits in home and community-based services (HCBS) waivers under section 1915(c) of the Social Security Act.

In attachments to this letter, we address certain questions related to State discretion in the design and operation of HCBS waivers under section 1915(c) of the Social Security Act. We also explain some of the principles and considerations that the Health Care Financing Administration (HCFA) will apply in the review of waiver requests and waiver amendments. Finally, we respond to key questions that have arisen in the course of State or constituency deliberations to improve the adequacy and availability of home and community-based services, or recent court decisions.

We encourage you to continue forwarding your policy-related questions and recommendations to the ADA/Olmstead workgroup through e-mail at ADA/Olmstead@hcfa.gov.

HCFA documents relevant to Medicaid and the ADA are posted on the ADA/Olmstead website at **http://www.hcfa.gov/medicaid/olmstead/olmshome.htm**.

Sincerely,

Timothy M. Westmoreland
Director

Enclosures
Attachment 4-A "Allowable Limits and State Options in HCBS waivers"

State Medicaid Director – 2

cc:
HCFA Regional Administrators

HCFA Associate Regional Administrators for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
National Association of State Medicaid Directors

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors' Association

Robert Glover
Director of Governmental Relations
National Association of State Mental Health Program Directors

Brent Ewig
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Lewis Gallant
Executive Director
National Association of State Alcohol and Drug Abuse Directors, Inc.

Robert Gettings
Executive Director
National Association of State Directors of Developmental Disabilities Services

Virginia Dize
Director, State Community Care Programs
National Association of State Units on Aging.

Attachment 4-A
Subject: Allowable Limits and State Options in HCBS Waivers
Date: January 10, 2001

In this attachment, we discuss limits that States may place on the number of persons served and on services provided under an HCBS waiver. Current law requires States to identify the total number of people who may be served in an HCBS waiver in any year. States may derive this overall enrollment limit from the amount of funding the legislature has appropriated. However, once individuals are enrolled in the waiver, the State may not cap or limit the number of enrolled waiver participants who may receive a covered waiver service that has been found necessary by an assessment.

We have received a number of questions regarding limits that States may, or are required to, establish in HCBS waivers under section 1915(c) of the Social Security Act. Many of these questions have arisen in the course of discussions about the ADA and the Supreme Court Olmstead decision. Others have arisen in the context of certain court cases premised on Medicaid law. Examples include:

1. ***Overall Number of Participants:*** May a State establish a limit on the total number of people who may receive services under an HCBS waiver?

2. ***Fiscal Appropriation:*** May a State use the program's funding appropriation to specify the total number of people eligible for an HCBS waiver?

3. ***Access to Services Within a Waiver***: May a State have different service packages within a waiver? Once a person is enrolled in an HCBS waiver, can the individual be denied a needed service that is covered by the waiver based on a State limit on the number of enrollees permitted access to different waiver services?

4. ***Sufficiency of Amount, Duration, and Scope of Services***: What principles will HCFA apply in reviewing limitations that States maintain with respect to waiver services?

5. ***Amendments that Lower the Potential Number of Participants***: May a State reduce the total number of people who may be served in an HCBS waiver? Are there special considerations that need attention in such a case?

6. ***Establishing Targeting Criteria for Waivers:*** How much discretion does a State have in establishing the targeting criteria that will be used in a waiver program? May a State define a target group for the waiver that encompasses more than one of the categories of individuals listed in 42 CFR 441.301(b)(6)?

In subjects 1 and 2, we explain current law and policy regarding the setting of limits on the total number of people who may be eligible for an HCBS waiver. In subject 3, we provide new clarification with respect to the access that waiver enrollees must be afforded within a waiver, consistent with recent court decisions. In subject 4, we explain that, while section 1915(c) permits a waiver of many Medicaid requirements, the requirement for adequate amount, duration, and scope is not waived. In subject 5, we discuss special considerations that HCFA will apply when reviewing any waiver amendment request in which the total number of eligible individuals would be reduced, so that the implications of the proposed amendment are fully addressed in light of all applicable legal considerations. In subject 6, we seek to reduce State administrative expenses by permitting States to develop a single waiver for people who have a disability or set of conditions that cross over more than one current waiver category.

The answers to the questions below are derived from Medicaid law. However, because Medicaid HCBS waivers affect the ability of States to use Medicaid to fulfill their obligations under the ADA and other statues, we have included these answers as an Olmstead/ADA update.

1. Overall Number of Participants

May a State establish a limit on the total number of people who may receive services under an HCBS waiver?

Yes. Under 42 CFR 441.303(f)(6), States are required to specify the number of unduplicated recipients to be served under HCBS waivers:

> The State must indicate the number of unduplicated beneficiaries to which it intends to provide waiver services in each year of its program. This number will constitute a limit on the size of the waiver program unless the State requests and the Secretary approves a greater number of waiver participants in a waiver amendment.

Thus, unlike Medicaid State plan services, the waiver provides an assurance of service only within the limits on the size of the program established by the State and approved by the Secretary. The State does not have an obligation under Medicaid law to serve more people in the HCBS waiver than the number requested by the State and approved by the Secretary. If other laws (e.g., ADA) require the State to serve more people, the State may do so using non-Medicaid funds or may request an increase in the number of people permitted under the HCBS waiver. Whether the State chooses to avail itself of possible Federal funding is a matter of the State's discretion. Failure to seek or secure Federal Medicaid funding does not generally relieve the State of an obligation that might be derived from other legislative sources (beyond Medicaid), such as the ADA.

If a State finds that it is likely to exceed the number of approved participants, it may request a waiver

amendment at any time during the waiver year. Waiver amendments may be retroactive to the first day of the waiver year in which the request was submitted.

2. Fiscal Appropriation

May a State use the program's funding appropriation to specify the total number of people eligible for an HCBS waiver?

HCFA has allowed States to indicate that the total number of people to be served may be the lesser of either (a) a specific number pre-determined by the State and approved by HCFA (the approved "factor C" value), or (b) a number derived from the amount of money the legislature has made available (together with corresponding Federal match). The current HCBS waiver pre-print used by States to apply for waivers contains both options. States sometimes use the second option because of the need to seek Federal waiver approval prior to the appropriation process, and sometimes the legislative appropriations are less than the amount originally anticipated. In addition, the rate of turnover and the average cost per enrollee may turn out to be different than planned, thereby affecting the total number of people who may be served.

In establishing the maximum number of persons to be served in the waiver, the State may furnish, as part of a waiver application, a schedule by which the number of persons served will be accepted into the waiver. The Medicaid agency must inform HCFA in writing of any limit that is subsequently derived from a fiscal appropriation, and supply the calculations by which the number or limit on the number of persons to be served was determined. This information will be considered a notification to HCFA rather than a formal amendment to the waiver if it does not substantially change the character of the approved waiver program. If a State fails to report this limit, HCFA will expect the State to serve the number of unduplicated recipients specified in the approved waiver estimates.

3. Access to Services Within a Waiver

May a State have different service packages within a waiver? Once a person is enrolled in a HCBS waiver, can the individual be denied a needed service that is covered by the waiver based on a State limit on the number of enrollees permitted access to different waiver services?

No. A State is obliged to provide all people enrolled in the waiver with the opportunity for access to all needed services covered by the waiver and the Medicaid State plan. Thus, the State cannot develop separate and distinct service packages for waiver population subgroups within a single waiver. The opportunity for access pertains to all services available under the waiver that an enrollee is determined to need on the basis of an assessment and a written plan of care/support.

This does not mean that all waiver participants are entitled to receive all services that theoretically could be available under the waiver. The State may impose reasonable and appropriate limits or utilization

control procedures based on the need that individuals have for services covered under the waiver. An individual's right to receive a service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria that the State develops and applies fairly to all waiver enrollees.

This clarification does mean, however, that States are not allowed to place a cap on the number of enrollees who may receive a particular service within the waiver. There is no authority provided under law or regulation for States to impose a cap on the number of people who may use a waiver service that is lower than the total number of people permitted in the waiver. Denial of a needed and covered service within a waiver would have the practical effect of: (a) undermining an assessment of need, (b) countermanding a plan of care/support based on such an assessment of need, (c) converting a feasible service into one that arbitrarily benefits some waiver participants but not others who may have an equal or greater need, and (d) jeopardizing an individual's health or welfare in some cases.

Similarly, a State may not limit access to a covered waiver service simply because the spending for such a service category is more than the amount anticipated in the budget. In the same way that nursing facilities may not deny nursing or laundry services to a resident simply because the nursing or laundry expenses for the year have exceeded projections, the HCBS waiver cannot limit access to services within the waiver based on the budget for a specific waiver-covered service. It is only the overall budget amount for the waiver that may be used to derive the total number of people the State will serve in the waiver. Once in the waiver, an enrolled individual enjoys protection against arbitrary acts or inappropriate restrictions, and the State assumes an obligation to assure the individual's health and welfare.

We appreciate that a State's ability to provide timely access to particular services within the waiver may be constrained by supply of providers, or similar factors. Therefore, the promptness with which a State must provide a needed and covered waiver service must be governed by a test of reasonableness. The urgency of an individual's need, the health and welfare concerns of the individual, the nature of the services required, the potential need to increase the supply of providers, the availability of similar or alternative services, and similar variables merit consideration in such a test of reasonableness. The complexity of "reasonable promptness" issues may be particularly evident when a change of living arrangement is required. Where the need for such a change is very urgent (e.g., as in the case of abuse in a person's current living arrangement), then "reasonable promptness" could mean "immediate." Where the need for a change of living arrangement for a particular person is clear but not urgent, application of the reasonableness test to determine "reasonable promptness" could provide more time.

We recognize the question of reasonable promptness is a difficult one. We wish to call the issue to your attention as a matter of considerable importance that merits your immediate review. The issue will receive more attention from us in the future and is already receiving attention by the courts. The essential message is that the State's ability to deliver on what it has promised is very important. During CY 2001, we expect to work closely with States to improve our common understanding of what reasonable promptness requires. We also hope to collaborate with you on the infrastructure

improvements that States may need to improve local ability to provide quality, customer-responsive and adequate services or supports in a timely manner.

4. Sufficiency of Amount, Duration and Scope of Services

What principles will HCFA apply in reviewing limitations that States maintain with respect to waiver services?

Federal regulations at 42 CFR 440.230(b) require that each Medicaid service must be sufficient in amount, duration, and scope to achieve the purpose of the service category. Within this broad requirement, States have the authority to establish reasonable and appropriate limits on the amount, duration and scope of each service.

In exercising discretion to approve new waiver requests, we will apply the same sufficiency concept to the entire waiver itself, i.e., whether the amount, duration and scope of all the services offered through the waiver (together with the State's Medicaid plan and other services available to waiver enrollees) is sufficient to achieve the purpose of the waiver to serve as a community alternative to institutionalization and assure the health and welfare of the individuals who enroll.

In applying this principle, it is not our intent to imply or establish minimum standards for the number or type of services that must be in an HCBS waiver. Because the waiver wraps around Medicaid State plan services, and because the needs of each target group vary considerably, it is clear that the sufficiency question may only be answered by a three-way review of (a) the needs of the selected target group, (b) the services available to that target group under the Medicaid State plan and other relevant entitlement programs, and (c) the type and extent of HCBS waiver services. Whether the combination of these factors would permit the waiver to meet its purpose, particularly its statutory purpose to serve as a community alternative to institutionalization, is an analysis we would expect each State to conduct.

Where a waiver design is manifestly incapable of serving as such an alternative for a preponderance of the State's selected target group, we would expect the State to make the adjustments necessary to remedy the problem in its waiver application for any new waiver. In other cases, an exceptionally limited service design may prevent an existing waiver from being able to assure the health or welfare of the individuals enrolled. Where, subsequent to a HCFA review of quality in an existing waiver, it is very clear that the waiver design renders it manifestly incapable of responding effectively to serious threats to the health or welfare of waiver enrollees, we would expect the State to make the necessary design adjustments to enable the State to fulfill its assurance to protect health and welfare. The fact that States have the authority to limit the total number of people who may enroll in a waiver provides States with reasonable methods to control the overall spending. This means that States should be able to manage their waiver budgets without undermining the waiver purpose or quality by exceptional restrictions applied to services that will be available within the waiver.

5. Amendments That Lower the Potential Number of Participants

May a State reduce the total number of people who may be served in an HCBS waiver? Are there special considerations that need attention in such a case?

A State may amend an approved waiver to lower the number of potential eligibles, subject to certain limitations. The following represent special considerations that HCFA will take into account in reviewing such waiver amendments:

Existing Court Cases or Civil Rights Complaints: If the number of waiver eligibles is a material item to any ongoing legal proceeding, investigation, finding, settlement, or similar circumstance, we will expect the State to (a) notify HCFA and the court of the State's request for a waiver amendment, and (b) notify HCFA and the DHHS Office for Civil Rights whenever a waiver amendment is relevant to the investigation or resolution of any pending civil rights complaint of which the State is aware.

Avoiding or Minimizing Adverse Effects on Current Participants: Under section 1915(c)(2)(A), HCFA is required to assure that the State has safeguards to protect the health and welfare of individuals provided services under a waiver. Thus, a key consideration in HCFA's review of requests to lower the number of unduplicated recipients for an existing waiver is the potential impact on the current waiver population. By "current waiver population," we refer to people who have been found eligible and have enrolled in the waiver. Any reduction in the number of potential waiver eligibles must be accomplished in a manner that continues to assure the health, welfare, and rights of all individuals already enrolled in the waiver. An important consideration is whether a proposed reduction in waiver services would adversely affect the rights of current waiver enrollees to receive services in the most integrated setting appropriate, consistent with the ADA. The State may address these concerns in several ways:

- The State may provide an assurance that, if the waiver request is approved, the State will have sufficient service capacity to serve at least the number of current participants enrolled in the waiver as of the effective date of the amendment.

- The State may assure HCFA that no individuals currently served on the waiver will be removed from the program or institutionalized inappropriately due to the amendment. For example, the State may achieve a reduction through natural attrition.

- The State may provide an assurance and methodology demonstrating how individuals currently served by the waiver will not be adversely affected by the proposed amendment. For example, a State that no longer requires its waiver, because it has added as a State plan

service the principal service(s) provided by the waiver, may specify a method of transitioning waiver participants to the State plan service. We note that any individual who is subject to removal from a waiver is entitled to a fair hearing under Medicaid law, and the methodology of transition is particularly important in that context.

- The State may provide a plan whereby affected individuals will transition to other HCBS waivers without loss of Medicaid eligibility or significant loss of services. We anticipate that this may occur when a State seeks to consolidate two or more smaller waivers into one larger program.

This discussion should not be construed as limiting a State's responsibilities to provide services to qualified individuals with disabilities in the most integrated settings appropriate to their needs as required by the ADA or other Federal or State law.

6. Establishing Targeting Criteria for Waivers

How much discretion does a State have in establishing the targeting criteria that will be used in a waiver program? May a State define a target group for the waiver that encompasses more than one of the categories of individuals listed in 42 CFR 441.301(b)(6)?

Under 42 CFR 441.301(b)(6), HCBS waivers must "be limited to one of the following targeted groups or any subgroup thereof that the State may define: (i) aged or disabled or both, (ii) mentally retarded or developmentally disabled or both, (iii) mentally ill." States have flexibility in establishing targeting criteria consistent with this regulation. States may define these criteria in terms of age, nature or degree or type of disability, or other reasonable and definable characteristics that sufficiently distinguish the target group in understandable terms.

HCFA recognizes that discrete target groups may encompass more than one of the categories of individuals defined in this regulation. For example, persons with acquired brain injury may be categorized as either physically disabled in accordance with section 441.301(b)(6)(i) or developmentally disabled in accordance with section 441.301(b)(6)(ii) depending on the age of the person when the brain injury occurred. In such cases, HCFA will permit the State to have one waiver to serve the defined target population that could conceivably encompass more than one category of the regulations in order to avoid the unnecessary administrative expense resulting from the development of a second waiver for the target population.

Please refer any questions concerning this attachment to Mary Jean Duckett (410) 786-3294.

Attachment 4-B
Subject: EPSDT and HCBS Waivers
Date: January 10, 2001

In this attachment, we clarify ways in which Medicaid HCBS waivers and the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services interact to ensure that children receive the full complement of services they may need.

States may take advantage of Medicaid HCBS waivers under section 1915(c) of the Social Security Act to supplement the services otherwise available to children under Medicaid, or to provide services to children who otherwise would not be eligible for Medicaid. In both cases, States must ensure that (1) all children, including the children made eligible for Medicaid through their enrollment in a HCBS waiver, receive the EPSDT services they need, and (2) children receive all medically necessary Medicaid coverable services available under EPSDT. Because the HCBS waiver can provide services not otherwise covered under Medicaid, and can also be used to expand coverage to children with special health care needs, EPSDT and HCBS waivers can work well in tandem. However, a child's enrollment in an HCBS waiver cannot be used to deny, delay, or limit access to medically necessary services that are required to be available to all Medicaid-eligible children under federal EPSDT rules.

Under EPSDT requirements, generally children under age 21 who are served under the Medicaid program should have access to a broad array of services. State Medicaid programs must make EPSDT services promptly available [for any individual who is under age 21 and who is eligible for Medicaid] whether or not that individual is receiving services under an approved HCBS waiver.

Included in the Social Security Act at section 1905(r), EPSDT services are designed to serve a twofold purpose. First, they serve as Medicaid's well-child program, providing regular screenings, immunizations and primary care services. The goal is to assure that all children receive preventive care so that health problems are diagnosed as early as possible, before the problems become complex and treatment more difficult and costly. Under federal EPSDT rules, States must provide for periodic medical, vision, hearing and dental screens. An EPSDT medical screen must include a comprehensive health and developmental history, including a physical and mental health assessment; a comprehensive unclothed physical examination; appropriate immunizations; laboratory tests, including lead blood level assessments appropriate for age and risk factors; and health education, including anticipatory guidance.

The second purpose of EPSDT services is to ensure that children receive the services they need to treat identified health problems. When a periodic or inter-periodic screening reveals the existence of a problem, EPSDT requires that Medicaid-eligible children receive coverage of all services necessary to

diagnose, treat, or ameliorate defects identified by an EPSDT screen, as long as the service is within the scope of section 1905(a) of the Social Security Act. (Please note that we have long considered any encounter with a health care professional practicing within the scope of his/her practice inter-periodic screening.) That is, under EPSDT requirements, a State must cover any medically necessary services that could be part of the basic Medicaid benefit if the State elected the broadest benefits permitted under federal law (not including HCBS services, which are not a basic Medicaid benefit). Therefore, EPSDT must include access to case management, home health, and personal care services to the extent coverable under federal law

Medicaid's HCBS waiver program serves as the statutory alternative to institutional care. This program allows States to provide home or community-based services (other than room and board) as an alternative to Medicaid-funded long term care in a nursing facility, intermediate care facility for the mentally retarded, or hospital.

- Under an HCBS waiver, States may provide services that are not otherwise available under the Medicaid statute. These may include homemaker, habilitation, and other services approved by HCFA that are cost-effective and necessary to prevent institutionalization. Waivers also may provide services designed to assist individuals to live and participate in their communities, such as prevocational and supported employment services and supported living services. HCBS waivers may also be used to provide respite care (either at home or in an out-of-home setting) to allow family members some relief from the strain of caregiving.

- In addition, under a Medicaid HCBS waiver, a State may provide Medicaid to persons who would otherwise be eligible only in an institutional setting, often due to the income of a spouse or parent. This is accomplished through a waiver of section 1902(a)(10)(C)(i)(III) of the Social Security Act, regarding income and resource rules.

In all instances, HCBS waivers supplement but do not supplant a State's obligation to provide EPSDT services. A child who is enrolled in an HCBS waiver also must be assured EPSDT screening and treatment services. The waiver is used to provide services that are in addition to those available through EPSDT.

There are a number of distinctions between EPSDT services and HCBS waivers. While States may limit the number of participants under an HCBS waiver, they may *not* limit the number of eligible children who may receive EPSDT services. Thus, children cannot be put on waiting lists for Medicaid-coverable EPSDT services. While States may limit the services provided under an HCBS waiver in the ways discussed in attachment 4-A, States may *not* limit medically necessary services needed by a child who is eligible for EPSDT that otherwise could be covered under Medicaid. Children who are enrolled in the HCBS waiver must also be afforded access to the full panoply of EPSDT services. Moreover, under EPSDT, there is an explicit obligation to "make available a variety of individual and group providers qualified and willing to provide EPSDT services" 42 CFR 441.61(b).

Similarly, a State may use an HCBS waiver to extend Medicaid eligibility to children who otherwise would be eligible for Medicaid only if they were institutionalized. Such children are also entitled to the full complement of EPSDT services. Children made eligible for Medicaid through their enrollment in an HCBS waiver cannot be limited to the receipt of waiver services alone.

The combination of EPSDT and HCBS waiver services can allow children with special health care, as well as developmental and behavioral needs, to remain in their own homes and communities and receive the supports and services they need. The child and family can benefit most when the State coordinates its Medicaid benefits with special education programs in such a way as to enable the family to experience one system centered around the needs of the child. In developing systems to address the needs of children with disabilities, we encourage you to involve parents and other family members as full partners in your planning and oversight activities. HCFA staff will be pleased to consult with States that are working to structure children's programs around the particular needs of children with disabilities and their families.

Please refer any questions concerning this attachment to Mary Jean Duckett (410) 786-3294.