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National Senior Citizens Law Center

Summary of Florida's Long Term Care Managed Care Program

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Introduction

In February 2013, the Centers for Medicare and Medicaid Services (CMS) approved Florida's proposal to provide Medicaid long-term services and supports (LTSS) through managed care. As is generally the case in Medicaid managed care, Florida's move to managed care is being promoted by the state as a way to provide care in a more coordinated fashion, but in practice may limit access to care for many Medicaid beneficiaries.

On the positive side, for example, Florida's managed care program will offer a broad range of community-based services, and the description of the care planning process focuses on beneficiaries' needs and preferences. On the other hand, community-based services will be subject to an enrollment cap that essentially extends the same enrollment cap that has been in place for community-based services in recent years. Given the significant waiting list that currently

exists for Medicaid-funded community-based services in Florida, the continuation of the enrollment cap is troubling news for Florida beneficiaries.

This paper summarizes some important aspects of the Florida program. Identification of potential problems is key; for Florida Medicaid beneficiaries and their advocates, now is the time for further systemic advocacy. Especially to the extent that the federal approval has not completely addressed important issues, the state has the authority to establish consumer protections through the contracts with the managed care organizations (MCOs) and other guidance.

These issues are relevant to beneficiaries and their advocates in other states as well. States across the country are considering the transfer of Medicaid LTSS to managed care, and advocacy on beneficiaries' behalf, as soon as possible in the policy development process, will be vital if managed care systems truly are to provide care that is both coordinated and beneficiary-focused.

The Long Term Care Managed Care Program[1]

The Florida Long-Term Care Managed Care program (the Program) has been approved for three years, with an effective date of July 1, 2013. The Program will apply statewide and enrollment will be mandatory for eligible persons needing LTSS, with limited exceptions, and with the proviso that home and community-based services (HCBS) will be subject to an enrollment cap. The Program provides only nursing facility services and HCBS; non-LTSS Medicaid services (such as hospital and physician services) are the subject of a different managed care waiver application, which currently is under review by CMS. A recent letter from CMS states that the CMS and the State of Florida "have reached agreement in principle on granting the waiver," and currently are working through various details.[2]

Under the Program, care will be provided through managed care organizations (MCOs) paid on a capitated monthly rate for each enrollee or, alternatively, provider service networks paid on a fee-for-service mechanism that provides incentives for cost savings. Both the MCOs and the provider service networks will operate under the same rules, aside from the difference in reimbursement. For simplicity, this summary will refer to an "MCO" to describe the health plans that will provide LTSS to the Medicaid-eligible enrollees, rather than continually referencing *both* MCOs and provider service networks.

With limited exceptions, persons with level-of-care needs that would qualify them for nursing facility services will be required to

enroll in MCOs in order to receive LTSS. The MCOs will be responsible for providing both nursing facility services and HCBS.

For purposes of the Program, the state has been divided into 11 regions, each of which has a specified number of managed care plans. Enrollment will be phased in over an eight-month period from August 2013 through March 2014, beginning with the implementation of the Program in Region 7 (including Orlando) in August 2013.

The Program takes the place of four existing HCBS waivers that are being phased out: the Aged/Disabled Adult Waiver, the Assisted Living Waiver, the Channeling for the Frail Elderly Waiver, and the Nursing Home Diversion Waiver (the Diversion Waiver already uses managed care). The four waivers being phased out had a total enrollment cap of 35,852. The Program will operate under a comparable cap with an annual enrollment limitation of 36,795 for HCBS for each of the three years, with HCBS enrollment at any one time capped at 35,852 throughout the three-year period.

The Program will be administered by Florida's Agency for Health Care Administration (Florida's Medicaid agency), in partnership with Florida's Department of Elder Affairs.

Waiver Application History

Florida originally submitted its proposal to CMS in August 2011. The proposal was presented through two separate waiver applications – one application under Section 1915(b) of the Social Security Act to allow Medicaid mandatory managed care, and a second application under Section 1915(c) to authorize HCBS as an alternative to nursing facility services.

During the pendency of the waiver applications, negotiations took place between Florida and CMS, leading ultimately to revisions in the applications.[3] As a result, the approved applications fulfill the same purpose as documents issued by CMS in other situations to set conditions for waiver programs — for example, memoranda of understanding that set conditions for Medicare-Medicaid integration demonstration programs, and documents of Special Terms and Conditions that authorize Medicaid managed LTSS under a Section 1115 demonstration waiver.

The negotiation of revised Section 1915(b)/(c) applications resulted in much less policy detail than the issuance of Special Terms and Conditions under a request for a Section 1115 demonstration waiver. For example, Florida's revised application under Section 1915(b) in relation to network adequacy, does no more than promise to comply with the relevant federal statutes and regulations.[4] By contrast, Medicaid programs in New Jersey and New York recently received approvals under Section 1115 to move LTSS into managed care and, in each instance, the Special Terms and Conditions issued by CMS contain significantly more detail than do Florida's approved applications in relation to network adequacy and many other issues.[5]

Eligibility[6]

The Program will be available to persons of at least age 18 who are assessed to have a need for nursing facility services. Of course, as a Medicaid program, the Program also

will require that an applicant meet financial eligibility requirements. In this regard, SSI recipients are categorically eligible. Also eligible are persons with limited resources and monthly incomes no more than $2,130 (300% of the federal monthly SSI benefit of $710). Spousal impoverishment protections are available, to allow a beneficiary's spouse to retain certain allocations of resources and income.

Enrollment will be mandatory for eligible persons who wish to receive LTSS, with limited exceptions, such as persons residing in intermediate care facilities for the developmentally disabled, or persons receiving services through a Program of All-Inclusive Care for the Elderly (PACE). Furthermore, as discussed above, receipt of HCBS is limited by enrollment caps, which means that if HCBS enrollment already is at the designated limit, an otherwise-eligible person will not be able to receive HCBS at that time. Instead, the person will be placed on a waiting list, and may begin receiving services in a nursing facility as an alternative to the unavailable HCBS. It should be noted, however, that Florida advocates report that nursing facility services also are effectively limited by a shortage of Medicaid-certified nursing facility beds.

In general, persons living in the community will be allowed to retain income up to the special income limit of $2,130 monthly. For assisted living residents, however, the income limit will be the sum of the assisted living basic room and board rate, the cost of three meals per day, plus 20% of the federal poverty rate ($191.50 in 2013). To the extent that an enrollee's income exceeds the limit, he or she will be required to pay the excess as a contribution towards the cost of the health care services. MCOs are responsible for collecting such contributions, and capitation rates will be reduced slightly to take these collections into account, so that MCOs do not receive duplicate payments.

Aside from any contribution based on income level, enrollees will pay no premiums, enrollment fees, or co-payments.

Enrollment[7]

As mentioned, enrollment will be phased in over an eight-month period from August 2013 through March 2014. Region 7 (which includes Orlando) will be transitioned first, with enrollment beginning on August 1, 2013. The Miami area (Region 11) and the Tampa Bay area (Regions 5 and 6) will be transitioned in December 2013 and February 2014, respectively.

Approximately four months before enrollment, each affected Medicaid recipient will be sent a notice and then an enrollment information package, with instructions to review the material and receive telephonic or face-to-face counseling. Assistance also will be provided by case managers from existing waiver programs, for recipients in those waivers. Beneficiaries will have 30 days to select a plan; if they fail to do so, they will be assigned to a plan based on whether the plan has sufficient capacity, and whether the person is already enrolled in a plan through the Nursing Home Diversion Waiver.

Choice counselors will have provider listings for each plan's network. For persons who do not engage in the Choice Counseling Process, the state will have access to information regarding the person's enrollment (if any) in

a Special Needs Plan or Medicare Advantage Plan, in considering how to enroll the person, so that pre-existing relationships can be continued to the extent possible.

Once enrolled in an MCO, an enrollee will be able to change plans only within 90 days of enrollment, during an annual open enrollment period, and for good cause. Good cause is determined on a case-by-case basis, with the following scenarios being identified as good cause:

- Poor quality of care
- Lack of access to covered services
- Lack of access to providers experienced with enrollee's health care needs
- Enrollment in error
- MCO marketing violation
- State-imposed intermediate sanction[8]

Consumer Assistance[9]

CMS modified the Section 1915(b) application to ask explicitly for a description of "the state's ability to provide beneficiary assistance through call centers, ADRC [Aging and Disability Resource Center] assistance, and the independent advocacy/ Ombudsman."[10] National consumer advocates have recommended that managed LTSS systems include independent ombuds programs[11] but, notably, Florida's response in the approved application did not indicate any effort to develop such an independent program:

> The current recipient support framework, which includes Medicaid Area Offices, Long-Term Care Ombudsman, Aging and Disabilities Resource Centers, aging and disability advocacy groups and the state's extensive open government and public policy development and adoption process (which affords significant citizen involvement), will continue to serve recipients after long-term care managed care is implemented. The state is focusing its initial outreach and education efforts on these stakeholder groups and on long term care providers, as the long term care recipients are likely to contact them with questions.[12]

There is some indication, however, that CMS may revisit this issue. Approximately three weeks after the issuance of the approved waivers for the Program, CMS official Cindy Mann, the Director of the Center for Medicaid and CHIP Services, wrote in a letter to the State of Florida that "we will work together to ensure that a robust independent consumer support program is in operation to help beneficiaries navigate and access long-term care services and supports so that beneficiary concerns are identified and addressed," and that "we should continue to discuss whether this activity should be assured in the [pending managed care waiver application for non-LTC services] or through an amendment to the recent 1915(b)(c) approval" for the Program.[13]

Exemptions from Managed Care[14]

Medicaid recipients will be exempted from managed care on a case-by-case basis. The application gives two examples of situations in which a recipient *might* be exempted from managed care enrollment: residing in a specific nursing facility, or receiving services

from a hospice that is not part of a managed care network.

Available Services[15]

The following services will be available under the Program: adult day health care, case management, homemaker, respite, attendant care, intermittent and skilled nursing, medical equipment and supplies, occupational therapy, personal care, physical therapy, speech therapy, transportation, adult companion, assisted living, behavior management, caregiver training, home accessibility adaptations, medication administration, medication management, nutritional assessment and risk reduction, and personal emergency response. The State claims that all LTSS currently available through HCBS waivers will also be available through the new waiver, although in some cases the terminology will change.

All service providers will be required to encourage enrollee independence, inclusion, and integration in the community. MCOs must have the "maximum flexibility needed" to ensure that enrollees receive the services they need to maintain their health, safety and welfare in the community.

Federal regulations require an MCO to identify enrollees with special health care needs, develop treatment plans for those enrollees, and provide them with direct access to specialists.[16] MCOs in the Florida program will be excused from such requirements based on Florida's assertion in the applications that all enrollees will have special health care needs, and on the idea that the specialness of the enrollees' health care needs can be recognized in the provision of primary, acute and behavioral health care services (all of which are provided outside of the Program).

Level of Care[17]

Consistent with existing practice, level of care determinations will be performed by the Comprehensive Assessment and Review of Long-Term Care Services (CARES) Unit of the Department of Elder Affairs. The Unit is comprised of a physician, registered nurse, and other assessors with nursing or advanced social work degrees. The Unit's assessors complete the level of care evaluations based on an assessment form completed by a case manager.

The State will use the following performance measures to track its performance relative to level of care determinations:

- Percentage of new applicants receiving a level of care evaluation prior to enrollment
- Percentage of enrollees receiving annual determination within 365 days of previous level of care determination
- Percentage of enrollees having a current level of care based on state-approved assessment tool
- Percentage of level of care determinations made by qualified evaluators

Care Planning[18]

The waiver applications contain significant detail regarding care planning. A central requirement is that care plans should "enhance an individual's independence and

quality of life through community presence, choice, competence, respect, and community participation."[19] Personal goals in a care plan might include determining where and with whom to live, choosing service and supports, maintaining personal relationships, and making decisions about daily activities.

Prior to the care planning process, a case manager will conduct an assessment of the enrollee; this assessment must include health status, physical and cognitive functioning, environment, social supports and personal goals.

The approved HCBS Application states that the enrollee directs the care planning process, with the assistance of a case manager, and other individuals that the enrollee would like to include.[20] It is somewhat unclear, however, exactly how much authority is conferred by the word "directs." For one, development of the care plan is listed as the responsibility of the case manager, who must consult with the enrollee or guardian, and the caregiver, primary care physician, or enrollee's representative. The enrollee must be given information about network providers so he or she can make informed choices.

To prevent conflicts of interest, the HCBS Application states that the entities or individuals who provide services, do not have responsibility to monitor service plan implementation. This claim, however, is relatively weak, as the application provides no real assurance of separation, stating simply: "The State requires that responsibility for monitoring plan of care implementation and enrollee health and welfare within the plan be independent of any direct waiver services to avoid conflict of interest issues."[21]

A care plan must (among other things) establish personal goals for the enrollee; such goals must be measurable and specify a plan of action for reaching those goals. The care plan also must encourage integration of formal and informal supports, including the development of an informal volunteer network to assist the enrollee. Care plans must be developed within five business days of enrollment, or within seven days for nursing facility residents.

The care planning form will include a statement informing the enrollee that he or she can request a fair hearing if services are denied or reduced, or if he or she has been denied a choice of qualified providers. The case manager "assists the enrollee with filing for an appeal;"[22] the application provides no further detail on the extent of the case manager's assistance.

An MCO must provide an enrollee with procedures to follow to request a fair hearing or an appeal through the MCO's grievance procedures. In addition, the Department of Elder Affairs will audit care plans that are reduced as a result of a new MCO's assessments.

A case manager will be required to contact the enrollee at least monthly by telephone. Care plans must be reviewed with the enrollee, face-to-face, at least once every three months.

MCOs must "develop quality assurance tools and protocols that include internal safeguards for plan of care development."[23] Also, MCOs must audit a representative sample of care plans for goals, interventions, and other such elements related to community integration. On a quarterly basis, such data must be

aggregated and provided to the State.

In addition, the state's quality assurance clinical monitors review a random sample of an MCO's care plans. MCOs will be given 15 business days to fix any deficiencies.

The State will use the following performance measures to monitor the adequacy of care plans:

- Percentage of services delivered in accordance with care plan, regarding service type, amount, frequency, duration, and scope
- Percentage of care plans meeting all assessed needs and risks
- Percentage of care plans with personal goals and community integration goals
- Percentage of care plans distributed within 10 days to primary care physician
- Percentage of care plans signed by enrollee
- Percentage of care plans reviewed and updated every three months
- Percentage of care plans updated when enrollee's needs change
- Percentage of care plans indicating choice of provider, choice between HCBS and facility services, and choice of services and subcontractors

Participant-Directed Services[24]

Florida's current Medicaid LTSS system allows for participant direction, and the State expects 10 percent of enrollees to direct their own services under the Program. During enrollment and the care planning process, enrollees will receive information about participant direction. Participant direction is offered for the following services: adult companion, homemaker, attendant care, intermittent and skilled nursing care, and personal care.

Direction of services may be performed by the enrollee or by a non-legal representative selected by the enrollee. Once appointed, the representative can hire and fire workers and sign worker timesheets. The enrollee can change representatives at any time.

In any of the following situations, the State may involuntarily terminate participant direction: if the enrollee is unable to employ or manage workers, is admitted to a long-term care facility, moves out of the State, fails to choose a representative, or submits inaccurate time sheets.

Transition[25]

The Program contains some protections to ensure continuity of care for new enrollees. Most prominently, an MCO must continue a new enrollee's services for 60 days or until care plan assessment and service planning are completed. If an enrollee appeals, the right to continuing services will continue until the appeal is determined.

As mentioned, the Program is taking the place of four existing HCBS waivers. In order to continue services, current participants in these waivers will be required to enroll in an MCO through the Program. Transition from the phased-out waivers will be facilitated by the independent enrollment broker who will, among other duties, transfer provider enrollment files to the new providers. For continuity of care, the State will ensure payment to existing providers during the transition period, and MCOs will pay for out-of-network service until new person-centered care plans have been developed with the enrollee and then implemented.

MCOs currently participating in the Nursing Home Diversion Waiver will be required to develop transition plans for all enrollees, whether or not the MCO will be participating in the new Program.

Under state statute, participating MCOs for the first year must offer network contracts to all nursing facilities, hospices, and current aging services providers in the region. After that year, the MCO can exclude any of these providers only for failure to meet quality or performance criteria.[26]

Quality Of Care[27]

The waiver applications contain numerous quality of care provisions, many of which focus on data collecting and monitoring. One such requirement is that MCOs must submit monthly, quarterly, and annual reports on enrollee complaints, grievances, appeals, missed services, performance measures, and provider complaints.

Also, the State will conduct contract compliance monitoring with desk reviews, on-site visits, and face-to-face visits with a sample of enrollees. As part of the State's annual review, the State ensures that MCOs are contracting only with qualified providers; if any deficiency in this area involves health and safety issues, the deficiency must be remedied immediately.

The State will use the Health Plan Survey of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to gather information from enrollees. The State also will analyze records of grievances and appeals, disenrollment requests, and denials of requests for referrals.

An MCO annually must submit two performance improvement plans to the State and the External Quality Review Organization (EQRO); if the EQRO discovers a deficiency, the MCO must submit a corrective action plan.

The Department of Elder Affairs (DOE) is required to submit monitoring reports to the Medicaid Agency. AHCA will use these reports as evidence-based validation of AHCA's assurances to CMS.

AHCA will measure systemic quality improvement by reporting its status to CMS in areas such as: how many level of care determinations were complete by the enrollment date, what percentage of waiver expenditures are less than or equal to appropriated funds, and the percentage of long-term care direct calls processed by the enrollment broker.

In addition to the measures above, within 18 months of a contract award, each MCO must receive accreditation by at least one national accreditation organization.

MCO Selection[28]

MCOs generally are selected through a competitive procurement process. There is an exception for Medicare Advantage plans or Medicare Advantage Special Needs Plans if the plan's Medicaid enrollees are comprised exclusively of persons eligible for both Medicaid and Medicare. Such a plan can participate in the Program automatically, without going through the procurement process.[29]

The procurement was completed prior to CMS approval of the waiver applications. Every region has between two and seven plans. American Eldercare, which is a provider service network rather than a capitated MCO, has been selected to participate in each of the regions.

Network Adequacy[30]

The State has assured CMS that it will comply with federal statutory and regulatory standards pertaining to network adequacy. The Medicaid agency and Department of Elder Affairs will conduct a readiness review of each MCO. This review will include review of the MCO's provider network for service adequacy and credentialing. Review also will include review of policies, written materials (whether for the general public, enrollees, or providers), information technology, and MCO staff. MCOs will be monitored on-site on an annual basis.

Service Provider Qualification[31]

Under the Program, the State and MCOs are required to ensure that all provider requirements are satisfied. The MCO will be required to remedy any observed problems, and penalties or sanctions will be imposed as appropriate. Sanctions will range from a corrective action plan to suspended enrollment.

To ensure that providers meet standards, the State will collect the following data:

- Percentage of new MCOs that satisfy provider qualifications prior to delivering services
- Percentage of licensed subcontractors, by type, within the MCO provider network, that meet provider qualifications prior to delivering services
- Percentage of licensed subcontractors that meet provider qualifications continuously
- Percentage of MCOs continuously qualified on an annual basis

Enrollee Health And Safety[32]

This section of the HCBS waiver application focuses on negative events such as accidents and abuse. For example, providers must report critical incidents to the MCO within 24 hours of the incident. Within 24 hours of knowing of a death or adverse incident, an MCO is required to report the incident to the State, which in turn must submit an annual report on adverse incidents to the Florida Legislature.

To protect enrollees' health and welfare, the State will collect and monitor the following measures:

- Percentage of enrollees with substantial reports of abuse, neglect or exploitation that had appropriate follow-up by the MCO
- Percentage of enrollees with handbooks containing directions on reporting abuse, neglect and exploitation
- Percentage of enrollee case files indicating that advance directives were discussed with the enrollee
- Percentage of health and safety welfare issues reported in adverse incident reports within 48 hours
- Percentage of reports of abuse, neglect or exploitation whose investigations were commenced within 24 hours of being reported to Adult Protective Services
- Percentage of enrollees who received a telephone contact at least every 30 days to assess health status, satisfaction with services, and any additional needs
- Percentage of enrollees with information on reporting grievance and complaint procedures as evidenced by a signed acknowledgement
- Percentage of grievances that received recommended follow-up

Assisted Living Facilities[33]

An issue receiving increased attention at the national level is whether and when assisted living facilities are suitably community-based to be considered a non-institutional option for Medicaid reimbursement. In line with this increased attention, MCOs in Florida will be required to ensure that their assisted living facilities offer the following features:

- Choice of private or semi-private room
- Choice of roommate in semi-private room;
- Lockable door to living unit
- Choice of schedule in eating and sleeping
- Access to telephone without limit to length of use
- Choice of facility and community activities
- Unrestricted ability to have visitors
- Snacks as desired, with ability to prepare snacks

An MCO will be allowed to disenroll an enrollee for residing in an assisted living facility that has not complied with the Program's requirements.

Accessibility Requirements[34]

Under the waiver applications, an MCO will be required to provide materials in languages other than English if at least five percent of the county's population speaks that language. In speaking with persons whose primary language is not English, an MCO will be required to provide in-person interpreter services when practical, and otherwise over

the telephone. For persons with hearing, speech, or vision impairments, translation requirements include TTY/TDD services, Braille materials, and audiotapes.

Marketing Requirements[35]

An MCO will not be allowed to conduct face-to-face marketing, but will be able to use mass marketing strategies approved by the state. "Marketing is permitted at health fairs and public events for the primary purpose of providing community outreach. All marketing activities must be approved by the State in advance of managed care plan participation and all marketing materials must be approved by the State prior to distribution."[36] By state statute, MCOs may not provide inducements to Medicaid recipients to obtain enrollees, and cannot prejudice recipients against other MCOs.

Conclusion

As shown by this summary, the Program will be a complex undertaking. Much work remains to be done to ensure that the Program operates as intended and provides enrollees with the coordinated, high-quality LTSS that they require.

In some instances, the approved waiver applications are inadequate, and additional consumer protections should be developed through the contracts between the State and the MCOs, or through other mechanisms. In addition, even in instances where the waiver applications adequately address an issue, continued attention and effort will be required to analyze the various data collected and to otherwise monitor the Program's performance.

ENDNOTES

1 Florida's proposal was made through two separate waiver applications – one application under Section 1915(b) of the Social Security Act to allow Medicaid mandatory managed care, and a second application under Section 1915(c) to authorize home and community-based services (HCBS) as an alternative to nursing facility services. Subsequently, to refer to the managed care application and the HCBS application, this summary uses the citations "MC App." and "HCBS App.", respectively. The Basic Information section of this paper is based on HCBS App., pp. 1-3, 12-13, 34, 213; and MC App., pp. 5, 18-21, 48-49.

2 Letter from Cindy Mann, Director of Center for Medicaid and CHIP Services, to Justin Senior, Florida Agency for Health Care Administration (Feb. 20, 2013).

3 The approved applications and other approval documents are available from the Florida Agency for Health Care Administration (Florida's Medicaid agency) at *http://ahca.myflorida.com/medicaid/statewide_mc/index.shtml*.

4 MC App., p. 32.

5 *See* National Senior Citizens Law Center, *Medicaid Managed Long-Term Services and Supports: A Review and Analysis of Recent CMS Waiver Approvals in New Jersey and New York* (March 2013).

6 HCBS App., pp. 31- 45, 217; MC App., pp. 21-22.

7 MC App., pp. 36-37, 47-51, 54-58, 60.

8 *See also* Fla. Admin. Code § 59G-8.600 (good-cause reasons for disenrollment).

9 MC App., pp. 52-53.

10 MC App., p. 52.

11 Designing State-Based Ombuds Programs in MLTSS and the Dual Eligible Demonstrations (Jan. 2013), *available at http://dualsdemoadvocacy.org/wp-content/uploads/2013/01/ombuds-1_8-2.pdf*.

12 MC App., p. 52.

13 Letter from Cindy Mann, Director of Center for Medicaid and CHIP Services, to Justin Senior, Florida Agency for Health Care Administration (Feb. 20, 2013).

14 MC App., p. 59.

15 HCBS App., pp. 56-145; MC App., pp. 35-36.

16 42 C.F.R. § 438.208(c).

17 HCBS App., pp. 44–53.

18 HCBS App., pp. 54, 145-70; MC App, pp. 50-51.

19 HCBS App., p. 148.

20 HCBS App., p. 146.

21 HCBS App., p. 154.

22 HCBS App., p. 147.

23 HCBS App., p. 146.

24 HCBS App., pp. 173-74.

25 HCBS App., pp. 9-12; MC App., pp. 11-12, 23-24, 54-58.

26 Fla. Stat. § 409.982(1)(c).

27 HCBS App, pp. 15-16, 28-30, 154-71; MC App., pp. 73-75.

28 MC App., p. 16.

29 *See also* Fla. Stat. § 409.981(5).

30 HCBS App, pp. 152-53; MC App., p. 32.

31 HCBS App, pp. 132-43.

32 HCBS App., pp. 183-201.

33 HCBS App., pp. 125-26; MC App., pp. 53-54.

34 HCBS App., p. 55; MC App., pp. 44-46.

35 HCBS App., p. 55; MC App., p. 44.

36 MC App., p. 44.

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