Meeting Date
09/16/14

AGENDA	
Section	CONSENT
Item No.	II.B.4

AGENDA REPORT

BREVARD COUNTY BOARD OF COUNTY COMMISSIONERS

SUBJECT:	Approval of Florida Medicaid Waiver Services Agreement re: Med-Waiver Community-Based Services Transportation Program (Fiscal Impact: $190,000)
DEPT/OFFICE:	Transit Services Department/Space Coast Area Transit

Requested Action:

It is requested that the Board of County Commissioners approve and authorize the Chairman to sign the Medicaid Waiver Services Agreement for the Home and Community-Based Waiver/Family and Supported Living Waiver Program with Agency for Persons with Disabilities.

Summary Explanation & Background:

On August 2, 2013, we received a new agreement for Medicaid Waiver Services for the State of Florida, Area 07 to provide transportation services for consumers served by the Developmental Disabilities Program, Home and Community-Based Services Waiver. This agreement will be for the period October 1, 2014 (or the date on which it has been signed by both parties, whichever is later) through September 30, 2015.

Space Coast Area Transit provides transportation for developmentally disabled citizens to and from five centers in Brevard. The locations are:

- Brevard Achievement Center in Rockledge
- Behavioral Services of Brevard in Cocoa
- East Coast Contracting, Inc. in Titusville
- Easter Seals in Palm Bay
- Bridges, Inc. in Rockledge

Space Coast Area Transit has been providing this service since 1974 and the developmentally disabled are one of Space Coast Area Transit's core customers. From October 2013 through July of this year, Space Coast Area Transit has provided 29,220 trips under contract with the Agency for Persons with Disabilities.

The Agreement will provide SCAT with some of the necessary funding to provide the Med-Waiver transportation; SCAT will receive $7.17 per trip. Please note this is a non-negotiated rate that is set by the Agency for Persons with Disabilities and does not cover the full cost of the service, which is estimated to be $11.00 to $14.00 per trip. SCAT uses Federal, State and Local Operating funds to supplement the remaining cost of the trip.

Fiscal Impact:

	Bus Area	Cost Center	Amount	Description
FY2014-2015	4130	R30373	$190,000	Medicaid Waiver

Name: Jim Liesenfelt, Transit Services Director
Phone: 635-7815 ext. 601

Exhibits Attached: (2) Medicaid Waiver Services Agreement

Contract /Agreement (If attached): Reviewed by County Attorney	Yes	☒	No	☐	PR ☐

County Manager	Assistant County Manager	Department Director / Extension
Stockton Whitten	Venetta Valdengo	James P. Liesenfelt, Director 635-7815 ext. 601

BREVARD County
BOARD OF COUNTY COMMISSIONERS

FLORIDA'S SPACE COAST

Tammy Etheridge, Clerk to the Board, 400 South Street • P.O. Box 999, Titusville, Florida 32781-0999

Telephone: (321) 637-2001
Fax: (321) 264-6972

September 17, 2014

M E M O R A N D U M

TO: James Liesenfelt, Transit Services Director

RE: Item II.B.4., Florida Medicaid Waiver Services Agreement with State of Florida, Agency for Persons with Disabilities for Med-Waiver Community Based Services Transportation Program

The Board of County Commissioners, in regular session on September 16, 2014, approved the Medicaid Waiver Services Agreement with the State of Florida, Agency for Persons with Disabilities, for the Home and Community-Based Waiver/Family and Support Living Waiver Program. Enclosed are two executed copies of the Medicaid Waiver Services Agreement for your action.

Upon execution by the State of Florida, Agency for Persons with Disabilities, please return the fully-executed copy of the Agreement to this office for inclusion in the official minutes.

Your continued cooperation is always appreciated.

Sincerely,

BOARD OF COUNTY COMMISSIONERS
SCOTT ELLIS, CLERK

Tammy Etheridge

Tammy Etheridge, Deputy Clerk

/ds

Encls. (2)

cc: Contracts Administration
Finance
Budget

MEDICAID WAIVER SERVICES AGREEMENT

This Agreement is entered into between the Florida Agency for Persons with Disabilities, hereinafter referred to as "APD", and Brevard County Board County Commissioners dba Space Coast Area Transit, hereinafter referred to as the "Provider". Pursuant to the terms and conditions of this Agreement, APD authorizes the Provider to furnish I-Budget/DD Home and Community-Based Services (HCBS) Medicaid waiver services to eligible APD clients, and to receive payment for such services. The services that may be provided in any one APD service area are limited to the services that the APD area office, pursuant to the standards specified in Florida's HCBS waivers, authorizes the Provider to furnish in that service area.

I. AGREEMENT DOCUMENTS:

A. The Medicaid Waiver Services Agreement consists of the terms and conditions specified in this Agreement, any attachments, and the following documents, which are incorporated by reference:

1. ***The Developmental Disabilities Waiver Services Coverage and Limitations Handbook***, dated July 2007, and any updates or replacements thereto. The Handbook can be found at the Medicaid fiscal agent's Web Portal: http://mymedicaid-florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The Handbook lists the requirements for specific services as well as the Core Assurances, which provide the terms and conditions by which the provider of Developmental Disabilities HCBS waiver services agrees to be bound.

2. ***Attachment*** B, providing individually negotiated unit rates of payment for services not already established and available on APD's website: http://apd.myflorida.com/providers, as referenced in II.E., and any other service or data requirements, as applicable.

B. Prior to executing this Agreement and furnishing any waiver services, the Provider must have executed a Medicaid Provider Agreement with the Agency for Health Care Administration (AHCA), and be issued a Medicaid provider number by AHCA. The Provider must at all times during the term of this Agreement, maintain a current and valid Medicaid Provider Agreement with AHCA, and comply with the terms and conditions of the Medicaid Provider Agreement.

II. THE PROVIDER AGREES:

To comply with all of the terms and conditions contained within this Agreement, including all documents incorporated by reference and any attachments.

A. Monitoring, Audits, Inspections, and Investigations

To permit persons duly authorized by APD, the Agency for Health Care Administration (AHCA), or representatives of either, to monitor, audit, inspect, and investigate any recipient records, payroll and expenditure records (including electronic storage media), papers, documents, facilities, goods and services of the Provider which are relevant to this Agreement, and to interview any recipients receiving services and employees of the Provider to assure APD of the satisfactory performance of the terms and conditions of this Agreement.

1. Following such monitoring, audit, inspection, or investigation, APD or its authorized representative, will furnish to the Provider a written report of its findings and, if deficiencies are found, request for development, by the Provider, a Quality Improvement Plan (QIP) for needed corrections. The Provider hereby agrees to correct all noted deficiencies identified by APD, AHCA, or their authorized representatives within the specified period of time identified within the report documentation. Failure to correct noted deficiencies within stated time frames may result in termination of this Agreement.

2. Upon demand, and at no additional cost to the APD, AHCA, or their authorized representatives, the Provider will facilitate the duplication and transfer of any records or documents (including electronic storage media), during the required retention period of six years after termination of the Agreement, or if an audit has been initiated and audit findings have not been resolved at the end of six years, the records shall be retained until resolution of the audit findings or any litigation which may be based on the terms of this Agreement, at no additional cost to APD.

3. To comply and cooperate immediately with APD requests for information, records, reports, and documents deemed necessary to review the rate setting process to ensure that provider rates are based on accurate information and reflect the existing operational requirements of each service. Any individual who knowingly misrepresents the information required in rate setting commits a felony of the third degree, punishable as provided in sections 775.082 and 775.083, F.S.

4. To comply and cooperate immediately with any inspections, reviews, investigations or audits deemed necessary by APD's Office of the Inspector General pursuant to section 20.055, F.S.

5. To include the aforementioned audit, inspections, investigations and record keeping requirements in all subcontracts and assignments.

B. Confidentiality of Client Information

Not to use or disclose any information concerning a client receiving services under this Agreement for any purpose prohibited by state or federal law or regulation, except with the written consent of a person legally authorized to give that consent or when authorized by law. This includes compliance with: the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, and all applicable regulations provided in 45 CFR Parts 160, 162, and 164; and 42 CFR, Part 431, Subpart F, relating to the disclosure of information concerning Medicaid applicants and recipients.

C. Indemnification

1. To be liable for and indemnify, defend, and hold APD, AHCA and all of their officers, agents, and employees harmless from all claims, suits, judgments, or damages, including attorneys' fees and costs, arising out of any act, actions, neglect, or omissions by the Provider, its agents, employees, or subcontractors during the performance or operation of this Agreement or any subsequent modifications thereof, whether direct or indirect, and whether to any person or tangible or intangible property. The Provider shall not be liable for that portion of any loss or damages proximately caused by the negligent act or omission of APD or AHCA.

2. That its inability to evaluate its liability or its evaluation of liability shall not excuse the Provider's duty to defend and to indemnify within 7 days after notice by APD or AHCA by certified mail. After the highest appeal taken is exhausted, only an adjudication or judgment specifically finding the Provider not liable shall excuse performance of this provision. The Provider shall pay all costs and fees, including attorneys' fees related to these obligations and their enforcement by APD or AHCA. APD or AHCA's failure to notify the Provider of a claim shall not release the Provider of these duties.

D. Insurance

To obtain and maintain at all times continuous and adequate liability insurance coverage during the term of this Agreement. The Provider accepts full responsibility for identifying and determining the type and extent of liability insurance necessary to provide reasonable financial protection for the Provider and APD clients served by the Provider. All insurance policies shall be through insurers authorized or eligible to write policies in Florida. Such coverage may be provided by a self-insurance program established and operating under Florida law.

E. Payment

To accept payment for goods and services at rates periodically established by AHCA and APD. The most current rates are available on APD web site: http://apd.myflorida.com/providers. The signatories recognize that APD is limited by appropriation and acknowledge that Florida law requires AHCA and APD to make any adjustment necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, including but not limited to adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or limiting enrollment. [See sections 393.0661, 409.906, 409.908, F.S.]

F. Return of Funds

To be responsible for the timely correction of all billing or reimbursement errors resulting in an overpayment, including reimbursement for services not properly authorized or documented. Reimbursement will be made pursuant to the Florida Medicaid Provider Reimbursement Handbook, CMS-1500. Federal regulations, 42 CFR § 433.312, require refund of overpayments within 60 days of discovery. AHCA will be the final authority regarding the timeliness of the reimbursement process.

G. Independent Status

That the Provider acts at all times in the capacity of an independent service provider and not as an officer, employee, or agent of APD, AHCA, or the State of Florida. The Provider shall not represent to others that it has the authority to bind the APD or AHCA unless specifically authorized in writing to do so. In addition to the Provider, this is also applicable to the Provider's officers, agents, employees, or subcontractors in performance of this Agreement.

III. TERMINATION:

A. This Agreement may be terminated by either party without cause, upon no less than 30 calendar days notice in writing to the other party unless a lesser time is mutually agreed upon in writing by both parties. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

B. This Agreement may be terminated for the Provider's unacceptable performance, non-performance or misconduct upon no less than 24 hours notice in writing to the Provider. Waiver by either party of any breach of any term or condition of this Agreement shall not be construed as a waiver of any subsequent breach of any term or condition of this Agreement. If APD determines that the Provider is not performing in accordance with any term or condition in this Agreement, APD may, at its exclusive option, allow the Provider a period of time to achieve compliance. The provisions herein do not limit APD's right to any other remedies at law or in equity.

IV. GOVERNING LAW:

This Agreement shall be construed, performed, and enforced in all respects in accordance with all the laws and rules of the State of Florida, and any applicable federal laws and regulations.

V. AGREEMENT DURATION:

This Agreement shall be effective 10/1/2014 or the date on which it has been signed by both parties, whichever is later, and shall terminate on 9/31/2017 which is no later than three years from the effective date.

VI. OFFICIAL REPRESENTATIVES (Names, Address, Telephone Number, and E-mail Address):

1. The Provider's contact person and street address where financial and administrative records are maintained is:

Name:	James Liesenfelt
Telephone Number:	321-635-7815
Address:	401 S. Varr Avenue, Cocoa, FL 32922
E-mail Address:	Jim.Liesenfelt@brevardcounty.us

2. The representative of the Provider responsible for administration of the services under this Agreement is:

Name:	James Liesenfelt
Telephone Number:	321-635-7815
Address:	401 S. Varr Avenue, Cocoa, FL 32922
E-mail Address:	Jim.Liesenfelt@brevardcounty.us

3. The Agency for Persons with Disabilities contact person for this Agreement is:

Name:	Clarence Lewis
Telephone Number:	407-245-0440
Address:	400 West Robinson Street Suite S-430 Orlando, Fl. 32801
E-mail Address:	clarence.lewis@apdcares.org

4. Upon change of the representative's names, addresses, telephone numbers, and e-mail addresses, by either party, notice shall be provided in writing to the other party and the notification attached to the originals of this Agreement.

VII. INTEGRATED AGREEMENT:

Only this Agreement, any attachments referenced, the Medicaid Provider Agreement, the *Developmental Disabilities Waiver Services Coverage and Limitations Handbook*, and the *Family and Supported Living Waiver Services Directory*, which are incorporated into this Agreement by reference, contain all the terms and conditions agreed upon by the parties.

There are no provisions, terms, conditions, or obligations other than those contained herein, and this Agreement shall supersede all previous communications, representations, or agreements, either verbal or written between the parties. If

any term or provision of the Agreement is found to be illegal or unenforceable, the remainder of the Agreement shall remain in full force and effect and such term or provision shall be stricken.

The Provider, by signing below, attests that the Provider has received and read the entire Agreement, inclusive of its attachment's and documents as referenced in Section I, A., including the service-specific requirements and Core Assurances for enrolled providers, contained in the *Developmental Disabilities Waiver Services Coverage and Limitations Handbook* and the *Family and Supported Living Waiver Services Directory*, and understands each section and paragraph.

IN WITNESS THEREOF, the parties hereto have caused this 5 page Agreement to be executed by their undersigned officials as duly authorized.

PROVIDER:
Brevard County Board of County Commissioners
dba Space Coast Area Transit

SIGNED BY: Mary Bolin Lewis

NAME: Mary Bolin Lewis

TITLE: Chairman

DATE: As approved by the Board on 09/16/14

STATE OF FLORIDA,
AGENCY FOR PERSONS WITH DISABILITIES

SIGNED BY:

NAME: **Clarence Lewis**

TITLE: **Regional Operations Manager**

DATE:

Medicaid Provider #: 99882696 (DD Waiver) **and/or** -- (FSL Waiver)

Reviewed for Legal Form and Content by:

8/22/14

Matthew Soss, Assistant Co Atty - Date

Attachment B
Medicaid Waiver Services Agreement
Transportation Services

The following rates have been approved for use by the Provider. In order for the Provider to bill for individual transportation services, the Providers must be in receipt of a current Service Authorization form from a client's waiver support coordinator. The Service Authorization form will indicate the rate approved for transportation services, as well as the frequency and intensity of the service provision.

Approved Transportation Rates for Area 7:

Billing Method	Wheelchair Accessible Rate	Non-Wheelchair Accessible Rate	Non-Specified Rate
Trip	N/A	N/A	$7.17
Mile	N/A	N/A	N/A
Month	N/A	N/A	N/A

BOARD OF COUNTY COMMISSIONERS

INITIAL CONTRACT FORM

1. Contractor: Agency for Persons with Disabilities	
2. Fund/Account #: 4130-R30373-5340000	**3 Division Name: TRANSIT SERVICES**
4. Contract Description: Medicaid Waiver Service Agreement	
5. Contract Monitor: Cathy Lively	**6. Mail Stop #: 44**
7. **Dept/Office Director: James Liesenfelt**	**8. Class Code: ZIGS**
ACTION DATE: *30 days from entry*	**ACTION REQUIREMENT:** ***Need complete data***

SECTION II

The following departments must approve all contracts submitted to the Board:

APPROVAL

COUNTY OFFICE	Yes	no	INITIALS	Date
User Agency	x	0	JPL	08/13/2014
Risk Management	0	0		
County Attorney	~~0~~	0	MDi	8/15/14
User Agency	0	0		

If any office denies approval, the package will be returned immediately to the User Agency.

NOTE: *This form should be attached to all new contracts being submitted to the Board for approval. After the contract has been approved, the contract package, including this form, will go to the Clerk to the Board. The Clerk's office will then forward the Initial Contract Form to Contracts Administration and the contract will be entered into the Contract Monitoring System. This initial entry will generate an entry on your monthly contract report and the first report will always show a "Required Action" for the contract. See AO-29 for additional information.*

NOTE: PLEASE REVIEW AND RETURN BY _____, IN ORDER TO MEET DEADLINES FOR THE __09/16/14__ BCC MEETING.

BOARD OF COUNTY COMMISSIONERS

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APPROVAL

COUNTY OFFICE	Yes	no	INITIALS	Date
User Agency	x	0	JPL	08/13/2014
Risk Management	X	0	GV	8/19/14
County Attorney	0	0		
User Agency	0	0		

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NOTE: PLEASE REVIEW AND RETURN BY _____, IN ORDER TO MEET DEADLINES FOR THE __09/16/14__ BCC MEETING.

RECEIVED

AUG 21

SPACE COAST AREA TRANSIT

AO-29: EXHIBIT