agency for persons with disabilities
State of Florida

**SUNCOAST REGION**
**OPERATING PROTOCOL**

**SUBJECT: INVESTIGATING COMPLAINTS OF PROVIDERS** **DATE ISSUED: 10/01/01**

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**TOPIC:** The uniform procedure for reviewing complaints submitted regarding business practices and services delivered by all Medicaid Waiver Providers.

**PURPOSE:**

1. This protocol establishes procedures for recognizing, responding and reporting complaints received by the Agency for Persons with Disabilities. Complaints may be made against general providers, support coordinators, Delmarva or Maximus.
2. A reportable complaint is defined as one that alleges fact, which if true, is a violation of law, department rule or regulation, Agency for Persons with Disabilities policy or policy directive, or is a breach of the provider's DD/HCBS Medicaid Waiver Agreement and Core Assurances.
3. This protocol will provide uniformity in addressing fact-based complaints or concerns. Most, but not all complaints are violations of the Core Assurances or the Medicaid Waiver Agreement. Complaints that arise due to conflicts between individuals served, family or guardian and the provider are defined in the DD Waiver Coverage and Limitations Handbook section 3.10 as Grievances. These should not be addressed with this complaint protocol. Each provider maintains a Grievance Procedure and log for resolution of Grievances
4. For investigation purposes, this protocol is not intended to replace protocols established for incident reporting or Medicaid Fraud. If there is suspected improper billing, the complaint will be investigated by the appropriate Medicaid Program, but should be reported to the Agency for Persons with Disabilities for tracking purposes only. In addition, this protocol does not replace the abuse, neglect & exploitation reporting required by state law & rule. Allegations of abuse, neglect or exploitation must be reported immediately to the Florida Abuse Hotline at (800) 962-2873. (Chapter 415.1034 F.S.)
5. Data collected will be aggregated and used to identify system-wide issues, for risk prevention and to improve the quality of services. The Regional Program Supervisor of the Quality Unit will direct an analysis of the compiled data. This will include trends in type and provider and effectiveness of district response. This analysis will be part of the quality management team activities and will be reviewed on a monthly basis.

TYPES OF COMPLAINTS:

1. Failure to Comply with Federal and State Law and Regulations.

   Examples of Federal Laws and Regulations that must be followed include HIPPA, Title VI of the Civil Rights Acts of 1964, the Americans with Disabilities Act of 1990 and Title 42 Code of Federal Regulations (CFR) 431.51 regarding freedom of choice. Complaints might involve allegations of exploitation, undue influence, and failure to allow individuals served to make their own choices.

   Examples of State Law and Regulations that must be followed include Chapter 393 F.S. Developmental Disabilities , 409 F.S. Chapters 65G-8, 65 G-11, and 59G-8 FAC, Chapter 429 F.S. Part 1 Assisted Living Facilities, 58A-5 F.A.C. and 393.506 F.S. Administration of Medication, 393.067 F.S. Licensure of Facilities, 65G-6 FAC

2. Failure to uphold the rights and privileges of recipient's with developmental disabilities as specified in Chapter 393.23 F.S.

3. Failure to comply with program requirements.

   Examples include
   - Disclosing information of recipients receiving services under the waiver without written consent.
   - Not reporting suspect incidents of abuse, neglect or exploitation as mandated by 415.1034
   - Failure to safeguard the health, safety and well-being of individuals served.
   - Falsifying records to obtain services that are not medically necessary or failure to supply documentation to continue services that are medically necessary.
   - Not participating in personal outcome process for a recipient, not following recommendations of a person-centered review, not implementing person-centered supports and services
   - Refusal to participate in discussions of an individual's progress for the purpose of support plan or implementation plan development
   - Failure to attend the support plan meeting when invited.
   - Not providing opportunities for training to assist individuals served to reach their goals.
   - Not meeting transportation requirements (See 6.Screening)
   - Incorrect billing (See 10.Recoupment)
   - Not attending required training (See 3. Training)

4. Failure to meet required training.

   Examples include:
   - Failure to comply with training requirements as mandated in Core Assurances Section 2.1[X]
   - Not participating in required training for a service as specified in the handbook.
   - Not participating in mandatory meetings.
   - Not participating in training for an individual's needs.

5. Failure to make required Notification as mandated by Core Assurances 2.2[XI]

   Examples include:
   - Failure to assist individuals served in maintaining eligibility for Medicaid.
   - Failure to notify providers working with individuals served regarding pending loss of Medicaid.
   - Failure to follow incident reporting procedure

6. Disregard of Administrative Policies, Procedures, and Practices

   Examples include:
   - Provider fails to have policies and procedures that meet minimum requirements as specified.
   - Provider fails to follow their own written policies and procedures
   - Lack of current table of organization for group or agency provider.

7. Not meeting screening requirements

   Examples include:
   - Not ensuring that all direct service providers meet Level Two background screening requirements as specified in Chapter 393.0655[XII]
   - Failure to ensure national criminal history background checks for any officer, director, billing agent, managing employee and any affiliated person.

8. Failure to report changes in Provider Status

   Examples include:
   - Not reporting any change in provider status including the sale or transfer of ownership, change from solo to agency or voluntary termination of service.

9. Violation of Financial Requirements

   Examples include:
   - Failure to maintain a separate checking account for the personal funds of individuals served.

10. Unethical Marketing Practices

    Examples include:
    - Engaging in solicitation of individuals served
    - Providing undue influence on an individual or to the circle of supports

    Note: These are also violations of Title 42 Code of Federal Regulations (CFR) 431.51

11. Recoupment issues regarding Goods and Services

    Examples include:
    - Lack of documentation completed in accordance with the Developmental Disabilities Waiver Services Coverage and Limitations Handbook
    - Required documentation not filed in the central record prior to submitting a claim for services rendered.
    - Failure to maintain documentation in accordance with procedures as specified in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook and Medicaid Waiver Provider Agreement.
    - No service authorization on file for service billed
    - Billing for services at rate, time or frequency other than that on the service authorization.
    - Inability to produce required documentation at the time of monitoring

    Note: These complaints must be referred to the Quality Assurance Unit.

12. Note the following payment provisions as defined in Core Assurances 3.8[XIII]

    Examples include:
    - Filing for payment before the service is rendered.
    - Filing for payment for services not rendered.
    - Submission of claim for a service that is not authorized.

    Note: These complaints must be referred to the Quality Assurance Unit.

**PROTOCOL:**

1. The Human Services Program Director of the Quality Improvement Unit or designee shall be responsible for receiving complaints, logging complaints and assigning Quality Improvement staff to review complaints.

2. Complaints may be submitted both verbally and in writing. Persons submitting verbal complaints will be encouraged to put the complaints in writing. Complaints can be received through mail, email or fax. Anonymous complaints will be reviewed in situations that allege issues that are critical to the health and safety of an individual served. Complaints alleging abuse, neglect or exploitation will not be handled through this protocol. Reporters will be redirected to report these in accordance with 415.1034 F.S. Any redirection to the Abuse Registry by APD will be followed up with an inquiry from the APD office to DCF to insure that the case was called in to the Registry. The case will be tracked by the APD office for disposition and the results placed in the provider file if the case results in a verified abuse, neglect or exploitation finding.

3. A text file or Excel spreadsheet will be used to log the complaints. The discrete data elements that must be included will be identified by the Regional Program Supervisor. This file must be maintained on a shared volume, have security and be backed up by the system daily.

4. Complaints will be screened to ensure they meet the criteria as listed in this protocol and to ensure they are factual. The complaint will then be assigned to staff. If the complaint is not accepted, the complainant will be notified for educational purposes or further clarification.

5. All complaints will be logged within **2 working days** of being received by the Region Data will be extracted from the log and added to the Sun Coast Region Database programmatically weekly for reporting purposes. A letter acknowledging receipt of the complaint will be generated to the complainant at that time.

6. The assigned staff member will initiate an investigation of the allegations **within 7 working days** of receipt of the complaint. The inquiry should be confined to the allegations found in the complaint.

7. The staff member assigned will be responsible for making and documenting all necessary inquiries, contacts and actions taken. A separate provider file will be created for complaint investigations. Documentation regarding the investigation should be added to the file within 24 hours of action taken. Written documentation of a confirmed complaint and the disposition of the complaint will be maintained in the Provider file.

8 Complaint investigations may include but are not confined to interviews with the consumer, support coordinator or other appropriate individuals, record reviews, staff interviews and site visits. ABC or FMMIS screens may be reviewed as well as documentation for billing and monitoring.

9 Once the inquiry is complete staff will log the resolution to the complaint along with any recommendations, a completion date and any follow up needed. Unless authorized by the Regional Program Supervisor due to special circumstances, complaints need to be resolved within **30 Calendar Days.**

10. Complaints will be determined founded or unfounded. Actions that staff may take include:

- No action needed
- Technical assistance required
- Recoupment/Overpayment as per APD OP 18-002
- Referral to Peer Review Organization for Quality Assurance monitoring
- Recommendation for the Initiation of Termination of Medicaid Waiver Services Agreement
- Referral to Abuse Registry hotline
- Referral to Inspector General
- Development of a Quality Improvement Plan (QIP) and approval of that plan by APD

11. Only verified complaints will be documented in the Central Provider File. Follow-up reports, subsequent monitoring and corrective action plans should include signatures of Regional Program Supervisor and the Human Services Program Director of the Quality Improvement Unit or designee and should be kept in the Provider File. The effectiveness of the follow up should be included in narrative format and shown quantitatively if possible.

12. A "Determination of Findings" letter will be generated by the Sun Coast Region Database and sent to the complainant upon completion of the investigation.

13. Providers can request reconsideration and review by submitting additional information to be considered. This letter will include any necessary follow-up activities that are required of the provider. These activities must be completed within 60 days unless a health and safety violation is involved. Corrective actions to health and safety violations must be completed within 10 calendar days.

14. The assigned staff must ensure that follow up activities required of the provider are completed within the mandated time frames and are documented upon receipt in the file used to log the initial complaint. This data will be extracted and added to the Suncoast Regional Database for reporting purposes.

15. Further, all complaints against Waiver Support Coordinators will be logged on the form provided by Tallahassee and will be forwarded to the Central Program Office on a monthly basis as required by APD 18-003.

Attachments

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[I] ***The Agency for Persons with Disabilities does not tolerate fraud. To report Medicaid Fraud and False Claims, please contact:***

Medicaid Program Integrity, AHCA, at 1-888-419-3456

Medicaid Fraud Control Unit, Office of the Attorney General, at 1-866-966-7226

Office of the Inspector General, APD, at 1-866-APD-CARE (273-2273)

***Examples of Fraud and Abuse:***

- Billing for Services Not Provided; filing a claim for a service that was not actually provided to a consumer
- Upcoding; filing a claim for a higher level of service than was actually provided
- Self-Dealing/Kickbacks; accepting items of value for improper favoritism toward a provider or consumer

[II] **415.1034 Mandatory reporting of abuse, neglect, or exploitation of vulnerable adults; mandatory reports of death.**--

(1) MANDATORY REPORTING.--

(a) Any person, including, but not limited to, any:

1. Physician, osteopathic physician, medical examiner, chiropractic physician, nurse, paramedic, emergency medical technician, or hospital personnel engaged in the admission, examination, care, or treatment of vulnerable adults;

2. Health professional or mental health professional other than one listed in subparagraph 1.

3. Practitioner who relies solely on spiritual means for healing;

4. Nursing home staff; assisted living facility staff; adult day care center staff; adult family-care home staff; social worker; or other professional adult care, residential, or institutional staff;

5. State, county, or municipal criminal justice employee or law enforcement officer;

6. An employee of the Department of Business and Professional Regulation conducting inspections of public lodging establishments under s. 509.032;

7. Florida advocacy council member or long-term care ombudsman council member; or

8. Bank, savings and loan, or credit union officer, trustee, or employee,

who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited shall immediately report such knowledge or suspicion to the central abuse hotline.

[III] **TITLE 42** - PUBLIC HEALTH CHAPTER IV - CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER C - MEDICAL ASSISTANCE PROGRAMS PART 431 - STATE ORGANIZATION AND GENERAL ADMINISTRATION subpart b - GENERAL ADMINISTRATIVE REQUIREMENTS 431.51 - Free choice of providers. This choice included freedom to select non-waiver funded supports, to change providers or supports, to receive supports at mutually agreeable times, to end participation in the waiver.

[IV]

Title XXIX PUBLIC HEALTH Chapter 393 DEVELOPMENTAL DISABILITIES

[V] Title XXX Social Welfare Chapter 429 Assistance Care Communities Part 1 Assisted Living Facilities

[VI] Florida Administrative Code Rule Chapter 58A-5 Chapter Title: ASSISTED LIVING FACILITIES

[VII] Title XXIX Public Health Chapter 393 DEVELOPMENT DISABILITIES 393.506 Administration of medication

[VIII] **393.067 Facility licensure.--**

(1) The agency shall provide through its licensing authority and by rule license application procedures, provider qualifications, facility and client care standards, requirements for client records, requirements for staff qualifications and training, and requirements for monitoring foster care facilities, group home facilities, residential habilitation centers, and comprehensive transitional education programs that serve agency clients.

(2) The agency shall conduct annual inspections and reviews of facilities and programs licensed under this section.

(3) An application for a license under this section must be made to the agency on a form furnished by it and shall be accompanied by the appropriate license fee.

(4) The application shall be under oath and shall contain the following:

(a) The name and address of the applicant, if an applicant is an individual; if the applicant is a firm, partnership, or association, the name and address of each member thereof; if the applicant is a corporation, its name and address and the name and address of each director and each officer thereof; and the name by which the facility or program is to be known.

(b) The location of the facility or program for which a license is sought.

(c) The name of the person or persons under whose management or supervision the facility or program will be conducted.

(d) The number and type of residents or clients for which maintenance, care, education, or treatment is to be provided by the facility or program.

(e) The number and location of the component centers or units which will compose the comprehensive transitional education program.

(f) A description of the types of services and treatment to be provided by the facility or program.

(g) Information relating to the number, experience, and training of the employees of the facility or program.

(h) Certification that the staff of the facility or program will receive training to detect and prevent sexual abuse of residents and clients.

(i) Such other information as the agency determines is necessary to carry out the provisions of this chapter.

(5) As a prerequisite for issuance of an initial or renewal license, the applicant, and any manager, supervisor, and staff member of the direct service provider of a facility or program licensed under this section, must have submitted to background screening as required under s. 393.0655. A license may not be issued or renewed if the applicant or any manager, supervisor, or staff member of the direct service provider has failed background screenings as required under s. 393.0655. The agency shall determine by rule the frequency of background screening. The applicant shall submit with each initial or renewal application a signed affidavit under penalty of perjury stating that the applicant and any manager, supervisor, or staff member of the direct service provider is in compliance with all requirements for background screening.

(6) The applicant shall furnish satisfactory proof of financial ability to operate and conduct the facility or program in accordance with the requirements of this chapter and adopted rules.

(7) The agency shall adopt rules establishing minimum standards for facilities and programs licensed under this section, including rules requiring facilities and programs to train staff to detect and prevent sexual abuse of residents and clients, minimum standards of quality and adequacy of client care, incident reporting requirements, and uniform fire safety standards established by the State Fire Marshal which are appropriate to the size of the facility or of the component centers or units of the program.

(8) The agency, after consultation with the Department of Community Affairs, shall adopt rules for foster care facilities, group home facilities, and residential habilitation centers which establish minimum standards for the preparation and annual update of a comprehensive emergency management plan. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; post disaster activities, including emergency power, food, and water; post disaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; and responding to family inquiries. The comprehensive emergency management plan for all comprehensive transitional education programs and for homes serving individuals who have complex medical conditions is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the agency and the Department of Community Affairs, at a minimum, are given the opportunity to review the plan. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions.

(9) The agency may conduct unannounced inspections to determine compliance by foster care facilities, group home facilities, residential habilitation centers, and comprehensive transitional education programs with the applicable provisions of this chapter and the rules adopted pursuant hereto, including the rules adopted for training staff of a facility or a program to detect and prevent sexual abuse of residents and clients. The facility or program shall make copies of inspection reports available to the public upon request.

(10) Each facility or program licensed under this section shall forward annually to the agency a true and accurate sworn statement of its costs of providing care to clients funded by the agency.

(11) The agency may audit the records of any facility or program that it has reason to believe may not be in full compliance with the provisions of this section; provided that, any financial audit of such facility or program shall be limited to the records of clients funded by the agency.

(12) The agency shall establish, for the purpose of control of licensure costs, a uniform management information system and a uniform reporting system with uniform definitions and reporting categories.

(13) Facilities and programs licensed pursuant to this section shall adhere to all rights specified in s. 393.13, including those enumerated in s. 393.13(4).

(14) An unlicensed facility or program may not receive state funds. A license for the operation of a facility or program shall not be renewed if the licensee has any outstanding fines assessed pursuant to this chapter wherein final adjudication of such fines has been entered.

(15) The agency is not required to contract with new facilities licensed after October 1, 1989, pursuant to this chapter. Pursuant to chapter 287, the agency shall continue to contract within available resources for residential services with facilities licensed prior to October 1, 1989, if such facilities comply with the provisions of this chapter and all other applicable laws and regulations.

IX 3) RIGHTS OF ALL PERSONS WITH DEVELOPMENTAL DISABILITIES.--The rights described in this subsection shall apply to all persons with developmental disabilities, whether or not such persons are clients of the agency.

(a) Persons with developmental disabilities shall have a right to dignity, privacy, and humane care, including the right to be free from sexual abuse in residential facilities.

(b) Persons with developmental disabilities shall have the right to religious freedom and practice. Nothing shall restrict or infringe on a person's right to religious preference and practice.

(c) Persons with developmental disabilities shall receive services, within available sources, which protect the personal liberty of the individual and which are provided in the least restrictive conditions necessary to achieve the purpose of treatment.

(d) Persons with developmental disabilities shall have a right to participate in an appropriate program of quality education and training services, within available resources, regardless of chronological age or degree of disability. Such persons may be provided with instruction in sex education, marriage, and family planning.

(e) Persons with developmental disabilities shall have a right to social interaction and to participate in community activities.

(f) Persons with developmental disabilities shall have a right to physical exercise and recreational opportunities.

(g) Persons with developmental disabilities shall have a right to be free from harm, including unnecessary physical, chemical, or mechanical restraint, isolation, excessive medication, abuse, or neglect.

(h) Persons with developmental disabilities shall have a right to consent to or refuse treatment, subject to the provisions of s. 393.12(2)(a) or chapter 744.

(i) No otherwise qualified person shall, by reason of having a developmental disability, be excluded from participation in, or be denied the benefits of, or be subject to discrimination under, any program or activity which receives public funds, and all prohibitions set forth under any other statute shall be actionable under this statute.

(j) No otherwise qualified person shall, by reason of having a developmental disability, be denied the right to vote in public elections.

[X] 2.1 Required Training

The provider and its employees will ensure they receive the specific training required to successfully serve each recipient including the following topics:

1. Emphasis on individual choice and rights;
2. The responsibilities of and procedures for maintaining the health, safety, and well being of recipient's served;
3. Recognition of abuse and neglect and required reporting procedures, to include domestic violence and sexual assault;
4. Development and implementation of the required documentation for each waiver service;
5. The Medicaid Waiver Services Agreement and its Attachments. The Developmental Disabilities Waiver Services Coverage and Limitations Handbook and its appendices, and the use of personal outcomes to establish a person-centered approach to service delivery;
6. Other training specific and appropriate to the needs of the recipient's served by the provider and required for specific services listed in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, for which the provider is enrolled and eligible to provide; and
7. All direct service providers are required to complete training in the Department's Direct Care Core Competencies Training, or an equivalent curriculum approved by the Department within 120 days from the effective date of this rule. Said training may be completed using the Department's web based instruction, self-paced instruction or classroom-led instruction.

The provider shall maintain on file for review, adequate and complete documentation to verify its participation, and the participation of its employees, in the required training sessions. This documentation shall, at a minimum, include the training topic(s), length of training session, date and location of training, name and signature of trainer, name and signature of person(s) in attendance.

[XI] 2.2 Department Notification

The provider will share responsibility and assist the Department and others in the notification and resolution of the following issues and concerns for, or on behalf of, each recipient served by the provider:

A. Notifying the District and other providers of issues concerning:

1. The recipient's continued eligibility for waiver services. Any provider that becomes aware of a recipient's loss of Medicaid benefits shall immediately contact the recipient's waiver support coordinator.
2. The possibility of losing Medicaid eligibility. Any provider that becomes aware of a recipient's pending loss of Medicaid benefits shall immediately contact the recipient's waiver support coordinator.
3. Plans to move out of the district or state; and
4. Plans to discontinue receiving services from the provider, waiver or the Department.

B. Immediate notification to the District of an emergency or of an unusual occurrence or circumstance. Said notification of an unusual occurrence or circumstance includes, but is not limited to:

1. Hospitalization of the recipient;
2. Involvement of law enforcement agencies;
3. Concerns about abuse, neglect, or exploitation and reporting of abuse, and reportable events; and
4. Death of a recipient.

[XII] **393.0655 Screening of direct service providers.--**

(1) MINIMUM STANDARDS.--The agency shall require level 2 employment screening pursuant to chapter 435 for direct service providers who are unrelated to their clients, including support coordinators, and managers and supervisors of residential facilities or comprehensive transitional education programs licensed under this chapter and any other person, including volunteers, who provide care or services, who have access to a client's living areas, or who have access to a client's funds or personal property. Background screening shall include employment history checks as provided in s. 435.03(1) and local criminal records checks through local law enforcement agencies.

(a) A volunteer who assists on an intermittent basis for less than 40 hours per month does not have to be screened if the volunteer is under the direct and constant visual supervision of persons who meet the screening requirements of this section.

(b) Licensed physicians, nurses, or other professionals licensed and regulated by the Department of Health are not subject to background screening pursuant to this section if they are providing a service that is within their scope of licensed practice.

(c) A person selected by the family or the individual with developmental disabilities and paid by the family or the individual to provide supports or services is not required to have a background screening under this section.

(d) Persons 12 years of age or older, including family members, residing with a direct services provider who provides services to clients in his or her own place of residence are subject to background screening; however, such persons who are 12 to 18 years of age shall be screened for delinquency records only.

(e) A direct service provider who is awaiting the completion of background screening is temporarily exempt from the screening requirements under this section if the provider is under the direct and constant visual supervision of persons who meet the screening requirements of this section. Such exemption expires 90 days after the direct service provider first provides care or services to clients, has access to a client's living areas, or has access to a client's funds or personal property.

(2) EXEMPTIONS FROM DISQUALIFICATION.--The agency may grant exemptions from disqualification from working with children or adults with developmental disabilities only as provided in s. 435.07.

(3) PAYMENT FOR PROCESSING OF FINGERPRINTS AND STATE CRIMINAL RECORDS CHECKS.--The costs of processing fingerprints and the state criminal records checks shall be borne by the employer or by the employee or individual who is being screened.

(4) TERMINATION; HEARINGS PROVIDED.--

(a) The agency shall deny, suspend, terminate, or revoke a license, certification, rate agreement, purchase order, or contract, or pursue other remedies provided in s. 393.0673, s. 393.0675, or s.

393.0678 in addition to or in lieu of denial, suspension, termination, or revocation for failure to comply with this section.

(b) When the agency has reasonable cause to believe that grounds for denial or termination of employment exist, it shall notify, in writing, the employer and the person affected, stating the specific record that indicates noncompliance with the standards in this section.

(c) The procedures established for hearing under chapter 120 shall be available to the employer and the person affected in order to present evidence relating either to the accuracy of the basis of exclusion or to the denial of an exemption from disqualification.

(d) Refusal on the part of an employer to dismiss a manager, supervisor, or direct service provider who has been found to be in noncompliance with standards of this section shall result in automatic denial, termination, or revocation of the license or certification, rate agreement, purchase order, or contract, in addition to any other remedies pursued by the agency.

[XIII] 3.8 Payment Provisions

A. The provider understands and agrees that all claims for duly authorized and rendered services will be submitted directly through the Medicaid FMMIS system. Claims submitted for payment and the corresponding support documentation must be correct and legible.

B. The provider understands and agrees that the Medicaid fiscal agent or the Office of the Comptroller will not pay a different Medicaid waiver payment rate for the same level of service for the same provider-type and will only pay for those services authorized and directly related to the recipient's goals as identified in his current support plan and that are authorized on the recipient's current and approved cost plan.

C. The provider understands and agrees that payment from the Medicaid fiscal agent is made to a Provider that is determined eligible by a District Office and has executed a Medicaid Waiver Services Agreement. The provider further understands that payment is contingent upon its enrollment in Medicaid as a waiver provider of Developmental Disabilities Home and Community-Based Services Waiver services.

D. The provider understands that Medicaid payment will be payment in full for the services provided. The provider understands that it may not bill the recipient or family for any service that is authorized for reimbursement by Medicaid.

E. The provider understands and agrees that payment from the Medicaid fiscal agent will be made only After services are rendered.

F. Payment shall not be made for services not rendered.

G. The provider understands and agrees that the Department is under no obligation to fund or fill Vacancies created, under any circumstance.

H. The provider understands and agrees that submission of a claim for a service that is not authorized on The service authorization form is grounds for termination of the Medicaid provider agreement.