A bill to be entitled

An act relating to the Agency for Persons with Disabilities; amending s. 393.065, F.S.; revising provisions relating to the order of priority for clients with developmental disabilities waiting for waiver services; extending the date for implementation for certain categories of clients; amending s. 393.0661, F.S.; specifying assessment instruments to be used for the delivery of home and community-based Medicaid waiver program services; revising provisions relating to assignment of clients to waiver tiers; providing for tier one annual expenditure cap; directing the agency to eliminate behavior assistance services; reducing the geographic differential for Miami-Dade, Broward, Palm Beach, and Monroe Counties for residential habilitation services; creating s. 393.0662, F.S.; establishing the iBudget program for the delivery of home and community-based services; providing for amendment of current contracts to implement the iBudget system; providing for the phasing in of the program; requiring clients to use certain resources before using funds from their iBudget; requiring the agency to provide training for clients and evaluate and adopt rules with respect to the iBudget system; amending s. 393.125, F.S.; providing for hearings on Medicaid programs administered by the agency; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (5) of section 393.065, Florida Statutes, is amended to read:

393.065 Application and eligibility determination.—

(5) Except as otherwise directed by law, beginning July 1, 2010, the agency shall assign and provide priority to clients waiting for waiver services in categories 1 and 2 and, beginning July 1, 2012, shall assign and provide priority to clients waiting for waiver services in categories 3, 4, 5, 6, and 7, in the following order:

(a) Category 1, which includes clients deemed to be in crisis as described in rule.

(b) Category 2, which includes children on the wait list who are from the child welfare system with an open case in the Department of Children and Family Services' statewide automated child welfare information system.

(c) Category 3, which includes, but is not required to be limited to, clients:

1. Whose caregiver has a documented condition that is expected to render the caregiver unable to provide care within the next 12 months and for whom a caregiver is required but no alternate caregiver is available;

2. At substantial risk of incarceration or court commitment without supports;

3. Whose documented behaviors or physical needs place them or their caregiver at risk of serious harm and other supports are not currently available to alleviate the situation; or

4. Who are identified as ready for discharge within the

next year from a state mental health hospital or skilled nursing facility and who require a caregiver but for whom no caregiver is available.

(d) Category 4, which includes, but is not required to be limited to, clients whose caregivers are 70 years of age or older and for whom a caregiver is required but no alternate caregiver is available.

(e) Category 5, which includes, but is not required to be limited to, clients who are expected to graduate within the next 12 months from secondary school and need support to obtain or maintain competitive employment, or to pursue an accredited program of postsecondary education to which they have been accepted.

(f) Category 6, which includes clients 21 years of age or older who do not meet the criteria for category 1, category 2, category 3, category 4, or category 5.

(g) Category 7, which includes clients younger than 21 years of age who do not meet the criteria for category 1, category 2, category 3, or category 4.

Within categories 3, 4, 5, 6, and 7, the agency shall maintain a wait list of clients placed in the order of the date that the client is determined eligible for waiver services.

Section 2. Paragraph (a) of subsection (1) and subsections (3), (4), and (5) of section 393.0661, Florida Statutes, are amended to read:

393.0661 Home and community-based services delivery system; comprehensive redesign.—The Legislature finds that the

home and community-based services delivery system for persons with developmental disabilities and the availability of appropriated funds are two of the critical elements in making services available. Therefore, it is the intent of the Legislature that the Agency for Persons with Disabilities shall develop and implement a comprehensive redesign of the system.

(1) The redesign of the home and community-based services system shall include, at a minimum, all actions necessary to achieve an appropriate rate structure, client choice within a specified service package, appropriate assessment strategies, an efficient billing process that contains reconciliation and monitoring components, a redefined role for support coordinators that avoids potential conflicts of interest, and ensures that family/client budgets are linked to levels of need.

(a) The agency shall use either the Department of Children and Family Services' Individual Cost Guidelines or the agency's Questionnaire for Situational Information as an assessment instrument ~~that is reliable and valid~~. The agency may contract with an external vendor or may use support coordinators to complete client assessments if it develops sufficient safeguards and training to ensure ongoing inter-rater reliability.

(3) The Agency for Health Care Administration, in consultation with the agency, shall seek federal approval and implement a four-tiered waiver system to serve eligible clients through the developmental disabilities and family and supported living waivers. The agency shall assign all clients receiving services through the developmental disabilities waiver to a tier based on the Individual Cost Guidelines or the Questionnaire for

Situational Information; ~~a valid assessment instrument,~~ client characteristics, including, but not limited to, age; and other appropriate assessment methods.

(a) Tier one is limited to clients who have service needs that cannot be met in tier two, three, or four for intensive medical or adaptive needs and that are essential for avoiding institutionalization, or who possess behavioral problems that are exceptional in intensity, duration, or frequency and present a substantial risk of harm to themselves or others. Total annual expenditures under tier one may not exceed $120,000 per clients each year.

(b) Tier two is limited to clients whose service needs include a licensed residential facility and who are authorized to receive a moderate level of support for standard residential habilitation services or a minimal level of support for behavior focus residential habilitation services, or clients in supported living who receive more than 6 hours a day of in-home support services. Total annual expenditures under tier two may not exceed $55,000 per client each year.

(c) Tier three includes, but is not limited to, clients requiring residential placements, clients in independent or supported living situations, and clients who live in their family home. Total annual expenditures under tier three may not exceed $35,000 per client each year.

(d) Tier four includes individuals who were enrolled in ~~is~~ the family and supported living waiver on July 1, 2007, who shall be assigned to this tier without the assessments required by this section. Tier four also ~~and~~ includes, but is not limited

to, clients in independent or supported living situations and clients who live in their family home. Total annual expenditures under tier four may not exceed $14,792 per client each year.

(e) The Agency for Health Care Administration shall also seek federal approval to provide a consumer-directed option for persons with developmental disabilities which corresponds to the funding levels in each of the waiver tiers. The agency shall implement the four-tiered waiver system beginning with tiers one, three, and four and followed by tier two. The agency and the Agency for Health Care Administration may adopt rules necessary to administer this subsection.

(f) The agency shall seek federal waivers and amend contracts as necessary to make changes to services defined in federal waiver programs administered by the agency as follows:

1. Supported living coaching services may not exceed 20 hours per month for persons who also receive in-home support services.

2. Limited support coordination services is the only type of support coordination service that may be provided to persons under the age of 18 who live in the family home.

3. Personal care assistance services are limited to 180 hours per calendar month and may not include rate modifiers. Additional hours may be authorized for persons who have intensive physical, medical, or adaptive needs if such hours are essential for avoiding institutionalization.

4. Residential habilitation services are limited to 8 hours per day. Additional hours may be authorized for persons who have intensive medical or adaptive needs and if such hours

are essential for avoiding institutionalization, or for persons who possess behavioral problems that are exceptional in intensity, duration, or frequency and present a substantial risk of harming themselves or others. This restriction shall be in effect until the four-tiered waiver system is fully implemented.

5. Chore services, nonresidential support services, and homemaker services are eliminated. The agency shall expand the definition of in-home support services to allow the service provider to include activities previously provided in these eliminated services.

6. Massage therapy, medication review, behavior assistance services, and psychological assessment services are eliminated.

7. The agency shall conduct supplemental cost plan reviews to verify the medical necessity of authorized services for plans that have increased by more than 8 percent during either of the 2 preceding fiscal years.

8. The agency shall implement a consolidated residential habilitation rate structure to increase savings to the state through a more cost-effective payment method and establish uniform rates for intensive behavioral residential habilitation services.

9. Pending federal approval, the agency may extend current support plans for clients receiving services under Medicaid waivers for 1 year beginning July 1, 2007, or from the date approved, whichever is later. Clients who have a substantial change in circumstances which threatens their health and safety may be reassessed during this year in order to determine the necessity for a change in their support plan.

10. The agency shall develop a plan to eliminate redundancies and duplications between in-home support services, companion services, personal care services, and supported living coaching by limiting or consolidating such services.

11. The agency shall develop a plan to reduce the intensity and frequency of supported employment services to clients in stable employment situations who have a documented history of at least 3 years' employment with the same company or in the same industry.

(4) Effective July 1, 2010, the geographic differential for Miami-Dade, Broward, and Palm Beach Counties for residential habilitation services shall be 4.5 ~~7.5~~ percent.

(5)(a) Effective July 1, 2010, the geographic differential for Monroe County for residential habilitation services shall be 15 ~~20~~ percent.

(b) Effective July 1, 2011, the geographic differential for Monroe County for residential habilitation services shall be 10 percent.

Section 3. Section 393.0662, Florida Statutes, is created to read:

393.0662 Individual budgets for delivery of home and community-based services; iBudget system established.—The Legislature finds that improved financial management of the existing home and community-based Medicaid waiver program is necessary to avoid deficits that impede the provision of services to individuals who are on the waiting list for enrollment in the program. The Legislature further finds that clients and their families should have greater flexibility to

choose the services that best allow them to live in their community within the limits of an established budget. Therefore, the Legislature intends that the agency, in consultation with the Agency for Health Care Administration, develop and implement a comprehensive redesign of the service delivery system using individual budgets as the basis for allocating the funds appropriated for the home and community-based services Medicaid waiver program among eligible enrolled clients. The service delivery system that uses individual budgets shall be called the iBudget system.

(1) The agency shall establish an individual budget, referred to as an iBudget, for each individual served by the home and community-based services Medicaid waiver program. The funds appropriated to the agency shall be allocated through the iBudget system to eligible, Medicaid-enrolled clients. The iBudget system shall be designed to provide for: enhanced client choice within a specified service package; appropriate assessment strategies; an efficient consumer budgeting and billing process that includes reconciliation and monitoring components; a redefined role for support coordinators that avoids potential conflicts of interest; a flexible and streamlined service review process; and a methodology and process that ensures the equitable allocation of available funds to each client based on the client's level of need, as determined by the variables in the allocation algorithm.

(a) In developing each client's iBudget, the agency shall use an allocation algorithm and methodology. The algorithm shall use variables that have been determined by the agency to have a

statistically validated relationship to the client's level of need for services provided through the home and community-based services Medicaid waiver program. The algorithm and methodology may consider individual characteristics, including, but not limited to, a client's age and living situation, information from a formal assessment instrument that the agency determines is valid and reliable, and information from other assessment processes.

(b) The allocation methodology shall provide the algorithm that determines the amount of funds allocated to a client's iBudget. The agency may approve an increase in the amount of funds allocated, as determined by the algorithm, based on the client having:

1. An extraordinary need that would place the health and safety of the client, the client's caregiver, or the public in immediate, serious jeopardy unless the increase is approved. An extraordinary need may include, but is not limited to:

a. A documented history of significant, potentially life-threatening behaviors, such as recent attempts at suicide, arson, nonconsensual sexual behavior, or self-injurious behavior requiring medical attention;

b. A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a nonlicensed person;

c. A chronic co-morbid condition. As used in this subparagraph, the term "co-morbid condition" means a medical condition existing simultaneously but independently with another medical condition in a patient; or

d. A need for total physical assistance with activities such as eating, bathing, toileting, grooming, and personal hygiene.

However, the presence of an extraordinary need alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm.

2. A significant need for one-time or temporary support or services that, if not provided, would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy, unless the increase, as determined by the total of the algorithm and any adjustments based on subparagraphs 1. and 3., is approved. A significant need may include, but is not limited to, the provision of environmental modifications, durable medical equipment, services to address the temporary loss of support from a caregiver, or special services or treatment for a serious temporary condition when the service or treatment is expected to ameliorate the underlying condition. As used in this subparagraph, the term "temporary" means a period of fewer than 12 continuous months.

3. A significant increase in the need for services after the beginning of the service plan year that would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy because of substantial changes in the client's circumstances, including, but not limited to, permanent or long-term loss or incapacity of a caregiver, loss of services authorized under the state Medicaid plan due to a change in age, or a significant change in medical or functional status which

requires the provision of additional services on a permanent or long-term basis that cannot be accommodated within the client's current iBudget. As used in this subparagraph, the term "long-term" means a period of 12 or more continuous months.

The agency shall reserve portions of the appropriation for the home and community-based services Medicaid waiver program for adjustments required pursuant to this paragraph and may use the services of an independent actuary in determining the amount of the portions to be reserved.

(c) A client's iBudget shall be the total of the amount determined by the algorithm and any additional funding provided pursuant to paragraph (a). A client's annual expenditures for home and community-based services Medicaid waiver services may not exceed the limits of his or her iBudget. The total of a client's projected annual iBudget expenditures may not exceed the agency's appropriation for waiver services.

(2) The Agency for Health Care Administration, in consultation with the agency, shall seek federal approval to amend current waivers, request a new waiver, and amend contracts as necessary to implement the iBudget system to serve eligible, enrolled clients through the home and community-based services Medicaid waiver program and the Consumer-Directed Care Plus Program.

(3) The agency shall transition all eligible, enrolled clients to the iBudget system. The agency may gradually phase in the iBudget system.

(a) While the agency phases in the iBudget system, the

agency may continue to serve eligible, enrolled clients under the four-tiered waiver system established under s. 393.065 while those clients await transitioning to the iBudget system.

(b) The agency shall design the phase-in process to ensure that a client does not experience more than one-half of any expected overall increase or decrease to his or her existing annualized cost plan during the first year that the client is provided an iBudget due solely to the transition to the iBudget system.

(4) A client must use all available services authorized under the state Medicaid plan, school-based services, private insurance and other benefits, and any other resources that may be available to the client before using funds from his or her iBudget to pay for support and services.

(5) Rates for any or all services established under rules of the Agency for Health Care Administration shall be designated as the maximum rather than a fixed amount for individuals who receive an iBudget, except for services specifically identified in those rules that the agency determines are not appropriate for negotiation, which may include, but are not limited to, residential habilitation services.

(6) The agency shall ensure that clients and caregivers have access to training and education to inform them about the iBudget system and enhance their ability for self-direction. Such training shall be offered in a variety of formats and at a minimum shall address the policies and processes of the iBudget system; the roles and responsibilities of consumers, caregivers, waiver support coordinators, providers, and the agency;

information available to help the client make decisions regarding the iBudget system; and examples of support and resources available in the community.

(7) The agency shall collect data to evaluate the implementation and outcomes of the iBudget system.

(8) The agency and the Agency for Health Care Administration may adopt rules specifying the allocation algorithm and methodology; criteria and processes for clients to access reserved funds for extraordinary needs, temporarily or permanently changed needs, and one-time needs; and processes and requirements for selection and review of services, development of support and cost plans, and management of the iBudget system as needed to administer this section.

Section 4. Subsection (1) of section 393.125, Florida Statutes, is amended to read:

393.125 Hearing rights.—

(1) REVIEW OF AGENCY DECISIONS.—

(a) For Medicaid programs administered by the agency, any developmental services applicant or client, or his or her parent, guardian advocate, or authorized representative, may request a hearing in accordance with federal law and rules applicable to Medicaid cases and has the right to request an administrative hearing pursuant to ss. 120.569 and 120.57. These hearings shall be provided by the Department of Children and Family Services pursuant to s. 409.285 and shall follow procedures consistent with federal law and rules applicable to Medicaid cases.

(b) ~~(a)~~ Any other developmental services applicant or

client, or his or her parent, guardian, guardian advocate, or authorized representative, who has any substantial interest determined by the agency, has the right to request an administrative hearing pursuant to ss. 120.569 and 120.57, which shall be conducted pursuant to s. 120.57(1), (2), or (3).

(c) ~~(b)~~ Notice of the right to an administrative hearing shall be given, both verbally and in writing, to the applicant or client, and his or her parent, guardian, guardian advocate, or authorized representative, at the same time that the agency gives the applicant or client notice of the agency's action. The notice shall be given, both verbally and in writing, in the language of the client or applicant and in English.

(d) ~~(c)~~ A request for a hearing under this section shall be made to the agency, in writing, within 30 days after ~~of~~ the applicant's or client's receipt of the notice.

Section 5. This act shall take effect July 1, 2010.