A bill to be entitled

An act relating to Developmental Disabilities; amending s. 393.063,F.S.; redefining the term support coordinator; amending s. 393.0661, F.S.; specifying the use of an assessment instrument; providing for enrollment into tier waivers; revising criteria for tier waivers; directing establishment of performance criteria for and evaluation of support coordinator services; revising content and dates for a report; deleting obsolete statutes; amending s.393.0662, F.S.; specifying use of an allocation algorithm; providing steps for determining iBudget amounts; requiring a report on the iBudget system; amending s. 393.067, F.S.; providing exceptions for inspections in accredited facilities; amending s. 393.11, F.S.; authorizing the agency to petition the court for involuntary admission to residential services; amending s. 393.125, F.S.; providing the agency with final order authority in Medicaid program hearings; creating s. 393.28, F.S.; providing authority and procedures for food service and environmental health protection in licensed facilities and programs; providing an effective date.

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

Section 1. Subsection (37) of section 393.063, Florida Statutes, is amended to read:

393.063 Definitions.—For the purposes of this chapter, the term:

(37) "Support coordinator" means a person who ~~is~~ contracts with ~~designated by~~ the agency to assist individuals and families in identifying their capacities, needs, and resources, as well as finding and gaining access to necessary supports and services; locating or developing employment opportunities; coordinating the delivery of supports and services; advocating on behalf of the individual and family; maintaining relevant records; and monitoring and evaluating the delivery of supports and services to determine the extent to which they meet the needs ~~and expectations~~ identified by the individual, family, and others who participated in the development of the support plan.

Section 2. Section 393.0661, Florida Statutes, is amended to read:

393.0661 Home and community-based services delivery system; Medicaid waiver ~~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.~~, and 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 the Questionnaire for Situational Information, or other ~~an~~ assessment instruments deemed by ~~instrument that~~ the agency ~~deems~~ to be reliable and valid~~, including, but not limited to, the Department of Children and Family Services' Individual Cost Guidelines or the agency's Questionnaire for Situational Information~~. 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.

(b) The agency, with the concurrence of the Agency for Health Care Administration, may contract for the determination of medical necessity and technical services related to the establishment of individual budgets.

(2) A provider of services rendered to persons with developmental disabilities pursuant to a federally approved waiver shall be reimbursed according to a rate ~~methodology based upon an analysis of the expenditure history and prospective costs of providers participating in the waiver program, or under any other methodology~~ developed by the Agency for Health Care Administration, in consultation with the Agency for Persons with Disabilities, and approved by the Federal Government in accordance with the waiver.

(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. For the purpose of this waiver program, eligible clients shall include individuals with a diagnosis of Down syndrome or a developmental disability as defined in s. 393.063. The agency shall assign all clients receiving services through the ~~developmental disabilities~~ waiver to a tier based on the ~~Department of Children and Family Services' Individual Cost Guidelines, the~~ agency's Questionnaire for Situational Information, or another such assessment instrument deemed ~~to be~~ valid and reliable by the agency; client characteristics, including, but not limited to, age; and other appropriate assessment methods. The agency must determine a waiver slot is available before final determination of tier eligibility and before enrollment of a client in any tier. Waiver clients who are eligible for services covered by the Medicaid state plan must obtain these services through the Medicaid state plan. When the same service is covered by both the waiver and the Medicaid state plan, the payment rates and coverage limits shall be the same under the waiver as in the Medicaid state plan.

(a) Tier one is limited to clients who have intensive medical or adaptive 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 $150,000 per client each year, provided that expenditures for clients in tier one with a documented medical necessity requiring intensive behavioral residential habilitation services, intensive behavioral residential habilitation services with medical needs, or special medical home care, as provided in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, are not subject to the $150,000 limit on annual expenditures.~~

(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. Tier two also includes clients whose need for authorized services meets the criteria of tier one and the client's needs can be met within the expenditure limit of tier two. Total annual expenditures under tier two may not exceed $53,625 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. Tier three also includes clients whose need for authorized services meets the criteria for tiers one or two and the client's needs can be met within the expenditure limit of tier three. Total annual expenditures under tier three may not

exceed $34,125 per client each year.

(d) Tier four includes clients ~~individuals~~ who were enrolled in the family and supported living waiver on July 1, 2007, who were ~~shall be~~ assigned to this tier without the assessments required by this section. Tier four also 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 $14,422 per client each year.

(e) The Agency for Health Care Administration shall also seek federal approval to provide a consumer-directed option for clients ~~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.~~

4.~~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.

5~~6~~. Massage therapy, medication review, 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.~~

6.~~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.~~

7.~~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.

8.~~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.

(g) The agency and the Agency for Health Care Administration may adopt rules as necessary to administer this subsection.

(4) The geographic differential for Miami-Dade, Broward, and Palm Beach Counties for residential habilitation services is ~~shall be~~ 7.5 percent.

~~(5)~~ The geographic differential for Monroe County for residential habilitation services is ~~shall be~~ 20 percent.

~~(6) Effective January 1, 2010, and except as otherwise provided in this section, a client served by the home and community-based services waiver or the family and supported living waiver funded through the agency shall have his or her cost plan adjusted to reflect the amount of expenditures for the~~

~~previous state fiscal year plus 5 percent if such amount is less than the client's existing cost plan. The agency shall use actual paid claims for services provided during the previous fiscal year that are submitted by October 31 to calculate the revised cost plan amount. If the client was not served for the entire previous state fiscal year or there was any single change in the cost plan amount of more than 5 percent during the previous state fiscal year, the agency shall set the cost plan amount at an estimated annualized expenditure amount plus 5 percent. The agency shall estimate the annualized expenditure amount by calculating the average of monthly expenditures, beginning in the fourth month after the client enrolled, interrupted services are resumed, or the cost plan was changed by more than 5 percent and ending on August 31, 2009, and multiplying the average by 12. In order to determine whether a client was not served for the entire year, the agency shall include any interruption of a waiver-funded service or services lasting at least 18 days. If at least 3 months of actual expenditure data are not available to estimate annualized expenditures, the agency may not rebase a cost plan pursuant to this subsection. The agency may not rebase the cost plan of any client who experiences a significant change in recipient condition or circumstance which results in a change of more than 5 percent to his or her cost plan between July 1 and the date that a rebased cost plan would take effect pursuant to this subsection.~~

(5)~~(7)~~ The agency shall collect premiums or cost sharing pursuant to s. 409.906(13)(d).

(6) The agency shall establish performance criteria in support coordinator service agreements. Continuation of a service agreement may be based on the agency's evaluation of the coordinator's performance in relation to the specified criteria. The agency may in the service agreement establish rewards for superior performance or sanctions for poor performance.

(7)(~~8~~) This section or related rule does not prevent or limit the Agency for Health Care Administration, in consultation with the agency ~~for Persons with Disabilities~~, from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or from limiting enrollment, or making any other adjustment necessary to comply with the availability of moneys and any limitations or directions provided in the General Appropriations Act.

(8)(~~9~~) The agency ~~for Persons with Disabilities~~ shall submit quarterly status reports to the Executive Office of the Governor, and the chairs of the legislative appropriations committees ~~chair of the Senate Ways and Means Committee or its successor, and the chair of the House Fiscal Council or its successor~~ regarding the financial status of home and community-based services, including the number of enrolled individuals who are receiving services through one or more programs; the number of individuals who have requested services who are not enrolled but who are receiving services through one or more programs, including ~~with~~ a description indicating the programs from which the individual is receiving services; the number of individuals who have refused an offer of services but who choose to remain on the list of individuals waiting for services; the number of

individuals who have requested services but who are receiving no services; a frequency distribution indicating the length of time individuals have been waiting for services; and information concerning the actual and projected costs compared to the amount of the appropriation available to the program and any projected surpluses or deficits. If at any time an analysis by the agency, in consultation with the Agency for Health Care Administration, indicates that the cost of services is expected to exceed the amount appropriated, the agency shall submit a plan in accordance with subsection (8) to the Executive Office of the Governor, and the chairs of the legislative appropriations committees ~~chair of the Senate Ways and Means Committee or its successor, and the chair of the House Fiscal Council or its successor~~ to remain within the amount appropriated. The agency shall work with the Agency for Health Care Administration to implement the plan so as to remain within the appropriation.

(9)(~~10~~) Implementation of ~~Medicaid~~ waiver programs and services authorized under this chapter is limited by the funds appropriated for the individual budgets pursuant to s. 393.0662 and the four-tiered waiver system pursuant to subsection (3). Contracts with independent support coordinators and service providers must include provisions requiring compliance with agency cost containment initiatives. The agency shall implement monitoring and accounting procedures necessary to track actual expenditures and project future spending compared to available appropriations for Medicaid waiver programs. When necessary based on projected deficits, the agency must establish specific corrective action plans that incorporate corrective actions of

contracted providers that are sufficient to align program expenditures with annual appropriations. If deficits continue during the 2012-2013 fiscal year, the agency in conjunction with the Agency for Health Care Administration shall develop a plan to redesign the waiver program based on a model that assures budget predictability and flexibility in service delivery. ~~and submit~~ The plan shall be submitted to the President of the Senate and the Speaker of the House of Representatives by ~~September 30~~ December 31, 2013. At a minimum, the plan must include the following elements:

(a) ~~Budget predictability.—Agency budget recommendations must include specific steps to restrict spending to budgeted amounts based on alternatives to the iBudget and four-tiered Medicaid waiver models.~~ An assessment of models for improving budget predictability and flexibility in service delivery. The models shall include at least the following three alternatives:

1. Development of a community-based care system in each service area;

2. Competitive procurement of a limited number of managed care plans that may include health maintenance organizations or risk-bearing provider service networks; and,

3. Establishment of managing entities responsible for administering regional block grants.

(b) ~~Services.—The agency shall identify core services that are essential to provide for client health and safety and recommend elimination of coverage for other services that are not affordable based on available resources.~~ A summary of comments received from public hearings held around the state to

gather input on alternative models.

(c) ~~Flexibility.—The redesign shall be responsive to individual needs and to the extent possible encourage~~ Recommended policies to preserve or increase client and family control over allocated resources for their needs.

(d) ~~Support coordination services.—The plan shall modify the manner of providing~~ Recommended organizational changes to support coordination services for each model pursuant to (10)(a).

(e) Recommendation of one model to achieve budget predictability and flexibility in service delivery and steps necessary to implement the recommendation.

The agency shall provide ~~monthly~~ reports to the President of the Senate and the Speaker of the House of Representatives on plan ~~progress and~~ development on ~~July 31~~ September 15, 2013, and ~~August 31~~ November 30, 2013. The implementation of a redesigned program is subject to legislative approval and shall occur no later than July 1, 2014. The Agency for Health Care Administration shall seek federal waivers as needed to implement the redesigned plan approved by the Legislature.

Section 3. Section 393.0662, Florida Statutes, is amended 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. For the iBudget system, eligible clients shall include individuals with a diagnosis of Down syndrome or a developmental disability as defined in s. 393.063. The iBudget system shall ~~be designed to provide for~~: enhance~~d~~ client choice ~~within a specified service package~~; utilize appropriate assessment strategies; provide 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; implement a flexible ~~and streamlined~~ service review

process; and establish a ~~methodology and~~ process to promote the ~~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~~.

(2) ~~(a)~~ To determine ~~In developing~~ each client's iBudget, the agency shall use an allocation algorithm and a methodology for determining additional need.

(a) The allocation algorithm shall ~~use variables that have been determined by the agency to have~~ consist of a statistically valid~~ated relationship to~~ formula that predicts the client's ~~level of~~ need for services ~~provided~~ through the ~~home and community-based services Medicaid~~ waiver program. The allocation algorithm ~~and methodology may consider~~ estimates the cost of client needs based on individual characteristics, ~~including, but not limited to~~, such as 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. The allocation algorithm shall calculate each client's share of available waiver funding. Available funding equals the agency's waiver appropriation less any amounts set aside by the agency, including, but not limited to funding for clients with additional needs pursuant to (b).

(b) The agency shall reserve portions of the appropriation for the waiver program for adjustments required to meet the additional needs pursuant to this paragraph and may use the services of an independent actuary in determining the amount of the portions to be reserved. The ~~allocation~~ methodology used ~~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 allocation~~ algorithm~~, based on the client having one or more of the following~~ for determining additional needs ~~that cannot be accommodated within the funding as determined by the~~ allocation ~~algorithm and having no~~ shall be based on the lack of any other resources, supports, or services ~~available~~ to meet one or more of the following needs for services:

1. Immediate serious jeopardy to ~~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~~ as evidenced by:

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 comorbid condition. As used in this subparagraph, the term "comorbid 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~~ pursuant to ~~(b)(1) alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the~~ allocation ~~algorithm.~~

2. ~~A significant need for~~ One-time or temporary ~~support or services that, if not provided, would~~ conditions that place the health and safety of the client, the client's caregiver, or the public in serious jeopardy, ~~unless the increase is approved~~. ~~A significant need may~~ Examples include~~, but is not limited to,~~ ~~the provision of~~ needs for 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. ~~However, the presence of such significant need for one-time or temporary supports or services alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the allocation algorithm.~~

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. ~~However, such significant increase in need for services of a permanent or long-term nature alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the allocation algorithm.~~

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

During the 2012-2013 fiscal year, the agency may also consider other criteria for determining additional need including individual characteristics based on a needs assessment, living setting, availability of supports from non-waiver funding, family circumstances and other factors that may affect service need.

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

(c) During the 2012-2013 fiscal year,the following steps shall be used to establish a client’s iBudget amount.

1. The agency shall calculate the allocation algorithm

amount for each client and compare the result to the cost plan for each client. If the cost plan amount is the lesser of these two amounts then the cost plan amount shall be the client's iBudget amount.

2. If the client has additional needs pursuant to(2)(b), which the agency determines cannot be met within the allocation algorithm amount, then the agency shall assess the amount, duration, frequency, intensity, and scope of services required to meet the additional needs and estimate the cost for providing these services. Based on the estimated costs and the availability of funds reserved for this purpose, the agency shall adjust the allocation algorithm amount to determine the iBudget amount.

3. The client's iBudget amount shall not be less than 50 percent of that client's cost plan amount.

4. During the 2012-2013 fiscal year, increases to an client's iBudget amount may be granted only if a significant change in circumstances has occurred consistent with the provisions of (2)(b)3.

(d) ~~(c) A client's iBudget shall be the total of the amount determined by the algorithm and any additional funding provided pursuant to paragraph (b).~~ 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 all clients' projected annual iBudget expenditures may not exceed the agency's appropriation for waiver services, less any amounts set aside by the agency.

(3) By October 31, 2012, the agency shall submit a report

to the President of the Senate and Speaker of the House, evaluating the iBudget system. The report shall include findings and recommendations in the following areas:

(a) The accuracy and effectiveness of the allocation algorithm in determining client need. The agency shall provide specific recommendations for modifying the allocation algorithm in order to minimize additional needs not captured by the algorithm.

(b) The adequacy of the methodology in (2)(b)to identify additional client needs and accurately determine the associated costs.

(c) The flexibility provided to clients using the iBudget system in obtaining needed services.

(d) The advantages and disadvantages of continuing the iBudget system.

(4)~~(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.

(5)(~~3~~) The agency shall transition all eligible, enrolled clients to the iBudget system by June 30, 2013. ~~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.~~

(6) ~~(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. The Medicaid waiver shall only provide funding if no other support or funding is available.

(7) ~~(5)~~ A client shall have the flexibility to determine the type, amount, frequency, duration, and scope of the services from his or her iBudget amount if the agency determines that such services meet his or her health and safety needs, meet the requirements contained in the Medicaid waiver Coverage and Limitations Handbook for each service included on the cost plan, and comply with the other requirements of this section. The service limitations in s. 393.0661(3)(f)1., 2., and 3. do not apply to the iBudget system.

(8) ~~(6)~~ 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 clients ~~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.

(9) ~~(7)~~ 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.

~~(8) The agency shall collect data to evaluate the implementation and outcomes of the iBudget system.~~

(10) ~~(9)~~ 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 (2) of section 393.067, Florida Statutes, is amended to read:

393.067 Facility licensure.—

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

unless the facility or program is currently accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation. Facilities or programs that are operating under such accreditation must be inspected and reviewed by the agency once every 2 years. If, upon inspection and review, the services and service delivery sites are not those for which the facility or program is accredited, the facilities and programs must be inspected and reviewed in accordance with this section and related rules adopted by the agency. Notwithstanding current accreditation, the agency may continue to monitor the facility or program as necessary with respect to:

(a) Ensuring that services paid for by the agency are being provided.

(b) Investigating complaints, identifying problems that would affect the safety or viability of the facility or program, and monitoring the facility or program's compliance with any resulting negotiated terms and conditions, including provisions relating to consent decrees which are unique to a specific service and are not statements of general applicability.

(c) Ensuring compliance with federal and state laws, federal regulations, or state rules if such monitoring does not duplicate the accrediting organization's review pursuant to accreditation standards.

Federal certification and precertification reviews are exempt from this subsection to ensure Medicaid compliance.

Section 5. Subsection (2) of section 393.11, Florida Statutes, are amended to read:

393.11 Involuntary admission to residential services.—

(2) PETITION.—

(a) A petition for involuntary admission to residential services may be executed by a petitioning commission or the agency.

(b) The petitioning commission shall consist of three persons. One of whom ~~these persons~~ shall be a physician licensed and practicing under chapter 458 or chapter 459.

(c) The petition shall be verified and shall:

1. State the name, age, and present address of the commissioners or the representative of the agency and their relationship to the person with mental retardation or autism;

2. State the name, age, county of residence, and present address of the person who is the subject of the petition with mental retardation or autism;

3. Allege that ~~the commission believes that~~ the person needs involuntary residential services and specify the factual information on which the belief is based;

4. Allege that the person lacks sufficient capacity to give express and informed consent to a voluntary application for services and lacks the basic survival and self-care skills to provide for the person's well-being or is likely to physically injure others if allowed to remain at liberty; and

5. State which residential setting is the least restrictive and most appropriate alternative and specify the factual information on which the belief is based.

(d) The petition shall be filed in the circuit court of the county in which the person who is the subject of the petition with mental retardation or autism resides.

Section 6. Paragraph (a) of 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. The hearing ~~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. At the conclusion of the hearing, the department shall submit its recommended order to the agency as provided in s.120.57(1)(k) and the agency shall issue final orders as provided in s. 120.57(1)(l).

Section 7. Section 393.28, Florida Statutes, is created to read:

393.28 Food service and environmental health protection and inspection.—

(1) AUTHORITY.—

(a) The Agency for Persons with Disabilities shall adopt and enforce sanitation standards related to food-borne illnesses

and environmental sanitation hazards to ensure the protection of individuals served in facilities licensed or regulated by the agency under s. 393.067 by inspecting or contracting for the inspection of those facilities.

(b) The agency may develop rules to administer this section. In the absence of rules, the agency shall defer to preexisting standards related to environmental health inspections of group care facilities as described in s. 381.006, preexisting standards related to food service establishments as described in s. 381.0072, and the rules relevant to these provisions.

(c) Rules under this section may provide additional or alternative standards to those referenced in paragraph (b), and may include sanitation requirements for the storage, preparation, and serving of food, as well as sanitation requirements to detect and prevent disease caused by natural and manmade factors in the environment.

(2) LICENSING SANCTIONS; PROCEDURES.—The agency may impose sanctions pursuant to s. 393.0673 against any establishment or operator licensed under s. 393.067 for violations of sanitary standards.

(3) CONTRACTING.—The agency may contract with another entity for the provision of food service protection and inspection services.

Section 8. This act shall take effect July 1, 2012.