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| **Tab 1** | **SB 82** by **Bean**; Individuals With Disabilities |

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| **Tab 2** | **SB 994** by **Passidomo (CO-INTRODUCERS) Stewart, Thurston**; (Similar to H 00709) Guardianship |

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| **Tab 3** | **SB 1324** by **Simpson**; (Compare to H 00043) Child Welfare |

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**The Florida Senate**

# COMMITTEE MEETING EXPANDED AGENDA

**CHILDREN, FAMILIES, AND ELDER AFFAIRS**
**Senator Book, Chair**
**Senator Mayfield, Vice Chair**

**MEETING DATE:** Wednesday, January 15, 2020
**TIME:** 10:30 a.m.—12:30 p.m.
**PLACE:** 301 Senate Building

**MEMBERS:** Senator Book, Chair; Senator Mayfield, Vice Chair; Senators Bean, Harrell, Rader, Torres, and Wright

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 1 | **SB 82**<br>Bean | Individuals With Disabilities; Requiring persons and entities under contract with the Agency for Persons with Disabilities to use the agency data management systems to bill for services; revising criteria used by the agency to develop a client's iBudget; requiring the Agency for Health Care Administration to seek federal approval to provide consumer-directed options; requiring the Agency for Persons with Disabilities to competitively procure qualified organizations to provide support coordination services, etc.<br><br>CF 01/15/2020 Favorable<br>AHS<br>AP | Favorable<br>Yeas 5 Nays 2 |
| 2 | **SB 994**<br>Passidomo<br>(Similar H 709) | Guardianship; Expanding factors for a court to consider when appointing a guardian; prohibiting a guardian from consenting to or signing on behalf of a ward an order not to resuscitate without court approval; revising requirements for a petition for the appointment of a guardian; prohibiting professional guardians from petitioning for their own appointment except under certain circumstances; prohibiting guardians from taking certain actions on behalf of an alleged incapacitated person or minor, etc.<br><br>CF 01/15/2020 Favorable<br>JU<br>RC | Favorable<br>Yeas 7 Nays 0 |
| 3 | **SB 1324**<br>Simpson<br>(Compare H 43, H 449, H 1105, S 122, CS/S 236, S 1548) | Child Welfare; Requiring the Florida Court Educational Council to establish certain standards for instruction of circuit and county court judges for dependency cases; authorizing circuit courts to create early childhood court programs; requiring the Department of Children and Families to contract with certain university-based centers; requiring the court to retain jurisdiction over a child under certain circumstances; requiring the department to conduct background screenings of prospective adoptive parents, etc.<br><br>CF 01/15/2020 Fav/CS<br>AHS<br>AP | Fav/CS<br>Yeas 7 Nays 0 |

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| | Other Related Meeting Documents | | |

**The Florida Senate**

# BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

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| BILL: | SB 82 |
| INTRODUCER: | Senator Bean |
| SUBJECT: | Individuals With Disabilities |
| DATE: | January 15, 2020 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Delia | Hendon | CF | **Favorable** |
| 2. | | | AHS | |
| 3. | | | AP | |

## I. Summary:

SB 82 makes operational changes to improve the fiscal stability of the Medicaid Home and Community Based Services (HCBS) waiver. The bill requires the Agency for Persons with Disabilities (APD) to competitively procure qualified organizations to provide waiver support coordination services for HCBS waiver clients. The bill also requires the Agency for Health Care Administration (AHCA) to competitively procure a qualified organization to perform medical necessity determinations for clients who request an increase to their initial funding amount under the HCBS waiver. The bill creates a definition of 'significant additional needs' for clients HCBS waiver clients. The bill provides APD with statutory authority to require service providers to both bill for services and submit all required documentation through the agency's electronic client data management system.

The bill eliminates obsolete language from chapter 393 of the Florida Statutes. The bill also requires APD to certify and document that an HCBS waiver client has utilized all available resources before submitting a request for a funding increase related to significant additional needs, and it prohibits such requests from occurring until the total amount of funding to be provided to a client under the waiver is determined. The bill also allows AHCA to seek federal approval to implement a payment rate for Medicaid intermediate care facilities serving individuals with developmental disabilities who may not be appropriate for placement in community settings.

The bill is expected to have a positive fiscal impact and takes effect July 1, 2020.

## II. Present Situation:

**Agency for Persons with Disabilities**

The Agency for Persons with Disabilities (APD) is responsible for providing services to persons with developmental disabilities. A developmental disability is defined as a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.[1]

Individuals who meet Medicaid eligibility requirements, including individuals who have Down syndrome,[2] may choose to receive services in the community through the state's Medicaid home and community-based services (HCBS) waiver for individuals with developmental disabilities administered by the APD or in an intermediate care facility for the developmentally disabled (ICF/DD).

The HCBS waiver, known as the iBudget, offers 28 supports and services to assist individuals to live in their community. Such services are not covered under the regular Medicaid program. Examples of HCBS waiver services include residential habilitation, behavioral services, companion, adult day training, employment services, and physical therapy.[3] Services provided through the HCBS waiver enable children and adults to live in the community in their own home, a family home, or in a licensed residential setting, thereby avoiding institutionalization.

While the majority of individuals served by APD live in the community, a small number live in ICF/DDs, which are defined in s. 393.063(22), F.S., as residential facilities licensed and certified by the Agency for Health Care Administration (AHCA). ICF/DDs are considered institutional placements and provide intermediate nursing care. In Florida, there are 88 privately-owned ICF/DD facilities.[4] As of April 2018, the ICF/DDs are 94.6 percent occupied, with 1,948 individuals in 2,060 possible slots. Facility size ranges from six to 120 beds. The most common ICF/DD facility size is six beds. The average number of beds across all ICF/DDs in Florida is about 24.[5]

**Home and Community-Based Services Waiver (iBudget Florida)**

The iBudget Florida program was developed in response to legislative direction requiring a plan for an individual budgeting approach for improving the management of the HCBS waiver program.[6] The iBudget involves the use of an algorithm, or formula, to set individual allocations for waiver services, allocating program funding based on the needs of each client. To assist clients, the iBudget offers various supports and services delivered by contracted service

[1] *See* s. 393.063(9), F.S.

[2] *See* s. 393.0662(1), F.S., provides eligibility for individuals with a diagnosis of Down syndrome.

[3] Agency for Persons with Disabilities, Monthly Surplus-Deficit Report for Waiver Program Expenditures: Fiscal Year 2019-20, December 2019. On file with the Senate Children Families and Elder Affairs Committee.

[4] Florida Medicaid ICF/IID Rate Study Report, prepared by Navigant for the Florida Agency for Health Care Administration. 2019. On file with the Senate Children Families and Elder Affairs Committee.

[5] *Id*.

[6] Agency for Persons with Disabilities, Report to the Legislature on the Agency's Plan for Implementing Individual Budgeting "iBudget Florida" (February 1 2010), *available at* http://apd.myflorida.com/ibudget/rules-regs.htm (last visited January 13, 2020).

providers. These services include residential habilitation, behavioral services, companion services, adult day training, employment services, and physical therapy.[7]

**Waiver Enrollment Prioritization**

As of October 17, 2019, 34,919 individuals were enrolled on the iBudget waiver.[8] The majority of waiver enrollees live in a family home with a parent, relative, or guardian. The Legislature appropriated $1,196,369,280 for Fiscal Year 2019-2020 to provide services through the HCBS waiver program, including state funding of $462,755,638 and a federal match of $733,613,642.[9] However, this funding is insufficient to serve all persons seeking waiver services. To enable APD to remain within legislative appropriations, waiver enrollment is limited. Accordingly, APD maintains a waiting list for waiver services. Prioritization for the wait list is provided in s. 393.065(5), F.S. Medicaid-eligible persons on the waiting list continue to receive Medicaid services not offered through the iBudget.

**Significant Additional Needs Requests**

State law provides for individuals to receive funding in addition to that allocated through the algorithm under certain conditions, such as when they have a temporary or permanent change in need or an extraordinary need that the algorithm did not address in the initial allocation of funding.[10]

APD annually authorizes a cost plan for each client outlining the client's approved services and costs for the fiscal year. To implement the algorithm under the HCBS waiver, clients and their families meet with Waiver Support Coordinators (WSCs) who are responsible for preparing an Amount Implementation Meeting (AIM) Worksheet that communicates a client's algorithm amount, identifies proposed services based on the algorithm amount, and documents significant additional needs (SANs), if any, that cannot be met by the algorithm amount.[11] The Agency conducts individual reviews to determine whether the services requested meet health and safety needs and waiver coverage limitations. The agency is to approve an amount greater than the algorithm amount if additional funding is required to meet a client's SANs. Within 30 days of receiving an AIM worksheet, APD is to advise the client or their representative of the agency's decision and approved cost plan amount.

Medical or allied care, goods, or services furnished or ordered pursuant to SANs requests must meet the following conditions in order for the funding increase to be approved:[12]

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain,

[7] *See* s. 393.0662, F.S.
[8] Attachment to e-mail from Jeff Ivey, Legislative Affairs Director, Agency for Persons with Disabilities. (Oct. 17, 2019). On file with the Senate Committee on Children, Families and Elder Affairs.
[9] *See* Specific Appropriation 245, ch. 2019-115, Laws of Florida.
[10] *See* s. 393.0662, F.S.
[11] SANs represent needs for additional funding that if not provided would place the health and safety of the client, their caregiver, or public in serious jeopardy that are authorized by Section 393.0662(1)(b), Florida Statutes.
[12] Rule 59G-1.1010, F.A.C.

- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs,
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational,
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide, and
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

**The iBudget and APD Deficits**

The State of Florida Auditor General evaluated the effectiveness of APD's allocation methodology and algorithm in achieving the legislative intent of the iBudget.[13] Prior audits have found a lack of documentation for justifying increases in the iBudgets. The report concluded that despite statistical validity underlying the algorithm, a lack of available funding to meet additional client needs and differences in client circumstances and needs have prevented APD from achieving the financial management goals of the iBudget and reducing the number of individuals on the waiting list.[14] The table below depicts the difference between annual appropriations, expenditures, surpluses/deficits, the number of clients served, the number of indivuals on the waiting list and the number moved off of the waitiling from FY 2013 – 2014 through FY 2017 – 2018:[15]

In 2019, the Legislature directed APD, in conjunction with AHCA, to develop and submit a plan to redesign the iBudget to the President of the Senate and the Speaker of the House of Representatives for consideration and potential legislative approval.[16] The plan was required to address the following areas:[17]

In response, APD submitted a proposed redesign of the iBudget consisting of the following elements:[18]

- Inclusion of the iBudget waiver program in the Social Services Estimating Conference;
- Implementation of a behavioral health intermediate care facility service rate;
- Individual caps on the dollar amount of services for waiver clients;
- Budget transfers from the Medicaid State Plan to the iBudget waiver program for waiver clients turning 21;
- Expansion of the Medicaid Assistive Care Services program to include waiver group homes;

[13] State of Florida Auditor General Report No. 2020-012, August 2019, *available at* https://flauditor.gov/pages/pdf_files/2020-012.pdf (last visited January 13, 2020).
[14] *Id*.
[15] *Id*.
[16] Ch. 2019-116, Laws of Florida.
[17] *Id*.
[18] Agency for Persons with Disabilities; Agency for Health Care Administration: 2019 iBudget Waiver Redesign. On file with the Senate Children, Families, and Elder Affairs Committee.

- Service limitations on Life Skills Development services;
- Centralization of the Significant Additional Needs approval process;
- Restructuring of support coordination services; and
- Implementation of a new client needs assessment tool, specifically the Next Generation Questionnaire for Situational Information.

**Waiver Support Coordinators**

WSCs are enrolled waiver providers of support coordination services selected by a waiver client or their guardian to assist the client in gaining access to waiver and Medicaid state plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.[19] WSCs are responsible for the ongoing monitoring of supports and services provided clients and are tasked with ensuring that clients receive the level of services they are entitled to and need under the HSBC waiver.[20]

WSCs must enroll as either solo or individual providers, or through an agency or group provider.[21] WSCs can be employed in a part-time capacity (known as 'limited support coordination') or full-time.[22] To be employed as a WSC, an individual:[23]

- Must be certified and enrolled as a Medicaid Waiver provider of Support Coordinator.
- May be either single (solo) providers or agency providers.
- If employed by an agency, must have a bachelor's degree and two years professional experience in developmental disabilities, special education, mental health, counseling, guidance, social work or health and rehabilitative services.
- If a solo provider, must have a bachelor's degree and three years' experience in developmental disabilities, special education, mental health, counseling, guidance, social work or health and rehabilitative services.
- Must have a minimum of 60 hours of pre-service training is required consisting of 34 hours of statewide pre-service training and 26 hours of district specific training which includes orientation to the district, local resources and local operational procedures.

Tasks performed by WSCs include:[24]

- Recording monthly progress notes, which adequately document the support coordination services rendered.
- Conducting, at a minimum, two monthly contacts with or on behalf of the individual. These include telephone contact, face-to-face visits in the individual's home or elsewhere, contact with another provider to discuss progress toward achieving goals identified on the support plan and letter writing if related to services and benefits specific to the individual's needs. Support coordinators are expected to meet the needs of the individuals they serve regardless of the number of contacts it takes to meet those needs.

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[19] *See* Rule 59G-13.070, F.A.C.
[20] *Id*.
[21] *Id*.
[22] Agency for Persons with Disabilities, Support Coordination Frequently Asked Questions (FAQs), *available at* http://apd.myflorida.com/waiver/support-coordination/frequently-asked-questions.htm (last visited January 13, 2020).
[23] *Id*.
[24] *Id*.

- Ensuring contacts are meaningful and relate to follow up on the individual or family's concerns, advocacy, increasing the individual's involvement in the community, monitor health and safety or assist the individual reach desired outcomes on the support plan.
- Having and maintaining on file in the individual's central record, the current annual support plan, cost plan and supporting documents.

Support coordinators are monitored on an annual basis; providers who have achieved at least an overall score of 85% are considered to have a successful monitoring; those below 85% must complete a plan of corrective action.[25] The quality assurance process includes both a provider performance review, which is a review of regulatory compliance, and a person-centered review that focuses on an interview with the individual receiving services to assure outcomes are being met, adequate follow through is being done and services are satisfactory to the individual.[26]

**Client Data Management System**

The Legislature appropriated a total of $2.86 million[27] for Fiscal Year 2015-2016 for the development of a client data management system to provide electronic verification of service delivery to recipients by providers, electronic billings for waiver services, and electronic processing of claims.[28] These changes were needed to improve efficiency and reduce fraud. APD must meet federal requirements for administering the iBudget HCBS waiver, such as tracking, measuring, reporting, and providing quality improvement processes for 32 specific program performance measures in order to ensure the program funding can continue. The federal Centers for Medicaid & Medicare Services further requires the state maintain a quality improvement system that includes data collection, data analysis, and reporting. Historically, APD has relied heavily on manual processes and disparate systems to collect, analyze, and report data consistently.

Service providers bill for services in the AHCA Florida Medicaid Management Information System (FMMIS).[29] Providers are able to offer services, receive payment, and provide documentation to the WSC for 10 days following provision of services. If providers submit documentation late or do submit any documentation, staff time is expended on obtaining the documentation or referring the provider to AHCA for the recoupment funds for undocumented services.[30]

APD has contracted with an external vendor to create a central client data management system, known as iConnect.[31] APD believes iConnect will serve as a central repository of information that will benefit and create efficiencies for providers, WSCs, and APD staff. The agency anticipates that this will result in an increase in program efficiency, accountability, and oversight, and that it will enable the agency to collect data, analyze trends, and evaluate service

[25] *Id*.
[26] *Id*.
[27] *See* Specific Appropriation 265 and section 41, ch. 2015-232, Laws of Florida.
[28] *See* Specific Appropriation 265, ch. 2015-232, Laws of Florida.
[29] Agency for Persons with Disabilities iConnect Proposed Redraft Analysis. On file with the Senate Children, Families, and Elder Affairs Committee.
[30] *Id*.
[31] *Id*.

effectiveness; identify and reduce fraud, waste and abuse; and report information related to client needs and services.[32]

## III. Effect of Proposed Changes:

**Section 1** amends s. 393.063, F.S., defining 'significant additional needs' as medically necessary needs for service increases arising after the beginning of the service plan year which would place the health and safety of the client, their caregiver, or the public in serious jeopardy. The bill also redefines support coordinators as employees of a qualified organization contracted by the agency.

**Section 2** amends s. 393.066, F.S., requiring agency providers to bill for services through the iConnect system and requiring submission of documentation verifying services rendered prior to receiving payment.

**Section 3** repeals section 393.0661, F.S. This section contains outdated provisions relating to the waiver program design prior to the implementation of the iBudget. Other provisions are moved to s. 393.0662, F.S.

**Section 4** amends s. 393.0662, F.S., providing that additional waiver client funding for significant additional needs, as defined in the bill, may be provided only after the determination of a client's initial iBudget allocation amount is assigned and after the agency has certified and documented, in the client's cost plan, the use of all available resources under the Medicaid state plan. The bill also eliminates the existing review criteria in statute for determining funding of significant additional needs requests. Such criteria has not been effective in limiting the iBudget increases approved by APD.

The bill also preserves language from current law in s. 393.0661, F.S., relating to premiums and cost sharing, rate adjustments, the ability of AHCA to seek federal approval to amend waivers as needed, and the responsibility of APD to submit quarterly status reports to the Governor and the Legislature containing information on the financial status of HCBS services, the number of individuals who have requested services, the number of individuals on the waiver waitlist, and information on the actual and projected costs of operating the waiver compared to the amount of the appropriation available to the program and any projected surpluses or deficits. The bill also provides rulemaking authority for both APD and AHCA regarding criteria and processes for clients to access funds for significant additional needs.

**Section 5** creates s. 393.0663, F.S., requiring APD to competitively procure two or more qualified organizations to provide all support coordination services to waiver clients. The bill requires the agency to consider price, quality, and accessibility when awarding contracts, and it requires procurement to begin on October 1, 2020. The bill provides that the contracts must:

- include provisions requiring compliance with existing agency cost-containment initiatives,
- require support coordinators to ensure client budgets are linked to respective levels of need,

[32] *Id*.

- require support coordinators to avoid potential conflicts of interest, and
- require the organizations awarded the contracts to perform and meet all standards related to support coordination currently in statute and rule.

The bill requires that the contracts be 3 years in length and may be renewed up to 3 times. The contracts may not exceed 1 year in length for each renewal. The bill also provides APD with discretion to choose whether support coordination services are provided statewide or by agency region.

**Section 6** amends s. 409.906, F.S., requiring AHCA to competitively procure a qualified organization to perform medical necessity determinations of all significant additional needs requests. The bill also directs AHCA to seek federal approval to implement a payment rate for Medicaid intermediate care facilities serving individuals with developmental disabilities, severe maladaptive behaviors, severe maladaptive behaviors and co-occurring complex medical conditions, or a dual diagnosis of a developmental disability and a mental illness.

**Section 7** amends s. 409.968, F.S., to conform a cross-reference.

**Section 8** amends s. 1002.385, F.S., to conform a cross-reference.

**Section 9** provides an effective date of July 1, 2020.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

There will be a negative but indeterminate fiscal impact on current waiver support coordinators who do not successfully bid for support coordination contracts provided under the bill. Qualified organizations who successfully acquire contracts for support coordination and for medical necessity determinations will see a positive fiscal impact.

Service providers who do not currently utilize the iConnect billing system may be required to purchase new hardware and train staff on the use of iConnect. Private providers may also incur costs associated with dual data entry if the provider already utilizes a different IT system. The impact of these requirements is indeterminate.

C. Government Sector Impact:

The Agency for Persons with Disabilities will likely experience a positive but indeterminate fiscal impact by contracting out support coordination and medical necessity determination functions to qualified organizations.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends sections 393.063, 393.066, 393.0662, 409.906, 409.968, and 1002.385 of the Florida Statutes.

This bill creates section 393.0663 of the Florida Statutes.

This bill repeals section 393.0661 of the Florida Statutes.

## IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

**By** Senator Bean

4-01661A-20 202082__

A bill to be entitled

An act relating to individuals with disabilities; amending s. 393.063, F.S.; defining the term "significant additional need"; revising the definition of the term "support coordinator"; amending s. 393.066, F.S.; requiring persons and entities under contract with the Agency for Persons with Disabilities to use the agency data management systems to bill for services; repealing s. 393.0661, F.S., relating to the home and community-based services delivery system; amending s. 393.0662, F.S.; revising criteria used by the agency to develop a client's iBudget; revising criteria used by the agency to authorize additional funding for certain clients; requiring the agency to certify and document the use of certain services before approving the expenditure of certain funds; requiring the Agency for Health Care Administration to seek federal approval to provide consumer-directed options; authorizing the Agency for Persons with Disabilities and the Agency for Health Care Administration to adopt rules; requiring the Agency for Health Care Administration to seek federal waivers and amend contracts under certain conditions; requiring the Agency for Persons with Disabilities to collect premiums or cost sharing; providing construction; providing for the reimbursement of certain providers of services; requiring the Agency for Persons with Disabilities to submit quarterly status reports to the Governor, the chair of the

Senate Appropriations Committee, and the chair of the House Appropriations Committee; requiring the Agency for Persons with Disabilities, in consultation with the Agency for Health Care Administration, to submit a certain plan to the Governor, the chair of the Senate Appropriations Committee, and the chair of the House Appropriations Committee under certain conditions; requiring the Agency for Persons with Disabilities, in consultation with the Agency for Health Care Administration, to provide quarterly reconciliation reports to the Governor and the Legislature within a specified timeframe; revising rulemaking authority of the Agency for Persons with Disabilities and the Agency for Health Care Administration; creating s. 393.0663, F.S.; requiring the Agency for Persons with Disabilities to competitively procure qualified organizations to provide support coordination services; requiring such procurement to be initiated on a specified date; providing requirements for contracts awarded by the agency; amending s. 409.906, F.S.; requiring the Agency for Health Care Administration to contract with an external vendor for certain medical necessity determinations; requiring the Agency for Persons with Disabilities to seek federal approval to implement certain payment rates; amending ss. 409.968 and 1002.385, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Present subsections (39) through (45) of section 393.063, Florida Statutes, are redesignated as subsections (40) through (46), respectively, a new subsection (39) is added to that section, and present subsection (41) of that section is amended, to read:

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

(39) "Significant additional need" means a medically necessary need for a service increase arising after the beginning of the service plan year which would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy.

(42) ~~(41)~~ "Support coordinator" means an employee of a qualified organization pursuant to s. 393.0663 ~~a person who is~~ 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; 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. Subsection (2) of section 393.066, Florida Statutes, is amended to read:

393.066 Community services and treatment.—

(2) Necessary services shall be purchased, rather than provided directly by the agency, when the purchase of services

is more cost-efficient than providing them directly. All purchased services must be approved by the agency. As a condition of payment, persons or entities under contract with the agency to provide services shall use agency data management systems to document service provision to clients before billing and must use the agency data management systems to bill for services. Contracted persons and entities shall meet the minimum hardware and software technical requirements established by the agency for the use of such systems. Such persons or entities shall also meet any requirements established by the agency for training and professional development of staff providing direct services to clients.

Section 3. Section 393.0661, Florida Statutes, is repealed.

Section 4. 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, shall manage 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 administer 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 developmental disability as defined in s. 393.063. The iBudget system shall 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 role for support coordinators that avoids potential conflicts of interest; a flexible and streamlined service review process; and the equitable allocation of available funds based on the client's level of need, as determined by the allocation methodology.

(a) In developing each client's iBudget, the agency shall use the allocation methodology as defined in s. 393.063(4), in conjunction with an assessment instrument that the agency deems to be reliable and valid, including, but not limited to, the agency's Questionnaire for Situational Information. The allocation methodology shall determine the amount of funds allocated to a client's iBudget.

(b) The agency may authorize additional funding based on a client having one or more significant additional needs ~~of the following needs~~ that cannot be accommodated within the funding determined by the algorithm and having no other resources,

supports, or services available to meet the needs. Such additional funding may be provided only after the determination of a client's initial allocation amount and after the agency has certified and documented the use of all available resources under the Medicaid state plan as described in subsection (2). ~~need:~~

~~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. However, the presence of an extraordinary need in and of itself does not warrant authorized funding by the agency. 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 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.~~

~~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. 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. However, the presence of such significant need for one-time or temporary supports or services in and of itself does not warrant authorized funding by the agency.~~

~~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 in and of itself does not warrant authorized funding by the agency.~~

~~4. A significant need for transportation services to a waiver-funded adult day training program or to waiver-funded employment services when such need cannot be accommodated within~~

~~a client's iBudget as determined by the algorithm without affecting the health and safety of the client, if public transportation is not an option due to the unique needs of the client or other transportation resources are not reasonably available.~~

~~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 to be reserved.~~

(c) A client's annual expenditures for home and community-based 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.

(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 manage the iBudget system, improve services for eligible and enrolled clients, and improve the delivery of services through the home and community-based services Medicaid waiver program and the Consumer-Directed Care Plus Program, including, but not limited to, enrollees with a dual diagnosis of a developmental disability and a mental health disorder.

(3) The agency must certify and document within each client's cost plan that the ~~a~~ client has used ~~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, and any significant additional needs as determined by a qualified organization contracted pursuant to s. 409.906(13)(c).

(4) Rates for any or all services established under rules of the Agency for Health Care Administration must 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.

(5) The agency shall ensure that clients and caregivers have access to training and education that inform them about the iBudget system and enhance their ability for self-direction. Such training and education must be offered in a variety of formats and, at a minimum, must address the policies and processes of the iBudget system and the roles and responsibilities of consumers, caregivers, waiver support coordinators, providers, and the agency, and must provide information to help the client make decisions regarding the iBudget system and examples of support and resources available in the community.

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

(7) The Agency for Health Care Administration shall seek federal approval to provide a consumer-directed option for persons with developmental disabilities. The agency and the Agency for Health Care Administration may adopt rules necessary

to administer this subsection.

(8) The Agency for Health Care Administration shall seek federal waivers and amend contracts as necessary to make changes to services defined in federal waiver programs as follows:

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

(b) Limited support coordination services are the only type of support coordination services which may be provided to persons under the age of 18 who live in the family home.

(c) 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.

(d) 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.

(e) 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.

(f) 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.

(g) The geographic differential for Miami-Dade, Broward, and Palm Beach Counties for residential habilitation services must be 7.5 percent.

(h) The geographic differential for Monroe County for residential habilitation services must be 20 percent.

(9) The agency shall collect premiums or cost sharing pursuant to s. 409.906(13)(c).

(10) This section or any related rule does not prevent or limit the Agency for Health Care Administration, in consultation with the agency, 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.

(11) 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, and approved by the Federal Government in accordance with the waiver.

(12) The agency shall submit quarterly status reports to the Executive Office of the Governor, the chair of the Senate Appropriations Committee or its successor, and the chair of the House Appropriations Committee or its successor containing all

of the following information:

(a) The financial status of home and community-based services, including the number of enrolled individuals who are receiving services through one or more programs.

(b) The number of individuals who have requested services who are not enrolled but who are receiving services through one or more programs, with a description indicating the programs from which the individual is receiving services.

(c) The number of individuals who have refused an offer of services but who choose to remain on the list of individuals waiting for services.

(d) The number of individuals who have requested services but who are receiving no services.

(e) A frequency distribution indicating the length of time individuals have been waiting for services.

(f) Information concerning the actual and projected costs compared to the amount of the appropriation available to the program and any projected surpluses or deficits.

(13) 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 (10) to the Executive Office of the Governor, the chair of the Senate Appropriations Committee or its successor, and the chair of the House Appropriations Committee 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.

(14) The agency, in consultation with the Agency for Health Care Administration, shall provide a quarterly reconciliation report of all home and community-based services waiver expenditures from the Agency for Health Care Administration's claims management system with service utilization from the Agency for Persons with Disabilities Allocation, Budget, and Contract Control system. The reconciliation report shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than 30 days after the close of each quarter.

(15) ~~(7)~~ 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 significant additional needs ~~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 5. Section 393.0663, Florida Statutes, is created to read:

393.0663 Waiver support coordination services.—The agency shall competitively procure two or more qualified organizations to provide support coordination services. In awarding a contract to a qualified organization, the agency shall take into account price, quality, and accessibility to these services. The agency shall initiate procurement on October 1, 2020.

(1) The contract must include provisions requiring compliance with agency cost-containment initiatives.

(2) The contract must require support coordinators to ensure client budgets are linked to levels of need.

(3) The contract must require support coordinators to avoid potential conflicts of interest.

(4) The contract must require the organization to perform all duties and meet all standards related to support coordination as provided in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook.

(5) The contract shall be 3 years in duration. Following the initial 3-year period, the contract may be renewed annually for 3 consecutive years and may not exceed 1 year in duration.

(6) The contract may provide for support coordination services statewide or by agency region, at the discretion of the agency.

Section 6. Present paragraphs (c) and (d) of subsection (13) of section 409.906, Florida Statutes, are redesignated as paragraphs (d) and (e), respectively, a new paragraph (c) is added to that subsection, and subsection (15) of that section is amended, to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be

construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(13) HOME AND COMMUNITY-BASED SERVICES.—

(c) The agency shall competitively procure a qualified organization to perform medical necessity determinations of significant additional needs requests, as defined in s. 393.063.

(15) INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY DISABLED SERVICES.—The agency may pay for health-related care and services provided on a 24-hour-a-day basis by a facility licensed and certified as a Medicaid Intermediate Care Facility for the Developmentally Disabled, for a recipient who needs such care because of a developmental disability. Payment shall not include bed-hold days except in facilities with occupancy rates of 95 percent or greater. The agency is authorized to seek any federal waiver approvals to implement this policy. The agency shall seek federal approval to implement a payment rate for Medicaid intermediate care facilities serving individuals with developmental disabilities, severe maladaptive behaviors, severe maladaptive behaviors and co-occurring complex medical

conditions, or a dual diagnosis of developmental disability and mental illness.

Section 7. Paragraph (a) of subsection (4) of section 409.968, Florida Statutes, is amended to read:

409.968 Managed care plan payments.—

(4)(a) Subject to a specific appropriation and federal approval under s. 409.906(13)(e) ~~s. 409.906(13)(d)~~, the agency shall establish a payment methodology to fund managed care plans for flexible services for persons with severe mental illness and substance use disorders, including, but not limited to, temporary housing assistance. A managed care plan eligible for these payments must do all of the following:

1. Participate as a specialty plan for severe mental illness or substance use disorders or participate in counties designated by the General Appropriations Act;

2. Include providers of behavioral health services pursuant to chapters 394 and 397 in the managed care plan's provider network; and

3. Document a capability to provide housing assistance through agreements with housing providers, relationships with local housing coalitions, and other appropriate arrangements.

Section 8. Paragraph (d) of subsection (2) of section 1002.385, Florida Statutes, is amended to read:

1002.385 The Gardiner Scholarship.—

(2) DEFINITIONS.—As used in this section, the term:

(d) "Disability" means, for a 3- or 4-year-old child or for a student in kindergarten to grade 12, autism spectrum disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric

Association; cerebral palsy, as defined in s. 393.063(6); Down syndrome, as defined in s. 393.063(15); an intellectual disability, as defined in s. 393.063(24); Phelan-McDermid syndrome, as defined in s. 393.063(28); Prader-Willi syndrome, as defined in s. 393.063(29); spina bifida, as defined in s. 393.063(41) ~~s. 393.063(40)~~; being a high-risk child, as defined in s. 393.063(23)(a); muscular dystrophy; Williams syndrome; rare diseases which affect patient populations of fewer than 200,000 individuals in the United States, as defined by the National Organization for Rare Disorders; anaphylaxis; deaf; visually impaired; traumatic brain injured; hospital or homebound; or identification as dual sensory impaired, as defined by rules of the State Board of Education and evidenced by reports from local school districts. The term "hospital or homebound" includes a student who has a medically diagnosed physical or psychiatric condition or illness, as defined by the state board in rule, and who is confined to the home or hospital for more than 6 months.

Section 9. This act shall take effect July 1, 2020.

**The Florida Senate**

# COMMITTEE VOTE RECORD

**COMMITTEE:** Children, Families, and Elder Affairs
**ITEM:** SB 82
**FINAL ACTION:** Favorable
**MEETING DATE:** Wednesday, January 15, 2020
**TIME:** 10:30 a.m.—12:30 p.m.
**PLACE:** 301 Senate Building

| FINAL VOTE | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Yea** | **Nay** | **SENATORS** | **Yea** | **Nay** | **Yea** | **Nay** | **Yea** | **Nay** |
| X | | Bean | | | | | | |
| X | | Harrell | | | | | | |
| | X | Rader | | | | | | |
| | X | Torres | | | | | | |
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| 5 | 2 | **TOTALS** | | | | | | |
| **Yea** | **Nay** | | **Yea** | **Nay** | **Yea** | **Nay** | **Yea** | **Nay** |

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

# 2020 AGENCY LEGISLATIVE BILL ANALYSIS
# Agency for Persons with Disabilities

| BILL INFORMATION | |
|---|---|
| **BILL NUMBER:** | |
| **BILL TITLE:** | **iConnect – Proposed Redraft** |
| **BILL SPONSOR:** | |
| **EFFECTIVE DATE:** | July 1, 2020 |

| COMMITTEES OF REFERENCE |
|---|
| **1)** |
| **2)** |
| **3)** |
| **4)** |
| **5)** |

| CURRENT COMMITTEE |
|---|
| |

| SIMILAR BILLS | |
|---|---|
| **BILL NUMBER:** | |
| **SPONSOR:** | |

| PREVIOUS LEGISLATION | |
|---|---|
| **BILL NUMBER:** | |
| **SPONSOR:** | |
| **YEAR:** | |
| **LAST ACTION:** | |

| IDENTICAL BILLS | |
|---|---|
| **BILL NUMBER:** | |
| **SPONSOR:** | |

| Is this bill part of an agency package? |
|---|
| Yes |

| BILL ANALYSIS INFORMATION | |
|---|---|
| **DATE OF ANALYSIS:** | December 13, 2019<br>For further information, please contact Jeff Ivey at (850) 408-8951 |
| **LEAD AGENCY ANALYST:** | Lorena Fulcher |
| **ADDITIONAL ANALYST(S):** | Tom Rice |
| **LEGAL ANALYST:** | Francis Carbone, Esq. |
| **FISCAL ANALYST:** | Rose Salinas |

# POLICY ANALYSIS

## 1. EXECUTIVE SUMMARY

The bill provides the Agency for Persons with Disabilities (APD or Agency) clear statutory authority for APD to require providers to bill for services through iConnect. The bill also requires APD providers to submit all required documentation into iConnect for services rendered prior to billing. This requirement will end the current practice of allowing providers up to 10 days to provide supporting documentation to the WSC after billing. This requirement also has the potential to decrease the recoupment of Medicaid funds for invalid billings.

## 2. SUBSTANTIVE BILL ANALYSIS

### 1. PRESENT SITUATION:

**Agency for Persons with Disabilities**

APD serves approximately 35,000 individuals with developmental disabilities through the iBudget Waiver, which is a Medicaid Home and Community-Based Services Waiver program. There are another 21,000 individuals on the waiting list for Waiver services.

iBudget Waiver services are delivered by thousands of private sector Medicaid providers statewide.

The Waiver service providers bill for services in the AHCA Florida Medicaid Management Information System (FMMIS). Providers currently can render services, receive payment, then provide documentation to the WSC up to 10 days later. This process for payment results in after-the-fact enforcement when providers submit the documentation late or do not submit the required documentation at all. In these instances, staff time is expended on obtaining the documentation or, in some cases, referring the provider to AHCA for the recoupment funds for undocumented services.

The Waiver service providers are dependent upon the WSCs sending client service authorizations and changes in client service authorizations to them before they can provide the services. WSCs send the service authorization information either through paper or electronic means.

**Client Data Management System (iConnect)**

APD has contracted with Wellsky to develop a central client data management system, known as iConnect. iConnect will provide a central repository of information that will benefit and create efficiencies for providers, WSCs, and APD staff. The benefits to APD will include an increase in program efficiency, accountability, and oversight; enable the agency to collect data, analyze trends, and evaluate service effectiveness; identify and reduce fraud, waste and abuse; and report information related to client needs and services.

iConnect will be deployed in phases because of the large number of users and the large number of functions being implemented. The first phase of iConnect, which included APD staff and WSCs, was completed in December 2018. At this time, WSCs are maintaining client demographic information in iConnect. Plans are in place for a second phase in 2020 for providers of respite and personal support services. During this phase, providers will be required to bill in the system.

### 2. EFFECT OF THE BILL:

The bill allows APD to continue the timely development of iConnect by requiring providers to bill for services through iConnect and requires submission of documentation verifying services rendered prior to receiving payment. This requirement will eliminate staff time spent on obtaining the documentation and provide for better monitoring of client services.

The Agency for Health Care Administration (AHCA) is promulgating a rule (Rule 59G-13.070) amendment which specifies the required documentation to be submitted prior to billing.

**3. DOES THE LEGISLATION DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES?**

| | |
|---|---|
| If yes, explain: | Yes. The Agency may adopt rules regarding additional required documentation for the agency data management system. |
| What is the expected impact to the agency's core mission? | It will increase program efficiency, accountability, and oversight. |
| Rule(s) impacted (provide references to F.A.C., etc.): | |

**4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?**

| | |
|---|---|
| List any known proponents and opponents: | |
| Provide a summary of the proponents' and opponents' positions: | |

**5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL?**

| | |
|---|---|
| If yes, provide a description: | N/A |
| Date Due: | N/A |
| Bill Section Number(s): | N/A |

**6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC. REQUIRED BY THIS BILL?**

| | |
|---|---|
| Board: | N/A |
| Board Purpose: | N/A |
| Who Appoints: | N/A |
| Appointee Term: | N/A |
| Changes: | N/A |
| Bill Section Number(s): | N/A |

## FISCAL ANALYSIS

**1. WHAT IS THE FISCAL IMPACT TO LOCAL GOVERNMENT?**

| | |
|---|---|
| Revenues: | None |
| Expenditures: | None |

| | |
|---|---|
| Does the legislation increase local taxes or fees? | No |
| If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase? | N/A |

**2. WHAT IS THE FISCAL IMPACT TO STATE GOVERNMENT?**

| | |
|---|---|
| Revenues: | |
| Expenditures: | None, the funds for FY 2019-20 have already been appropriated. However, APD has requested a legislative budget request for FY 2020-21 to continue development of the project. |
| Does the legislation contain a State Government appropriation? | No |
| If yes, was this appropriated last year? | |

**3. WHAT IS THE FISCAL IMPACT TO THE PRIVATE SECTOR?**

| | |
|---|---|
| Revenues: | |
| Expenditures: | Recent survey and review of the impact to the private sector did not reveal any impact spurred by this statute change. That is to say, this change in and of itself did not impose any requirement not already being performed by providers. The change does not have an impact borne out of compliance with this statute.<br><br>It is in that way that any expenditure associated with the order of submission of documents and the format by which they are submitted do not impact a private sector that is required to submit these items. |
| Other: | |

**4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES?**

| | |
|---|---|
| Does the bill increase taxes, fees or fines? | No |
| Does the bill decrease taxes, fees or fines? | No |
| What is the impact of the increase or decrease? | No |
| Bill Section Number: | N/A |

## TECHNOLOGY IMPACT

| | |
|---|---|
| Does the legislation impact the agency's technology systems (i.e., IT support, licensing software, data storage, etc.)? | Yes |
| If yes, describe the anticipated impact to the agency including any fiscal impact. | The bill would allow APD to continue development of iConnect. |
| | |

## FEDERAL IMPACT

| | |
|---|---|
| Does the legislation have a federal impact (i.e. federal compliance, federal funding, federal agency involvement, etc.)? | |
| If yes, describe the anticipated impact including any fiscal impact. | |

## ADDITIONAL COMMENTS

## LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

| | |
|---|---|
| Issues/concerns/comments and recommended action: | |

# APD iBudget Waiver Waitlist Criteria

**Current Enrollment: 34,919** **Current Waitlist: 21,433***

| Category | Description | Client Count |
|---|---|---|
| **1** | Individuals in crisis, defined as (in order of priority):<br>• Currently homeless, living in a homeless shelter, or living with relatives in an unsafe environment;<br>• Exhibits behaviors that may result in severe bodily harm or create a life-threatening situation to themselves or others; or<br>• Caregiver is in extreme duress and no longer able to provide for the individual's health, safety, or welfare due to illness, injury, or age. | **0 (Automatically Enrolled)** |
| **2** | Includes the following individuals in the Child Welfare System:<br>• Finalizing adoption with placement in a family home;<br>• Reunification with family members with placement in a family home;<br>• Permanent placement with a relative in a family home;<br>• Guardianship with a nonrelative; or<br>• Individuals between the age of 18 and 21 in the extended foster care program. | **6 (Automatically Enrolled)** |
| **3** | Includes the following individuals with intensive needs:<br>• Caregiver is unable to provide care within 12 months;<br>• At risk of incarceration or court commitment;<br>• Currently incarcerated and expected to be released within 12 months;<br>• At risk or harm to themselves or their caregiver within next 12 months;<br>• Pending discharge from state mental health hospital, ICF/DD, skilled nursing facility, correctional facility, or secure forensic facility within next 12 months; or<br>• In receipt of Voluntary Protective Services or requesting assistance from DCF to prevent enrollment in foster care. | **918** |
| **4** | Individuals whose caregiver is age 70 or older. | **230** |
| **5** | Includes the following individuals:<br>• Expected to graduate from secondary school within next 12 months;<br>• Have received special diploma and need waiver services to obtain or maintain competitive employment; or<br>• Have been accepted to accredited institution of postsecondary education. | **143** |
| **6** | Individuals 21 years of age or older that do not meet any of the above criteria. | **10,279** |
| **7** | Individuals under the age of 21 that do not meet any of the above criteria. | **9,823** |

***includes 34 individuals who have not yet been assessed. Data as of October 1, 2019.

## Summary of Funding Provided to Remove Individuals from Waitlist

| Fiscal Year | GR | TF | Total | Purpose |
|---|---|---|---|---|
| **2013-14** | $15,000,000 | $21,293,249 | **$36,293,249** | Offered enrollment to portion of individuals in Categories 2, 3, and 4 as of July 1st. |
| **2014-15** | $8,088,000 | $11,912,000 | **$20,000,000** | Offered enrollment to remaining individuals in Categories 2, 3, and 4 as of July 1st. |
| **2015-16** | $16,086,659 | $24,567,015 | **$40,653,674** | Offered enrollment to individuals in Categories 3, 4, and 5 as of July 1st. |
| **2016-17** | $15,188,744 | $23,766,741 | **$38,955,485** | Offered enrollment to individuals in Categories 3 and 4, and 6 as of July 1st. |
| **2017-18** | $1,437,072 | $2,307,253 | **$3,744,325** | Offered enrollment to individuals in Categories 3 and 4 as of July 1st. |
| **Total** | **$55,800,475** | **$83,846,258** | **$139,646,733** | |

Last Updated: 10/15/2019

# Home and Community Based Services (HCBS) Waiver
# Monthly Surplus-Deficit Report for
# Waiver Program Expenditures
# FY 2019-20

**December 31, 2019**

**Waiver Expenditures and Projections**
**by Date of Payment**
**General Revenue Only**

| | Actual Expenditures | AHCA Total As of 11/30/2019 | AHCA Total with Actuals | 2019-20 GAA | Percent of Appropriation Remaining |
|---|---|---|---|---|---|
| **Month** | **FY 2019/20** | **FY 2019/20** | | **$ 463,517,392** | 100.0% |
| 2019 July | $ 21,505,499 | $ 20,440,993 | $ 21,505,499 | $ 442,011,893 | 95.4% |
| 2019 August | $ 33,274,311 | $ 38,427,669 | $ 33,274,311 | $ 408,737,582 | 88.2% |
| 2019 September | $ 39,803,229 | $ 38,230,252 | $ 39,803,229 | $ 368,934,353 | 79.6% |
| 2019 October | $ 51,012,815 | $ 49,319,399 | $ 51,012,815 | $ 317,921,538 | 68.6% |
| 2019 November | $ 47,351,941 | $ 40,223,096 | $ 47,351,941 | $ 270,569,597 | 58.4% |
| 2019 December | | $ 52,290,490 | $ 51,305,457 | $ 219,264,140 | 47.3% |
| 2020 January | | $ 37,169,747 | $ 36,469,554 | $ 182,794,586 | 39.4% |
| 2020 February | | $ 38,811,347 | $ 38,080,230 | $ 144,714,356 | 31.2% |
| 2020 March | | $ 50,956,329 | $ 49,996,429 | $ 94,717,928 | 20.4% |
| 2020 April | | $ 38,894,771 | $ 38,162,083 | $ 56,555,844 | 12.2% |
| 2020 May | | $ 39,062,701 | $ 38,326,849 | $ 18,228,995 | 3.9% |
| 2020 June | | $ 51,251,606 | $ 50,286,143 | $ (32,057,148) | -6.9% |
| 2020 July CF | | $ 22,625,827 | $ 22,199,609 | $ (54,256,757) | -11.7% |
| 2020 August CF | | $ 2,599,640 | $ 2,550,669 | $ (56,807,425) | -12.3% |
| 2020 Sept CF | | $ 1,112,146 | $ 1,091,195 | $ (57,898,621) | -12.5% |
| **Total** | **$ 192,947,795** | **$ 521,416,013** | **$ 521,416,013** | **$ (57,898,621)** | |
| **Projected FY 2018-19 Carry Forward Balance** | | | | **$ (41,101,299)** | |
| **Adjusted Balance Remaining** | | | | **$ (98,999,920)** | |

# *HCBS Waiver Enrollment*

| Enrollment Category | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Grand Total Clients Enrolled by Category |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Beginning Enrollment** | **34,732** | **34,797** | **34,883** | **34,919** | **34,934** | | | | | | | | |
| Crisis | | | | | | | | | | | | | |
| Non-Waiting List | 21 | 28 | 35 | 33 | 28 | | | | | | | | 145 |
| 3-Intensive Needs | 6 | 4 | 6 | 6 | 3 | | | | | | | | 25 |
| 4-Caregiver Over Age 70 | 1 | 6 | 0 | 3 | 1 | | | | | | | | 11 |
| 5-Transition from School | 1 | 0 | 1 | 2 | 1 | | | | | | | | 5 |
| 6-Age 21 and Older | 35 | 48 | 31 | 55 | 35 | | | | | | | | 204 |
| 7-Under Age 21 | 37 | 25 | 28 | 31 | 21 | | | | | | | | 142 |
| 8-Not Yet Assessed | 2 | 0 | 0 | 0 | 0 | | | | | | | | 2 |
| CBC Children | 14 | 4 | 9 | 7 | 9 | | | | | | | | 43 |
| Military Dependents | 0 | 0 | 0 | 0 | 0 | | | | | | | | 0 |
| Phelan-McDermid Syndrome | 0 | 0 | 0 | 0 | 0 | | | | | | | | 0 |
| Private ICF or Nursing Facility | 2 | 1 | 0 | 1 | 2 | | | | | | | | 6 |
| Public ICF - DDCs | 4 | 5 | 1 | 2 | 4 | | | | | | | | 16 |
| Waiting List to Waiver Offers (Previous Waves) | 0 | 0 | 0 | 0 | 0 | | | | | | | | 0 |
| Re-enrollments (< 1 year) | 4 | 4 | 3 | 1 | 11 | | | | | | | | 23 |
| Disenrollments | (62) | (39) | (78) | (126) | (53) | | | | | | | | (358) |
| **Ending Enrollment** | **34,797** | **34,883** | **34,919** | **34,934** | **34,996** | | | | | | | | **264** |

| | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Grand Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Significant Additional Needs (SANS) Annualized Allocations ALL FUNDS (Amounts provided are ALLOCATIONS ONLY and not actual expenditures)** | **$ 9,248,476** | **$ 8,531,540** | **$ 7,621,307** | **$ 8,075,961** | **$ 5,392,065** | | | | | | | | **$ 38,869,349** |
| **Client Count Represented by SANS Allocation** | **982** | **539** | **498** | **456** | **305** | | | | | | | | **2,780** |

# *Service Utilization*

APD monitors claims data and publishes data sets based on services provided. As the data sets are not final until AHCA compiles and adjusts the amounts, the totals are preliminary and useful in forecasting expenditures and service utilization. However, these totals do not represent the exact final amounts due. This table constitutes a consolidated view of all services for iBudget and CDC+ data.

| Service Groupings | December-18 | January-19 | February-19 | March-19 | April-19 | May-19 | June-19 | July-19 | August-19 | September-19 | October-19 | November-19 | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CDC+Allowance | 9,841,769 | 9,983,476 | 10,293,404 | 10,148,025 | 10,457,301 | 10,364,008 | 10,899,090 | 2,031,168 | 10,821,111 | 10,672,285 | 10,831,396 | 10,907,455 | **117,250,490** |
| Behavior Analysis | 1,559,869 | 1,694,475 | 1,533,672 | 1,523,841 | 1,453,890 | 1,861,815 | 1,524,426 | 1,517,582 | 1,534,317 | 1,430,954 | 1,924,744 | 1,583,152 | **19,142,738** |
| Behavior Assistance | 280,815 | 246,324 | 209,029 | 240,462 | 256,302 | 269,224 | 221,273 | 271,938 | 290,299 | 233,101 | 263,125 | 215,492 | **2,997,383** |
| Diet & Dental Care | 553,136 | 415,761 | 294,697 | 202,327 | 150,524 | 110,575 | 79,568 | 70,596 | 30,887 | 19,399 | 23,616 | 23,809 | **1,974,894** |
| Employment | 449,332 | 454,564 | 431,235 | 414,014 | 407,774 | 498,189 | 411,125 | 416,397 | 403,458 | 384,995 | 477,522 | 408,965 | **5,157,568** |
| Home & Environ Access | 220,230 | 113,419 | 104,384 | 156,061 | 107,088 | 169,579 | 102,234 | 140,645 | 68,121 | 66,838 | 181,462 | 104,256 | **1,534,318** |
| In-Home Svs/Companion | 26,153,266 | 30,742,666 | 26,401,843 | 25,713,634 | 25,866,343 | 32,117,623 | 26,729,644 | 25,487,967 | 26,441,355 | 26,690,329 | 32,746,020 | 27,097,710 | **332,188,401** |
| Med/Personal Equip | 94,737 | 141,987 | 50,455 | 96,689 | 56,759 | 62,908 | 63,323 | 78,662 | 99,845 | 117,651 | 98,972 | 79,891 | **1,041,880** |
| Medical Supplies | 1,300,576 | 1,138,517 | 1,100,307 | 1,212,262 | 1,044,423 | 1,701,774 | 1,184,384 | 1,056,028 | 1,237,204 | 1,127,834 | 1,540,534 | 1,131,510 | **14,775,353** |
| Nursing/Spcl Med Care | 3,502,342 | 4,149,530 | 3,729,960 | 3,394,316 | 3,683,359 | 4,500,201 | 3,558,891 | 3,458,997 | 3,681,486 | 3,594,316 | 4,840,921 | 3,519,715 | **45,614,035** |
| Residential Habilitation - Behavior Focus | 204,499 | 224,993 | 191,608 | 223,754 | 152,887 | 193,427 | 177,888 | 156,744 | 152,014 | 157,834 | 174,637 | 174,793 | **2,185,077** |
| Residential Habilitation - Intensive Behavior | 6,162,573 | 7,118,942 | 6,130,350 | 6,082,417 | 6,236,164 | 7,096,145 | 6,530,534 | 5,947,981 | 6,651,120 | 6,587,441 | 7,872,852 | 7,074,996 | **79,491,515** |
| Residential Habilitation - Standard or ALF | 33,713,928 | 48,205,528 | 20,335,189 | 32,654,300 | 32,830,348 | 43,766,219 | 25,315,247 | 32,790,450 | 20,346,617 | 35,477,956 | 52,373,908 | 21,337,726 | **399,147,417** |
| Respite | 1,173,119 | 1,402,662 | 1,137,192 | 1,097,701 | 1,084,033 | 1,373,175 | 1,174,687 | 1,190,710 | 1,150,133 | 1,097,822 | 1,290,495 | 1,074,192 | **14,245,921** |
| Support Coach | 1,990,568 | 2,274,389 | 2,035,459 | 2,045,477 | 1,990,747 | 2,363,288 | 2,032,730 | 1,875,013 | 1,957,030 | 1,941,149 | 2,399,501 | 2,007,233 | **24,912,584** |
| Support Coordination | 4,653,265 | 5,054,840 | 4,617,677 | 4,496,905 | 4,263,190 | 5,500,079 | 4,516,675 | 4,112,765 | 4,235,700 | 4,238,173 | 5,575,694 | 4,491,934 | **55,756,895** |
| Therapeutic Svs | 912,867 | 886,614 | 805,808 | 843,382 | 775,299 | 1,042,881 | 838,017 | 720,761 | 771,059 | 806,454 | 1,041,851 | 785,866 | **10,230,860** |
| Training - Facility | 7,672,176 | 6,800,505 | 7,526,696 | 7,756,494 | 7,324,978 | 8,787,251 | 8,016,307 | 6,749,645 | 8,002,867 | 7,819,723 | 7,508,022 | 8,446,771 | **92,411,435** |
| Training Off Site | 119,739 | 98,987 | 100,982 | 110,420 | 106,230 | 124,500 | 115,393 | 95,070 | 107,955 | 116,066 | 102,813 | 122,943 | **1,321,097** |
| Transportation | 2,797,108 | 2,647,983 | 3,043,540 | 2,854,677 | 2,691,422 | 3,439,523 | 2,984,843 | 2,604,895 | 2,897,987 | 3,041,729 | 3,359,279 | 3,144,069 | **35,507,056** |
| **Grand Total** | **103,355,913** | **123,796,163** | **90,073,486** | **101,267,159** | **100,939,063** | **125,342,384** | **96,476,280** | **90,774,015** | **90,880,564** | **105,622,051** | **134,627,363** | **93,732,479** | **1,256,886,918** |

*Source: APD's Allocation, Budget and Contract Control (ABC) System.*

***NOTE: For clarity, Behavior Intensive Services and Behavior Habilitation have been relabeled to reflect they are part of the Residential Habilitation services groupings.***

If you have questions, please feel free to contact:

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NAVIGANT

# FLORIDA MEDICAID ICF/IID RATE STUDY REPORT

Summer 2019

Prepared for:


Florida Agency for Health Care Administration

## Table of Contents

## Section 1: Introduction

The State of Florida Agency for Health Care Administration (AHCA) retained Navigant Consulting, Inc. (Navigant) to provide an analysis of Florida's private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Medicaid reimbursement methodology. In particular, AHCA requested a review of ICF/IID payment options that would include recognition of costs for residents with "severe behavioral needs."

Recently, ICF/IID providers have cited increased behavioral severity in some residents leading to additional staffing, an increased need for behavioral services, and higher overall costs. In some cases, providers are unable to accommodate these clients if it is determined the resident's needs are higher than the resources available in the current reimbursement system. The request of Navigant was to identify and present potential changes to the Medicaid ICF/IID reimbursement methodology that would recognize the higher facility cost of care for recipients with severe behavioral needs.

This report fulfills that request. The report is presented in seven sections and provides background on the ICF/IID landscape in Florida and selected comparison states, including assessment approaches for identifying individuals with severe behavioral needs. There is also an overview of the key issues regarding ICF/IIDs in Florida, a discussion of financing reimbursement for these individuals, a discussion of options to modify the reimbursement methodology, and potential next steps.

- **Section 1:** provides a brief introduction and defines the purpose of this rate study.
- **Section 2:** describes background regarding key issues regarding ICF/IIDs in Florida and describes the current Florida ICF/IID landscape, including discussions on facility and population characteristics, and the current reimbursement methodology.
- **Section 3:** provides an overview of other states' ICF/IID program practices and structure and discusses their reimbursement methodologies specifically to address individuals with "severe behavioral needs."
- **Section 4:** shares assessment approaches and considerations for identifying individuals with "severe behavioral needs" within an ICF/IID context.
- **Section 5:** discusses Florida Medicaid financing for potential increased rates for individuals with severe behavioral needs in both a budget neutral and a non-budget neutral manner. This also includes a discussion of the closing of Carlton Palms, the iBudget Waiver, and estimates of the annual state share cost for an increased ICF/IID rate under two different scenarios.
- **Section 6:** presents options for the State to consider for modifying Florida Medicaid's ICF/IID reimbursement methodology to address individuals with "severe behavioral needs." The options are presented on a continuum from the least level of effort to implement to the highest level of effort. Options include developing a definition for individuals with "severe behavioral needs," creating a third reimbursement level, and a more sweeping reimbursement methodology change related to converting to a fully prospective payment system from the cost-based payment system used today.

- **Section 7:** provides AHCA with potential next steps for making changes to the ICF/IID reimbursement methodology, including additional considerations.

Much of this report is based on insights from materials provided by and interviews with ICF/IID stakeholders over the course of several months. Stakeholders included key AHCA staff and leaders from multiple bureaus, the Agency for Persons with Disabilities (APD), a partner state agency, and the Florida Association for Rehabilitation Facilities (Florida ARF), a provider stakeholder group.

# Section 2: Background

## *Key Issues*

ICF/IID providers in Florida are reporting an increase in the number of recipients with severe behavioral needs, which require significant resources to provide appropriate care. This issue was highlighted recently when Carlton Palms closed. This was a group home that provided services to a large number of individuals with severe behavioral needs. Based on discussions with representatives from AHCA, APD, and the Florida ARF, there were challenges placing these individuals in new residential settings. According to Florida ARF, ICF/IIDs either did not have the capacity for recipients from Carlton Palms or were resistant to accept these recipients because of a lack of reimbursement for the increased costs associated with caring for them.

Although all the Carlton Palms residents were eventually placed in new housing, with the majority going to group homes, the challenges of placing these individuals, expressed by APD, in ICF/IIDs gave weight to concerns previously raised by the industry with the current ICF/IID reimbursement methodology and the lack of a mechanism for covering the costs of recipients with severe behavioral needs. Under the current reimbursement methodology, no provision exists to offer higher reimbursement for recipients with severe behavioral needs. The current methodology includes two levels of reimbursement, but the distinction between these two levels does not consider behavioral needs. According to Florida ARF, individuals with severe behavioral needs often qualify only for the lower of the two per diem rates. The current reimbursement method is based on providers' historic costs; providers are unable to obtain increased reimbursement at the time an individual with severe behavioral needs enters a facility (or when an existing resident may begin exhibiting severe behaviors). In other words, there is a potential lag between when a facility incurs the increased costs associated with caring for these individuals and when these costs are reflected in the facility's cost reports and associated reimbursement rates. In addition, total Medicaid ICF/IID reimbursement is limited by Legislative appropriation. If aggregate ICF/IID cost is above the Legislatively-set budget, then ICF/IID rates are reduced proportionally, per budget proviso language.

According to the Florida ARF, a number of ICF/IIDs continue to be hesitant or unwilling to take individuals with severe behavioral needs without special higher reimbursement because of the delay or budget limitations that prohibit the facilities' ability to obtain reimbursement to cover the increased costs for these individuals. Accordingly, the Florida ARF approached AHCA to request that it consider changing its reimbursement methodology to better align payments with the cost of care for these individuals. AHCA staff reviewed and discussed all options and have included these in the report.

Any change in reimbursement specific for recipients with severe behavioral needs will require creation of criteria to define and identify applicable recipients. Currently, AHCA policy documentation and administrative rules do not include a definition of severe behavioral needs. In addition, no process currently exists to identify such individuals, as there is no current need for such a process. In addition, the criteria defined to categorize these individuals will need to be as clear as possible because the intent is to provide higher reimbursement for recipients with severe behavioral needs, so ICF/IIDs will, have an incentive to try to maximize the number of recipients that qualify.

## Facility and Population Characteristics[1]

ICF/IIDs are relatively unique in that nearly all reimbursement for care provided in ICF/IIDs comes from Medicaid. AHCA's annual rate setting process assumes 4.5 percent of ICF/IID reimbursement will come from private sources and the rest will come from Medicaid. Thus, ICF/IIDs are dependent on Medicaid reimbursement to stay open. In addition, recipients within ICF/IIDs are relatively unique in the sense that they commonly reside in the facility for many years, even decades. In many cases, an ICF/IID is the recipient's home for much of his/her life.

In Florida, there are 88 privately-owned ICF/IID facilities. As of April 2018, the ICF/IIDs are 94.6 percent occupied, with 1,948 individuals in 2,060 possible slots. Facility size ranges from six to 120 beds. The most common ICF/IID facility size is six beds, with thirty-eight facilities. The average number of beds across all ICF/IIDs in Florida is about 24.

Because there is no established definition of "severe behavioral needs," available data (e.g., claims and assessment data) makes it difficult to quantify the current number of individuals with severe behavioral needs. This includes those currently being served in ICF/IIDs as well as individuals who may be in other settings. However, an informal survey performed by Florida ARF in October 2018 identified approximately seven percent of existing Medicaid recipients at ICF/IIDs would qualify as having severe behavioral needs.[2] This translates to approximately 137 individuals if we assume 1,957 total recipients residing in ICF/IIDs in Florida.[3] The Florida ARF survey estimated another three percent, 59 individuals, with severe behavioral needs that were not accepted into ICF/IIDs (over the past year) because of the significant cost required to care for these individuals. Florida ARF's survey is included as Appendix A. Section 4 of this report provides a detailed discussion of approaches to identifying and defining individuals with "severe behavioral needs."

## Current Reimbursement Methodology

### Facility-Specific, Cost-Based Rates

Florida Medicaid's current method for reimbursing ICF/IID services includes facility-specific cost-based per diem rates. The rates are updated annually based on historical cost reports with inflation applied to estimate facility cost in the upcoming rate year. ICF/IIDs generate cost reports at the end of their fiscal year that must be submitted to AHCA within five months after the facility's fiscal year ends. Cost reports received by AHCA by February 1st of each year are used to determine ICF/IID per diem rates effective July 1st of that year. Because of these timing requirements, costs used in determining rates are based on facility patient mix from a time period that is generally one or two years prior to the rate year. If facility patient mix changes in a way that changes the facility's cost structure, it often takes one or two years for that change in cost to impact the facility's Medicaid per diem rate.

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[1] Florida Agency for Health Care Administration. Private ICF/IID Profiles. 2018. Available online. http://ahca.myflorida.com/medicaid/cost_reim/pdf/ICF_Not_Public_Profiles_July_2018.pdf

[2] Florida ARF asked survey respondents to identify individuals with severe behavioral needs based on the following criteria: How many individuals would meet the following criteria: Individuals with Intellectual Disabilities who are under the care of a Psychiatrist, are receiving Psychotropic Medications, and have Support Plans that indicate a need for behavioral analysis services to control or minimize self-injurious and/or aggressive behaviors.

[3] 1,957 recipients calculated based on statistics provided by AHCA showing 2,060 ICF/IID beds in Florida and 95 percent utilization.

The Florida Medicaid ICF/IID reimbursement per diems are, for the most part, prospective. That is, the per diems are calculated prior to the beginning of each state fiscal year and are only occasionally adjusted post-payment based on actual facility cost during the rate year. AHCA audits cost reports or receives amended cost data and adjusts rates for a number of facilities each year through a process referred to as a post-payment cost settlement. With 88 non-state-owned ICF/IIDs in Florida, each facility goes through the cost-settlement process only once every few years.

Within the per diem rate calculation, ICF/IID cost for care of Medicaid recipients is categorized into four components, each of which is converted into a per diem independently and then summed to determine the full per diem for each facility. The four per diem components are resident care costs, operating costs, property costs, and return on equity (ROE) costs. The four components are further subdivided into two reimbursement classes based on two levels of care. As a result, each facility receives two per diems, one for each of the two different levels of care, and each of those per diems is made up of four components discussed above. The per diem rate calculation process is illustrated is Figure 2.1 below.

**Figure 2.1 – ICF/IID Per Diem Rate Calculation**


The subdivision based on level of care of the recipients in an ICF/IID has no effect on the percentage of cost coverage achieved through the per diem rates if the patient mix at the facility remains constant from the base cost report year to the rate year. If the patient mix remains the same, the ICF/IID would receive the same total reimbursement whether using one per diem or two. However, the creation of two per diems versus one allows for some flexibility in assigning an appropriate per diem when an ICF/IID admits a new recipient.

***Levels of Care***

The two levels of care, which translate into the two reimbursement levels in the current payment methodology, are based on the recipients' mobility. The specific description of these two reimbursement levels as documented in the Medicaid State Plan is included below:

- **Intermediate Care Facility Level of Reimbursement One** – A reimbursement level for recipients who are ambulatory or self-mobile using mechanical devices and are able to transfer themselves without human assistance, but may require assistance and oversight to ensure safe evacuation.

- **Intermediate Care Facility Level of Reimbursement Two** – A reimbursement level for recipients who are capable of mobility only with human assistance or require human assistance to transfer to or from a mobility device or require continuous medical and nursing supervision.[4]

The definitions for these reimbursement levels offer no consideration for a recipient's behavioral needs, despite the fact that care for recipients with severe behavioral needs often requires constant one-on-one and sometimes two-on-one staffing.

***Rate Caps***

Two limitations, or caps, are applied during the ICF/IID rate setting process to maintain control over State expenditures. One cap limits year-over-year increases in the operating and resident care portions of the per diem rate for each individual facility. This cap limits the operating and resident care portions of the per diem in a new rate year to be no more than 1.4 times the current year per diem components after the current year per diem components have been inflated forward one year.[5] For example, if the inflation factor is 1.02 from the current year to the upcoming rate year, then an ICF/IID's new rate year operating and resident care per diem components cannot be more than 142.8 percent (1.4 times 1.02) of the facility's current per diem components. Despite this policy allowing for rather significant increases in cost year-over-year, a relatively large number of non-publicly owned ICF/IIDs in Florida, 50 out of a total of 88 facilities, received a cap on one or more of their applicable per diem components in the SFY 2018/19 rate year.[6] Thus, 50 out of 88 facilities had an increase in cost of more than 140 percent for one or more of their per diem components from their previous cost report to their more current cost report used for SFY 2018/19 rate setting.

A second cap is applied equally across all facilities and ensures that the projected spend of state funds in the upcoming rate year remains within the Legislatively-set budget. All facility per diems are reduced proportionately, if the state share of reimbursement of 100 percent of cost (minus patient liability) for all facilities in an upcoming rate year is estimated to exceed the Medicaid ICF/IID budget defined in the annual General Appropriations Act (GAA). In SFY 2018/19, ICF/IID per diems were not reduced through this cap thanks to an increase of 11.5 million[7] in recurring funds allocated by the Florida Legislature to the Medicaid ICF/IID budget. In contrast, ICF/IID per diem rates were decreased through this aggregate cap by 2.7 percent in SFY 2017/18, 0 percent in SFY 2016/17 and 2.8 percent in SFY 2015/16.[8]

[4] Florida Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities Services Coverage Policy, effective July 2016. Available online. https://www.flrules.org/gateway/readRefFile.asp?refId=7010&filename=59G-4.170%20ICF_Coverage_Policy_Adoption.pdf

[5] Alternatively, if a facility's operating and/or resident care costs go down from one year to the next the upcoming rate year per diem is reduced by half of the difference from the older per diem to the newer per diem so that the facility may receive financial benefit from their cost cutting efforts.

[6] Agency for Health Care Administration. Statistics are based on SFY 2018/19 ICF/IID per diem rate setting documentation. July 2018.

[7] Comparison of SFY 2017/18 Florida General Appropriations Act (GAA), Specific Appropriation 216 versus SFY 2018/19 Florida General Appropriations Act (GAA), Specific Appropriation 216.

[8] Agency for Health Care Administration. Statistics from ICF/IID per diem rate setting documentation for state fiscal years 2015/16 through 2017/18.

### *Local Funding of a Portion of the State Share*

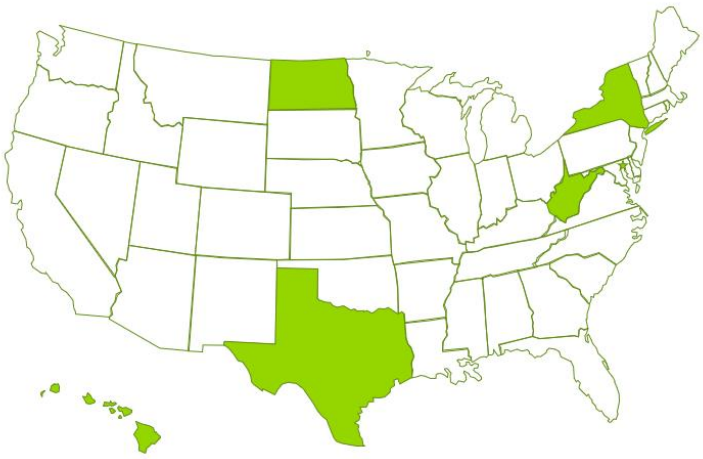
Whether or not reductions are made to the cost-based rates, it should be noted that a portion of the state share of Medicaid reimbursement comes from a healthcare-related provider assessment applied to the ICF/IIDs. A corresponding amount and the associated federal matching funds are used to increase the Medicaid reimbursement rates. For example, for rate year 2018/19, just under $16 million was collected from ICF/IIDs through the assessment, which amounts to 5.7 percent of total projected Medicaid ICF/IID reimbursement.[9]

[9] SFY 2018/19 Florida General Appropriations Act (GAA), Specific Appropriation 216.

# Section 3: Comparative State Research

## *Discussion of Practices, Program Structure, and Reimbursement*

At the request of AHCA, Navigant researched several states to highlight potentially interesting ICF/IID program structures and/or reimbursement methodologies. Specifically, the search focused on how states account for individuals with severe behaviors in their reimbursement methodologies. In addition to AHCA's initial request to examine Hawaii, North Dakota, and West Virginia, three additional states were added for a total of six states examined, including:



1. Hawaii
2. North Dakota
3. West Virginia
4. Texas
5. New York
6. District of Columbia

Each of the states we researched administers its ICF/IIDs relatively the same, although with some programmatic differences best-suited to the states' needs. Programs may differ by what entity administers the programs or who the state is partnered with, types and size of facilities, and what is considered part of the assessment in determining an individual's needs and their level of care. Severe behavior is dealt with differently depending on the state as well. See Appendix B for a full state comparison table.

Regarding behavior, states' ICF/IID programs differ in how individuals with "severe behavioral needs" are assessed and subsequently how the states calculate rates. We identified three general approaches taken by states, including:

| 1. In Behavioral Tier | 2. In Assessment | 3. Not Addressed in Either |
|---|---|---|
| A separate tier for individuals with intense / severe behaviors using acuity-factors of the resident (e.g., District of Columbia) | Accounted for "severe behavioral needs" through the needs assessment process (e.g., North Dakota, West Virginia, Texas, and New York) | No specific way to address individuals with intense / severe behaviors (e.g., Hawaii) |

Of the selected states, the District of Columbia is the only one using a separate behavioral tier approach to address individuals with "severe behavioral needs" and therefore provides an interesting system for AHCA to consider. Specifically, the District of Columbia tier facility rates based on acuity-factors of the resident in addition to facility-size. The assessment tool is highlighted along with the other states' assessment tools in Table 4.2 in Section 4. See Appendix C for additional information on District of Columbia's ICF/IID tiered approach and rate calculation.

Typically, as seen in four of the selected states, states identify and account for behaviors and "severe behavioral needs" as part of an assessment of the individual's overall needs. The assessment process is used to determine level of care, which is ultimately used to calculate a rate for the individual. As mentioned, behavior is only a part of the individual's assessment to

determine their level of care. For example, the Inventory for Client and Agency Planning (ICAP) assessment, used in North Dakota, Texas, and West Virginia, asks questions about the individual's physical ability, use of adaptive equipment, medications, and adaptive / maladaptive behaviors, among other categories to determine an overall level of care. The last approach, used by Hawaii, does not account for behaviors in either their rate calculation, or through their assessment process. Today, Florida would fall under the third approach because, although behavior is part of the needs assessment process, only recipient physical characteristics affect the rate calculation.

States' ICF/IID reimbursement levels and tiers can vary widely. Some have only two levels, while others have several more and include additional criteria for determining level of need or a change of need. For example, Texas has a comprehensive "Level of Need" assessment with five service levels, including four types of level of need increases to move a client between levels if there is a change in the assessment and planning score (ICAP). Specifically, an individual may be assigned the next higher category if they have dangerous behaviors that require a behavior support plan (BSP) that includes preventive actions by additional provider staff. A full discussion of assessment approaches is in Section 4.

This comparative state research illustrates potentially helpful programmatic and reimbursement differences and similarities for AHCA to consider if the Agency chooses to modify Florida's ICF/IID reimbursement methodology. Table 3.1 below, provides highlights from each states' reimbursement methodology, including how states address "severe behavioral needs."

**Table 3.1 – ICF/IID Program Reimbursement Methodology, by State**

| State | Reimbursement Methodology |
|---|---|
| **Hawaii** | **Reimbursement Methodology[10]**<br>• The program reimburses providers based on the number of days of care that the provider delivers to the resident, the acuity level that is medically necessary for each day of care (according to facility type), and the provider's Prospective Payment System (PPS) rate.<br>• Prospective cost based per diem with limits, full per diem paid for leave days.<br>• Calculating Basic PPS Rate:<br>  ○ The Hawaii Department of Human Services (DHS) requires the basic PPS rate shall be developed based on each provider's historical costs (as reflected in its Base Year Cost Report), to be increased annually by a specified inflation factor, and allocated to three components, which are subject to component cost ceilings; these are:<br>  1. Capital<br>  2. General & Administrative (G&A)<br>  3. Direct Nursing<br>  ○ Therefore, the Basic PPS Rate is the sum of the applicable per diem amounts for the direct nursing, capital, and G&A for each provider.<br>**Paying for Behavior-Related Care**<br>• *No Behavioral Component:* The reimbursement methodology rate calculation is **not** based on intensive ICF/IID resident behaviors and **does not** take behavior into account. Acuity is based on facility-type only and not on the individual's behaviors. |

[10] Hawaii Department of Human Services. *Medicaid Fee-For-Service Rates Effective July 1, 2018.* Available online. https://medquest.hawaii.gov/content/dam/formsanddocuments/provider-memos/qi-memos/qi-memos-2018/QI-1809.pdf

| State | Reimbursement Methodology |
|---|---|
| **North Dakota** | **Reimbursement Methodology[11]**<br>• In 2011, the North Dakota Legislature enacted Senate Bill 2043, which required the Department of Human Services to develop, in cooperation with service providers, a new payment system involving individualized rates, based on individual needs, using standard assessments.<br>• Cost based payment, full per diem paid for leave days.<br>• The rate established for ICF/IIDs is an all-inclusive rate for routine services. Routine services include supplies, therapies, nursing supplies, equipment, transportation, and non-legend drugs. Separate billings for these items will not be paid. Ancillary charges that are not included in the ICF/IID facility rate, such as x-ray, lab, drugs, etc. must be billed by the provider furnishing the service.<br>**Paying for Behavior-Related Care**<br>• *Behavioral Component:* The reimbursement methodology rate calculation is based on an all-inclusive level of care measure that considers behavioral needs, but does **not** provide a separate rate for individuals with severe behavioral needs |
| **West Virginia** | **Reimbursement Methodology[12]**<br>• The Bureau for Medical Services pays an all-inclusive per diem rate. This rate represents an inclusive payment for all services and items that are required to be provided by the ICF/IID.<br>• The basic vehicle for arriving at each facility's rate is the uniform Financial and Statistical Report for Behavioral Health Facilities and the acuity level of residents.<br>• The accepted WV service level score (from the ICAP) determines the reimbursement rate for each resident.<br>• Private facilities are paid prospective cost related and acuity adjusted per diems with limits based on operating costs plus capital.<br>• Leave days paid at the rate for the lowest level of acuity.<br>• Individual facility client specific rates are established on a prospective basis, considering cost to be expected and allowable during the rate period. The rate is not subject to retrospective revision. This does not exclude corrections for errors or omissions of data, or reconciliation of audit findings related to falsification of data or overstatement of costs.<br>**Paying for Behavior-Related Care**<br>• *Behavioral Component:* The reimbursement methodology rate calculation is based on an all-inclusive level of care measure that considers behavioral needs but does **not** provide a separate rate for individuals with severe behavioral needs. |
| **Texas** | **Reimbursement Methodology[13]**<br>• In 2010, the 81st Texas Legislature authorized the Texas Health and Human Services Commission (HHSC) by means of its appropriations to replace Fiscal Accountability |

[11] North Dakota. *ICF/IID Rate Matrix.* April 1, 2018. Available online.https://www.nd.gov/dhs/services/disabilities/docs/rate-matrix.pdf
[12] West Virginia Health & Human Resources. Bureau for Medical Services. June 6, 2016. Available online. https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20511%20-%20Intermediate%20Care%20Facilities%20for%20Individuals%20with%20Intellectual%20Disabilities%20%28ICF%20IID%29.pdf
[13] Texas Health and Human Services. *Intermediate Care Facilities Payment Rates.* September 1, 2017. Available online. https://rad.hhs.texas.gov/sites/rad/files/documents/long-term-svcs/2017/2017-09-icf-rates.pdf

| State | Reimbursement Methodology |
|---|---|
| | with a rate enhancement system to incentivize providers to increase attendant [caregiver] compensation and to hold providers accountable for the expenditure of any enhancement funds.<br>• Private facilities are paid acuity adjusted cost based per diems that vary by facility size.<br>• Cost based per diems are paid for public facilities.<br>• Each provider's total reported allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost-reporting period to the prospective reimbursement period as described in §355.108 of this title (relating to Determination of Inflation Indices).<br>• HHSC may adjust reimbursement if new legislation, regulations, or economic factors affect costs, according to §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).<br>**Paying for Behavior-Related Care**<br>• *Behavioral Component:* The reimbursement methodology rate calculation is based on an all-inclusive level of care measure that considers behavioral needs but does **not** provide a separate rate for individuals with severe behavioral needs. |
| **New York** | **Reimbursement Methodology**[14]<br>• Prospective cost based per diem with limits, full per diem paid for leave days.<br>• ICF/IID funding is based on the net of day services and tax assessment reimbursement. Adjustments are incorporated for inflationary or other changes authorized pursuant to State law, including the salary and salary related fringe benefit increases for direct care, support and clinical staff that took effect (most recently, i.e., using the 4/1/18 rates).<br>**Paying for Behavior-Related Care**<br>• *Behavioral Component:* The reimbursement methodology rate calculation is based on an all-inclusive level of care measure that considers behavioral needs but does **not** provide a separate rate for individuals with severe behavioral needs. |
| **District of Columbia** | **Reimbursement Methodology**[15]<br>• Prospective cost based per diem with efficiency incentives, up to Medicare limits.<br>• Full per diem paid for leave days less one-to-one services.<br>• The rates for ICF/IID services are developed based on Fiscal Year (FY) cost data reported by providers of different sizes serving individuals at varying acuity levels. The rates vary based on staffing ratios, facility size, and beneficiary acuity level.<br>**Paying for Behavior-Related Care**<br>• *Rate Based on Behavior:* The reimbursement methodology provides different rates for different facility tiers and the tiers are based on a combination of resident acuity-measures and facility size. |

[14] New York Department of Health. *Mental Hygiene Services Rates.* April 2018. Available online. https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/

[15] District of Columbia Federal Register. Department of Health Care Finance. *Medicaid Reimbursement for Intermediate Care Facilities.* Volume 65, No. 10. March 9, 2018. Available online. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Medicaid%20Reimbursement%20for%20Intermediate%20Care%20Facilities%20for%20Individuals%20with%20Intellectual%20Disabilities%20Notice%20of%20Final%20Rulemaking_0.pdf

In addition to examining each state's reimbursement methodologies, Navigant researched other states' ICF/IID rate schedules to compare against Florida's facility rates. For the selected comparison states, we were able to locate rates for four out of six states:

1. Hawaii
2. Texas
3. New York
4. District of Columbia

North Dakota and West Virginia did not make their rates public. These comparative rates illustrate potentially helpful information for AHCA to consider if the Agency would like to pursue action to modify Florida's rate structure / fee schedule for ICF/IIDs. Table 3.2 below contains ICF/IID rates for the selected states with available data. It is important to note when reading this table, that each state's reimbursement methodology should be considered in addition to the rates themselves. Given that each state's reimbursement methodology has nuanced differences, the rates should be considered a generalized comparison, but not necessarily an exact one.

**Table 3.2 – ICF/IID Rate Schedule Comparison, by State**

| State | Records Included | Average Rate | Median Rate | Lowest Rate | Highest Rate | Notes |
|---|---|---|---|---|---|---|
| **Florida**[16] | *Separate rates for each facility:*<br>Residential / Institutional (RI): 88<br>Non-Ambulatory / Medical (NM): 65 | RI: $326.50<br>NM: $423.42 | RI: $328.48<br>NM: $424.47 | RI: $229.04<br>NM: $260.71 | RI: $531.07<br>NM: $676.69 | RI rate is also known as the Level I rate.<br>NM rate is also known as the Level II rate.<br>RI / NM refers to the ICF/IID resident's level of care needed.<br>Operating expenses remain equal for both RI & NM residents, but the resident care component is higher for non-ambulatory residents. |
| **Hawaii**[17] | *Separate rates for each facility:*<br>Semi-Private room (SP): 39 | $421.00 | $375.00 | $294.00 | $831.00 | Hawaii separates its ICF/IID facilities by room type (private, semi-private, ward). Only semi-private room rates are shown in this table for comparison. |

[16] Florida Agency for Health Care Administration. *ICF/IID Calculation Sheet.* July 1, 2018. Available online. http://ahca.myflorida.com/medicaid/cost_reim/pdf/ICF_Not_Public_Calc_July_2018.pdf
[17] Hawaii Department of Health. *Health Care Utilization Report.* December 31, 2017. Available online. https://health.hawaii.gov/shpda/files/2018/10/Table-16-Long-Term-Care-Bed-Not-Staffed-by-County-2017-with-state-total-revised-20181203.pdf

| State | Records Included | Average Rate | Median Rate | Lowest Rate | Highest Rate | Notes |
|---|---|---|---|---|---|---|
| **Texas**[18] | *Non-facility specific rates:*<br>Level of Need (LON) 1: $118.04<br>LON 5: $134.06<br>LON 8: $158.90<br>LON 6: $190.24<br>LON 9: $385.84 | - | - | $118.04 | $385.84 | These base rates apply to all facilities. In addition, Texas allows add-on reimbursement rates. Add-ons are available for higher level need residents that meet certain criteria. There is a 5-cent add-on per level (up to 25 levels).<br>Texas separates its ICF/IID facilities by provider side (small, medium, large). Only medium-sized providers are shown here.<br>There are slightly higher rates for smaller facilities, and lower rates for larger facilities. |
| **New York**[19] | *Separate rates for each facility:*<br>83 | $455.93 | $440.62 | $272.20 | $928.39 | New York also has ICF Day Services and ICF Vocational Services. To appropriately compare New York to Florida, only the resident care ICF/IID service rates are shown. |
| **D.C.**[20] | *Non-facility specific rates:*<br>$520.88 (Base)<br>$668.86 (Extensive Behavioral) | - | - | $520.88 | $668.86 | D.C. separates its ICF/IID facilities by provider size (4-5 beds & 6 or more beds). They also separate by facility type (leased, owned, depreciated).<br>Only six bed, owned base and extensive behavioral rates are shown here (there are 12 levels total with higher rates for services such as 24-hour nursing).<br>There are slightly higher rates for smaller facilities, and lower rates for larger facilities. |

[18] Texas Health and Human Services. *Intermediate Care Facilities Payment Rates.* September 1, 2017. Available online. https://rad.hhs.texas.gov/sites/rad/files/documents/long-term-svcs/2017/2017-09-icf-rates.pdf
[19] New York Department of Health. *Mental Hygiene Services Rates.* April 2018. Available online. https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/
[20] District of Columbia Federal Register. Department of Health Care Finance. *Medicaid Reimbursement for Intermediate Care Facilities.* Volume 65, No. 10. March 9, 2018. Available online.

Only general comparisons of rates offered by various Medicaid agencies can be performed because each agency's payment method has nuanced differences. In addition, we were unable to find the number of applicable facilities for each rate for Texas and Washington, DC. As a result, we chose to compare the minimum and maximum rates we have documented for each state. When comparing minimum and maximum values, the above table illustrates that Florida Medicaid has lower ICF/IID rates than three out of four of our comparison states.

Using the Florida residential rate, the lowest ICF/IID rate is $229.04. By comparison,

- Hawaii's rate is **$64.96 dollars higher** than Florida ($294)
- New York's rate is **$43.16 dollars higher** than Florida ($272.20), and
- DC's rate is **$291.84 dollars higher** than Florida ($520.88).

On the other hand, Texas's rate is **$111 dollars lower** than Florida ($118.04). As a note Texas and District of Columbia have non-facility specific rates.

Florida's highest ICF/IID rate is $676.69. By comparison,

- Hawaii's rate is **$154.31 dollars higher** than Florida ($831)
- New York's rate is **$251.70 dollars higher** than Florida ($928.39), and

On the other hand, Texas's rate ($385.84) is **$290.85 lower** and DC's rate (668.86) is **$7.83 lower** than Florida. As a note Texas and District of Columbia have non-facility specific rates, which means their rates are set based on averages and are less likely to include very high and very low rates.

https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Medicaid%20Reimbursement%20for%20Intermediate%20Care%20Facilities%20for%20Individuals%20with%20Intellectual%20Disabilities%20Notice%20of%20Final%20Rulemaking_0.pdf

# Section 4: Assessment Approaches and Considerations for Identifying Individuals with Severe Behavioral Needs

As discussed in the Background Section, a definition of "severe behavioral needs" in Florida's ICF/IID programs has not yet been defined in statute or rule. A definition is a prerequisite for any of the options identified in Section 6 to modify the current ICF/IID reimbursement methodology. Should AHCA choose to move forward with modifying the reimbursement methodology to account for individuals with severe behaviors, developing a definition will be the first step. In addition, AHCA, in conjunction with APD, will need to develop a method for assessing whether an individual meets the definition of someone with "severe behavioral needs." This section provides key components and criteria for developing a definition, including behavioral criteria, care requirements, examples of how other states identify someone with "severe behavioral needs," and limitations that should be considered.

## *Identifying Individuals with "Severe Behavioral Needs"*

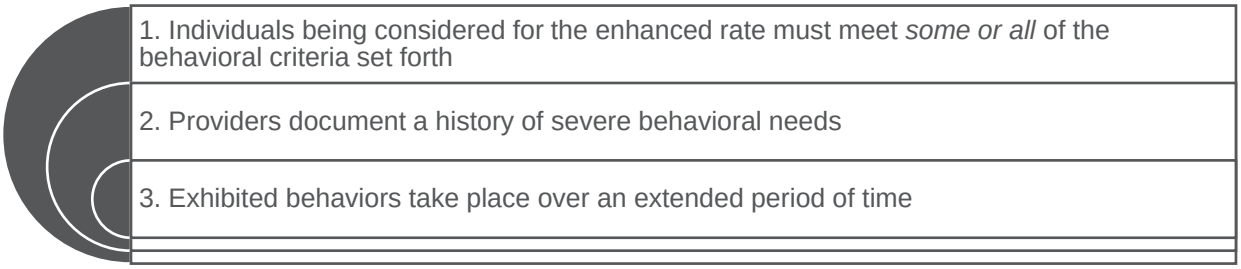
In developing a definition for individuals with "severe behavioral needs" residing in ICF/IIDs, the definition should explicitly state these key components:

1. Behaviors / behavioral criteria that must be exhibited and
2. Other justifications or minimum thresholds, if any, the provider must satisfy in caring for these individuals to qualify for an enhanced rate (e.g., staffing, care plan, medications, etc.).

The justification or minimum threshold requirements would help to safeguard the state against "inflation" of the number of recipients qualifying for an enhanced rate for severe behavioral needs. The requirements would also protect residents by defining the required standard of care for individuals with severe behavioral needs.

The State should also consider requiring the ICF/IID provider to demonstrate a history of severe behavioral needs for the individual through documentation such as behavioral support plans, and staffing logs, etc. Providers should need to document behaviors over an extended period of time. Admissible materials and the time period should be defined by AHCA in collaboration with other state agencies such as the Agency for Persons with Disabilities (APD), or any other entities that would be part of the assessment process. AHCA may also want to consult with behavioral analysts (housed in APD) to create a set of reasonable limitations. This should also address the concern that someone's behaviors may be sufficiently under control one day and sporadic the next. In summary, as highlighted in Figure 4.1, there are three general parameters that the state should establish for qualifying an individual as having severe behavioral needs for reimbursement purposes.

**Figure 4.1 – Parameters for Qualifying as Having Severe Behavioral Needs for Reimbursement Purposes**



The goal of establishing clear limitations and timeframes for the behavioral criteria is to align the enhanced behavioral rate specifically with individuals with severe behavioral needs who need an enhanced rate in order to receive appropriate care from an ICF/IID provider.

### *Discussion of Definitions and Assessment Methodologies in Florida and Other States*

As mentioned in the Background Section, the Florida ARF self-administered an ICF/IID provider survey and requested that providers identify if they had clients with the following three characteristics:

1. Individuals with intellectual disabilities who are under the care of a psychiatrist
2. Individuals receiving psychotropic medications
3. Individuals with a [Behavioral] Support Plan that indicates a need for behavioral analysis services to control or minimize:
    a. Self-injurious and/or
    b. Aggressive behaviors

Although these criteria were appropriate for developing a general estimate of the potential number of qualifying individuals, as discussed in the prior section, AHCA will need to develop a more robust definition for reimbursement purposes.

AHCA can consider a variety of sources including the background / behavioral information offered by the Florida ARF and criteria other states' use in their assessment process or support plans. See Appendix D for language provided by the Florida ARF regarding behavior descriptors they recommend to account for individuals with "severe behavioral needs." Partner state agencies may also be able to give AHCA criteria to consider to better coordinate abutting processes that the individual will experience, such as eligibility, transitioning into a new facility or to another setting, a change in level of care, etc.

States' behavioral criteria are usually found in their assessment tools. Assessments used by Texas and North Dakota, in particular, provide clear behavioral criteria, categories, and limitations. District of Columbia has two separate acuity levels to address "severe behavioral needs." The behavioral criteria from all three states are described below and offer a distinction between extensive behaviors and extremely high / severe behaviors.

From the Texas ICF/IID ICAP assessment, the state defines dangerous behavior as "frequency and/or severity could cause serious physical injury to the individual or someone else." Major categories for moving someone to a higher level of need include:[21]

1. Self-injurious behavior (such as self-inflicted tissue damage, pica, and access to food for individuals with Prader-Willi syndrome)
2. Serious disruptive behavior (such as threatening strangers, running into traffic, and public disrobing)
3. Aggressive behavior (includes physical attacks against others)
4. Sexually aggressive behaviors (such as assault, pedophilia, and public masturbation)

North Dakota Medicaid uses three dimensions to define ICF/IID behavior support needs; these are used for both the ICAP and the Supports Intensity Scale (SIS) assessments:[22]

[21] Texas Health and Human Services. *Criteria and Requirements for an Increased LON Due to Behavioral Challenges.* 2018. Available online. https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/idd-waivers-program-enrollmentutilization-review/lon-resources/criteria-requirements-increased-lon-due-behavioral-challenges

[22] North Dakota Department of Human Services. *SIS and ICAP Assessment Policy.* September 12, 2018. Available online. https://www.nd.gov/dhs/services/disabilities/docs/sis-icap-assessment-policy.pdf

1. Self-injury / Stereotyped / Withdrawn
2. Offensive / Uncooperative
3. Disruptive / Destructive / Hurts Others

The assessment criteria used by the District of Columbia includes two acuity levels (out of a total of six) designed specifically to address extensive or pervasive behaviors:[23]

- **Acuity Level 3 Criteria (Extensive – Behavioral):** Under this level, an individual must be dually diagnosed with an intellectual and developmental disability and with one or more behavioral disorders that:
    1. Are assaultive, self-abusive, including pica, or aggressive
    2. Require a written behavior plan which is based on current data and targets the identified behaviors
    3. Require intensive staff intervention and additional staff resources to manage the behaviors

- **Acuity Level 5 Criteria (Pervasive):** Under this level, an individual requires one-to-one (1:1) staffing and exhibits one or more of the following characteristics:
    1. A history of, or is at high risk for, elopement resulting in risk to beneficiary or others
    2. Exhibits behavior that is life-threatening to the beneficiary or others
    3. Exhibits destructive behavior that poses serious property damage, including fire setting
    4. Is a sexual predator
    5. A history of, or is at high risk for, falls with injury, and a primary care physician or advanced practice registered nurse order for one-to-one (1:1) supervision

Generally, the assessment tools used by the states we reviewed are either national, standardized tools or "home-grown" tools based on national standards. Florida, New York, and District of Columbia use "home-grown" tools, based on national standards that measure criteria including mobility, independence, physical needs, and behaviors. The other four states use a nationally recognized, standard assessment tool, or a slightly modified version of one. Hawaii uses an electronic version of the Preadmission Screening and Resident Review tool (ePASSR). North Dakota, Texas, and West Virginia Texas all use the Inventory for Client and Agency Planning (ICAP) assessment tool. North Dakota also uses the Supports Intensity Scale (SIS) assessment for adults (and only uses the ICAP for children, although the other states use it for all ages). Table 4.2 below, provides an overview of the states' assessment tools used to determine an individual's needs and level of care, including if the state's rate methodology accounts for recipient behaviors.

[23] District of Columbia Department of Health Care Finance. State Plan Amendment Establishing Reimbursement Principles and Methods for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs). Attachment 4.19-D, Part II. January 25, 2013. Available online. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/419DPart11.pdf

**Table 4.2 – ICF/IID Assessment Tools, by State**

| State | Assessment Tool(s) | Behaviors Accounted for in Rates? (Y/N) |
|---|---|---|
| **Florida** | CFA (Comprehensive Functional Assessment) | No |
| **Hawaii** | ePASRR (Electronic Preadmission Screening and Resident Review) | No |
| **North Dakota** | • Supports Intensity Scale (SIS) for adults<br>• Inventory for Client and Agency Planning (ICAP) for children | Yes |
| **West Virginia** | Inventory for Client and Agency Planning (ICAP) | Yes |
| **Texas** | Inventory for Client and Agency Planning (ICAP) | Yes |
| **New York** | ICF/MR-Level of Care Eligibility Determination (LCED Form) | Yes |
| **District of Columbia** | Level of Need Assessment and Risk Screening Tool (LON) | Yes |

AHCA may want to consider these other states' assessment tools and behavior support plans (as well as reviewing overall care plans) as a guide to developing an assessment methodology in Florida that will account for individuals with "severe behavioral needs."

Following conversations with AHCA leaders and staff throughout the Agency, a discussion of the iBudget Waiver (individualized budgeting waiver for individuals with developmental disabilities) highlighted potentially interesting approaches to consider for these new "severe behavioral needs" assessments for ICF/IIDs.

One potential option discussed with AHCA staff is to expand the State's existing quality improvement organization (QIO) contract with Qlarant Quality Solutions, to include assessments of individuals with severe behaviors in ICF/IIDs. Currently, the QIO provides quality assurance for Florida's Developmental Disabilities Services system in partnership with APD. Their current responsibilities are to manage the iBudget Waiver, which includes measuring the success of services and supports for the individual as well as program measures and requirements.[24] AHCA could also contract with a different vendor to assume this responsibility.

Another potential approach is to use an existing "expert review panel" currently coordinated by APD and used for iBudget Waiver participants. The expert panel consists of contractors that are certified behavioral analysts and determine if individuals in the waiver rise to a certain level of need according to an outset definition. Importantly, they have knowledge of the population and already convene to make these determinations. These individuals are not state employees but are contracted and serve a "term" as a panel member. The requirements to join the panel are a deep understanding of the population and a minimum number of years in practice. There is potential to expand this panel to serve the ICF/IID population especially since these individuals are already familiar with state agency authorities, limitations, and practices under Medicaid.

[24] Florida Agency for Health Care Administration. Quality Management Contracts. 2018. Available online. http://ahca.myflorida.com/Medicaid/Utilization_Review/index.shtml

AHCA and APD would need to determine how the expert panel could use its time or if additional members would be needed in order to accommodate this new assessment capability.

## Section 5: Financing Rates for Individuals with Severe Behavioral Needs

Any new provision allowing for greater reimbursement to ICF/IIDs for the care of recipients with severe behavioral needs could be implemented in a budget neutral fashion or through an increase in state and federal funds. Medicaid reimbursement for services provided by ICF/IIDs is funded the same as all other provider types, through a combination of state and federal dollars. The split between state and federal funds is based on the Federal Medical Assistance Percentage (FMAP) which is calculated separately for each state and is updated annually. For Florida, the FMAP in SFY 2018/19 is 61.10%. This means every dollar in reimbursement from Florida Medicaid to ICF/IIDs is funded with 61.1 cents from the federal government and 38.9 cents from the State of Florida.

### *Discussion of Budget Neutral Option without Inclusion of Funds from iBudget Waiver*

A change in rates to provide enhanced reimbursement for recipients with severe behavioral needs implemented in a budget neutral manner would require a reduction in existing Level 1 and Level 2 rates. The total Legislative allocation for privately owned ICF/IIDs in SFY 2018/19 is $266 million.[25] In SFY 2018/19, the $266 million is allocated based on facility-specific cost and utilization into per diems for two levels of care. The same amount of funds could be distributed through our "Option One," which would increase the number of recipients receiving Level 2 care, or through our "Option Two," which would create a new Level 3 reimbursement rate that is higher than both the Level 1 and Level 2 rates and is intended specifically for recipients with severe behavioral needs. With either option, the Level 1 and Level 2 reimbursement rates would need to be reduced to allow for higher reimbursement for recipients with severe behavioral needs, while maintaining budget neutrality. See Section 6 for details on each option.

Given the fact that not all ICF/IIDs currently care for one or more individuals with severe behavioral needs that would qualify for an increased rate, a budget neutral implementation would likely require a small shift in reimbursement levels across the facilities in Florida. During our meeting with the Florida ARF, they indicated a strong desire against any reimbursement change that would result in a change in reimbursement levels for individual facilities.[26] Accordingly, we believe implementation of new ICF/IID rates for recipients with severe behavioral needs in a budget neutral manner is unlikely to be accepted by the industry.

### *Discussion of Budget Neutral Option with Inclusion of Funds from iBudget Waiver*

In Section 2, we discuss that one of the reasons for this review of Florida Medicaid's ICF/IID rate methodology is the recent closing of the Carlton Palms facility. Anecdotally, it is our understanding that all, or nearly all, of the recipients that used to reside at this facility would qualify under some definition of severe behavioral needs. Also, care for these recipients was provided through the iBudget Waiver. The Florida ARF shared another option for consideration, regarding former Carlton Palms residents that involved using the funds currently distributed through the iBudget Waiver to fund former Carlton Palms residents receiving care in ICF/IIDs. This option could maintain current levels of state and federal funds and would result in the money following the recipient to whichever type of facility the recipient chooses to receive care. However, recipients cannot receive care in an ICF/IID and receive reimbursement through the

[25] SFY 2018/19 Florida General Appropriations Act (GAA), Specific Appropriation 216.
[26] Florida ARF's opinion is documented in Navigant notes from a meeting including Navigant, Florida ARF and AHCA representatives, held at the AHCA offices on September 20, 2018.

iBudget Waiver.[27] Thus, recipients who used to be residents in the Carlton Palms facility would need to exit the iBudget Waiver to receive care in an ICF/IID. As a result, the money can follow the recipient in a budget neutral manner for these recipients only if the state and federal funds come out of the iBudget Waiver and move into the traditional Medicaid budget. And with this shift, budget neutrality could only be maintained if each recipient moving to traditional Medicaid resulted in a corresponding reduction in head count within Florida's iBudget Waiver, which, as discussed below, is likely infeasible.

The iBudget Waiver is limited to 40,818 unduplicated recipients enrolled at any time in Waiver Demonstration Year 5, which applies from March 15, 2018 through March 14, 2019.[28] As of October 1, 2018, enrollment in the iBudget Waiver is full and there are 21,897 clients on a waitlist.[29] Thus, demand for the waiver exceeds the supply of funds. Also, as of the writing of this report, all recipients previously residing in Carlton Palms have found placement with two moving to ICF/IIDs, three going home, and the rest (198 individuals) moving to group homes. Lastly, general federal and Medicaid policy in recent years has prioritized care in community-based settings over institutional settings (thus, group homes have in recent years generally been considered preferable to the more institutional settings provided in ICF/IIDs). Given all these facts, Navigant believes it is unlikely that shifting funds from the iBudget Waiver to traditional Medicaid is an acceptable option.

### *Discussion of Increase in Medicaid Budget for ICF/IID Reimbursement*

Another option that would enable an increase in reimbursement at ICF/IIDs for care of recipients with severe behavioral needs while maintaining current Level 1 and Level 2 per diem amounts would be an increase in the annual allocation of state funds for ICF/IIDs. Any increase in state funds would require approval by the Florida Legislature. In addition, increases in state funds for reimbursement to ICF/IIDs would have associated increases in federal funds distributed to Florida Medicaid and, thus, would be subject to standard CMS Upper Payment Limits.

If the Florida Legislature is willing to provide additional state funds, the total cost to the State will depend on the number of recipients qualifying as having severe behavioral needs and the per diem rate made available for those recipients. As stated earlier in this report, no clear definition currently exists to categorize these individuals. Subsequently, data is not available to definitively state the total number of these individuals and their associated costs.

Despite these limitations, for purposes of this study we developed general estimates of the number of individuals with severe behavioral needs and their associated costs. A survey performed by the Florida ARF identified approximately seven percent of existing Medicaid recipients at ICF/IIDs would qualify as having severe behavioral needs. This translates to approximately 137 individuals if we assume 1,957 total recipients residing in ICF/IIDs in Florida.[30] The Florida ARF survey estimated another three percent, 59 individuals, with severe behavioral needs that were not accepted into ICF/IIDs (over an unspecified timeframe) because of the significant cost required to care for these individuals.

[27] The iBudget Waiver is designed to provide service location options other than institutional care for recipients with developmental disabilities. ICF/IIDs are categorized as institutional care, and, thus, are outside the scope of the iBudget Waiver.
[28] 2017 iBudget Waiver Amendment Request - Draft FL.027.01.03 - Jan 01, 2018, for changes requested to be effective starting January 1, 2018.
[29] Count of clients on the iBudget Waiver was provided by AHCA on October 17, 2018.
[30] 1,957 recipients calculated based on statistics provided by AHCA showing 2,060 ICF/IID beds in Florida and 95 percent utilization.

The reimbursement rate through the iBudget Waiver for "Enhanced Intensive Behavioral Residential Habilitation" ranged from $670 to $900 per day.[31] Even the lower end of this range is higher than the current Level 2 rate received by nearly every ICF/IID in Florida. In addition, a memo from Florida ARF to AHCA sent in October of 2018 indicated that cost of care for these recipients in an ICF/IID would likely range from "$525 per day for cluster models to as high as $598 per day for six-bed facilities."[32]

Combining this estimate of individuals with severe behavioral needs (a total of 196) with a per diem of $562, which is approximately midway between the low and high end of Florida ARF's estimate (between $525 per day for cluster models to as high as $598 per day for six-bed facilities) the total additional cost to Florida based on these assumptions is approximately $15.7 million per year, as shown in Figure 5.1 below.

**Figure 5.1 – Estimate of Annual State Share Cost for an Increased ICF/IID Rate for 196 Recipients with Severe Behavioral Needs**

| Applicable Recipients Currently in ICF/IIDs with Severe Behavioral Issues | Total Days per Year for Recipients with Severe Behavioral Issues | Estimated Per Diem | Total Computable Cost for Recipients with Severe Behavioral Issues | State Share of Cost for Potential Increased ICF/IID Rate for Recipients with Severe Behavioral Issues[33] |
|---|---|---|---|---|
| 196 | 71,589 | $562.00 | $40,233,018 | $15,650,644 |

However, it can likely be assumed that current SFY 2018/19 reimbursement rates fully cover the cost to all or nearly all facilities for care of the 138 individuals with severe behavioral needs that are currently residing in ICF/IIDs. In aggregate, the SFY 2018/19 ICF/IID rates cover 108 percent of ICF/IID allowable cost inflated to the SFY 2018/19 timeframe. At the individual facility level, the ICF/IID 2018/19 reimbursement rates amount to less than 100 percent of cost for only 8 of the 88 privately-owned facilities.[34] See Appendix E for cost and estimated reimbursement levels in SFY 2018/19 for the 88 privately-owned facilities.

Also, the recipients of the now-closed Carlton Palms facility have, as of the time this report was generated, all been placed into group homes (with the exception of two recipients who moved into ICF/IIDs). Thus, we might assume that the population of recipients for which new funding would be needed is actually 59 individuals (the number of individuals with severe behavioral needs that ICF/IIDs reported turning away in recent years). The information from Florida ARF did not indicate whether any of these 59 individuals had previously been residents of Carlton Palms, in which case they would already be placed in group homes, and no longer in need of an ICF/IID. But if we assume 59 individuals as a maximum and use our previous cost assumptions, the maximum additional cost to Florida to fund care for new ICF/IID residents with severe behavioral needs is approximately $4.7 million, as shown in Figure 5.2 below.

[31] Exact iBudget rate depends on location and staffing level of the facility. Regarding staffing level, two rates are created, one for facilities with three or less employees (designated as a "Solo" facility) and another rate for facilities with more than 3 employees (designated as an "Agency" facility).
[32] Memo from Florida ARF to AHCA summarizing results of the association's survey of Florida ICF/IIDs regarding the population of recipients with severe behavioral needs that are seeking care; sent by Florida ARF on October 15, 2018.
[33] Uses the Florida Medicaid blended FMAP percentage for SFY 2018/19 of 0.3890.
[34] Agency for Health Care Administration. Statistics are based on SFY 2018/19 ICF/IID per diem rate setting documentation. July 2018.

**Figure 5.2 – Estimate of Annual State Share Cost for an Increased ICF/IID Rate for 59 Recipients with Severe Behavioral Needs**

| Applicable Recipients Currently in ICF/IIDs with Severe Behavioral Issues | Total Days per Year for Recipients with Severe Behavioral Issues | Estimated Per Diem | Total Computable Cost for Recipients with Severe Behavioral Issues | State Share of Cost for Potential Increased ICF/IID Rate for Recipients with Severe Behavioral Issues[35] |
|---|---|---|---|---|
| 59 | 21,550 | $562.00 | $12,111,100 | $4,711,218 |

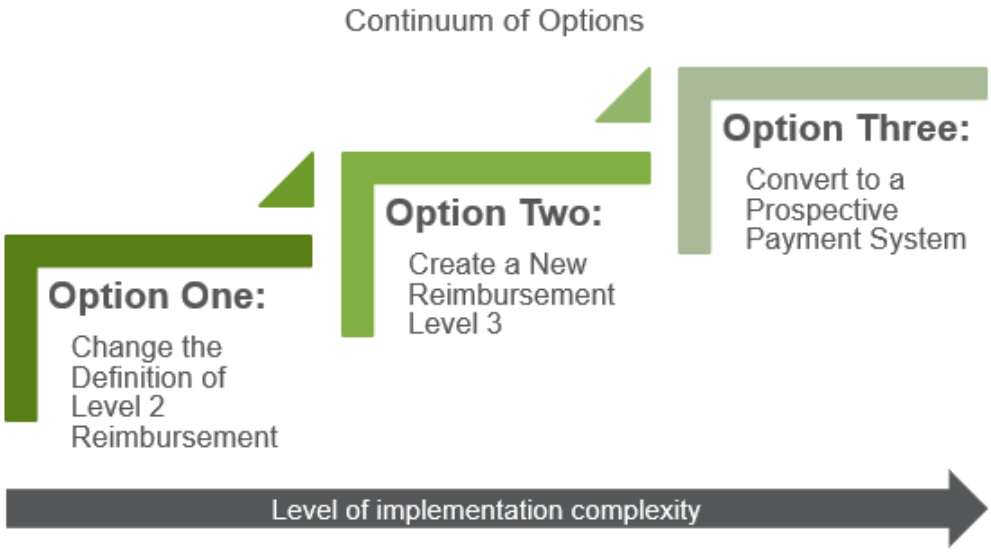
[35] Uses the Florida Medicaid blended FMAP percentage for SFY 2018/19 of 0.3890.

## Section 6: Overview of the Options to Modify Reimbursement Methodology

The overall purpose of this study is to provide AHCA with potential options for modifying the ICF/IID reimbursement methodology to account for individuals with severe behavioral needs.

In this section, three options are discussed and offered on a continuum illustrated in Figure 6.1. The first option is the least complex to implement relative to the other options, whereas the third option has the highest level of complexity and requires broader policy changes to implement. In addition, as discussed in Section 4, a prerequisite for implementing any of these options is the establishment of a definition of "severe behavioral needs" and a methodology for assessing and identifying these individuals. Lastly, as discussed in the previous section, AHCA could either take a budget neutral approach or additional funding would need to be appropriated to increase ICF/IID reimbursement when implementing any of these options.

**Figure 6.1 – Continuum of Options to Modify ICF/IID Reimbursement Methodology**




For each of the three options we provide a description and discussion of the potential political viability / industry acceptance of the option, including the potential reception from the ICF/IID industry in terms of how the option addresses their original desire for a rate increase for individuals with severe behavioral needs.

Following the options, we discuss three additional areas, including:

1. ***Impact to State Plan and Rule:*** *Discussion of the impacts to the State Plan and efforts needed to accommodate a higher reimbursement rate for recipients with severe behavioral needs.*
2. ***Development and Implementation of New Policies:*** *Discussion of the types of internal policy changes that AHCA, APD, and other state entities would need to implement to make the option possible.*
3. ***Legislative Impact:*** *Discussion of what, if any, legislative action is needed to enable the policy changes discussed.*

## *Option One: Change the Definition of Level 2 Reimbursement*

### *Description*

For Option One, the State would modify the current reimbursement methodology to expand the definition of the current Level 2 reimbursement category to include individuals with "severe behavioral needs." As discussed in Section 2, Reimbursement Level 2 is currently restricted to "non-ambulatory" individuals who are capable of mobility only with human assistance or require human assistance to transfer to or from a mobility device. Currently, a recipient's behavioral health status has no impact on his or her assignment to Level 1 or Level 2.

With this option, Florida Medicaid would expand the definition of Reimbursement Level 2 to include characteristics of severe behaviors. In the expanded Level 2 definition, the State would pay the same rate for individuals with severe behavioral needs as it does for non-ambulatory recipients residing in ICF/IIDs. Under this option, facilities with individuals currently being reimbursed at the Level 1 rate who are assessed as having a severe behavioral need, would qualify for reimbursement Level 2. Similar to the current process, in cases where a facility does not currently have an existing Level 2 rate and someone with severe behaviors is newly qualified at a Level 2 reimbursement rate, the facility would need to request an interim Level 2 rate from AHCA. Table 6.2 illustrates the proposed populations to be included under the modified reimbursement Level 2.

**Table 6.2 – Reimbursement Levels under Option One, by Population**

| Reimbursement | Current Level 1 | Current Level 2 | Proposed Level 2 |
|---|---|---|---|
| **Populations** | Ambulatory recipients residing in ICF/IIDs | Non-ambulatory recipients residing in ICF/IIDs | 1. Non-ambulatory recipients residing in ICF/IIDs<br>Or<br>2. Individuals with "severe behavioral needs" |

The initial level of effort required from AHCA to implement Option One would be the lowest compared to the other options. Although this option creates a shift in populations allowed under reimbursement Level 2, it does not require the establishment of a new reimbursement level altogether, nor does it change the nature of the payment system itself. The current two-level structure would be maintained. However, as with the other options, AHCA will still need to establish a definition of "severe behavioral needs" and develop an assessment approach.

### *Industry Acceptance*

Florida ARF's original request was to either "create a Level 2 add-on" or to "create a third reimbursement level" to acknowledge the fact that caring for individuals with severe behavioral needs creates higher costs. Option One does provide higher reimbursement for recipients who are mobile and have severe behavioral needs. In contrast, under the current payment regulations these individuals receive Reimbursement Level 1.

This option does not provide any additional reimbursement for recipients with severe behavioral needs who are also non-ambulatory. Recipients meeting both these criteria are already reimbursed at Level 2 rates. In addition, this option results in residents with severe behavioral needs being reimbursed at the same level as all non-ambulatory recipients. However, the Florida ARF has indicated that recipients who are potentially harmful to themselves or others (which are likely characteristics to be included in a definition of severe behavioral needs) require

more constant supervision than recipients who are non-ambulatory. Thus, it is anticipated that the Florida ARF would consider Option One to be a step in the right direction, but insufficient to recognize the unique level of care and costs for recipients with severe behavioral needs.

### *Option Two: Create a New Reimbursement "Level 3"*

#### *Description*

Option Two creates an altogether separate reimbursement "Level 3" for individuals with severe behavioral needs that is not distinguished by ambulation. In addition, the State would calculate a rate based on the cost of treating this specific type of individual (versus grouping these individuals with non-ambulatory individuals). Navigant anticipates that this rate would be the same for ambulatory and non-ambulatory recipients, although, if necessary, the criteria for this new level could be defined to include ambulation as part of the criteria because recipients who are ambulatory and have severe behavioral needs likely require greater supervision and greater cost to ICFs than recipients who are non-ambulatory. Like Option One, the first time a facility accepts a recipient who qualifies for Level 3 reimbursement, the facility would need to go through the process of requesting an interim rate from AHCA based on a budgeted cost report. Table 6.3 illustrates the proposed populations to be included under the new reimbursement Level 3.

**Table 6.3 – Reimbursement Levels under Option Two, by Population**

| Reimbursement | Current Level 1 | Current Level 2 | Proposed Level 3 |
|---|---|---|---|
| **Populations** | Ambulatory recipients residing in ICF/IIDs | Non-ambulatory recipients residing in ICF/IIDs | Individuals with "severe behavioral needs" |

This option is more holistic in its approach to addressing individuals with "severe behavioral needs" by more accurately reflecting the fact that the needs of individuals with severe behaviors are different than other recipients. In this option, the current two-level reimbursement structure changes to three levels, which may add another layer of complexity when updating and establishing new policies. This option also requires AHCA to establish a definition of "severe behavioral needs" and develop an assessment approach.

#### *Industry Acceptance*

Again, Florida ARF's original request was to either "create a Level 2 add-on" or to "create a third reimbursement level" to acknowledge the fact that caring for individuals with severe behavioral needs creates higher costs. Option Two creates this third reimbursement level.

Offering a new Reimbursement Level 3 would satisfy the ICF/IID industry's request for the state to provide an enhanced reimbursement rate for individuals with severe behavioral needs in recognition of the increased cost of care for this population. In addition, the ICF/IID industry in Florida will likely prefer Option Two over Option One because it provides an altogether separate reimbursement level which acknowledges the uniquely high cost of care for recipients with severe behavioral needs.

Even though this option generally aligns with the ICF/IID industry's suggestions for higher reimbursement for individuals with severe behavioral needs, the industry is likely to be more receptive to this change if it is implemented in a non-budget neutral fashion (i.e., it resulted in a net increase in reimbursement). Florida ARF has indicated that they will be less receptive to a reimbursement change that is implemented in a budget neutral manner, which would

necessitate a corresponding reduction in Level 1 and Level 2 rates to cover the rates for the newly qualified Level 3 recipients.

## *Option Three: Convert to a Prospective Payment System (PPS)*

### *Description*

Option Three is an altogether separate approach for the State to address the ICF/IID industry's concerns. Under this option, the payment system would shift from cost-based facility-specific rates to a prospective payment system (PPS) in which all or a primary portion of each facility's rate would be an average, or standardized, rate. The standardized portion of the rate could be defined for all facilities in the state or for all facilities within a peer group. If using peer groups, a variety of criteria could be applied to define the peer groups, such as facility size, geographic location, and patient mix. The implications of enacting this option are wide-sweeping and would require AHCA to undertake a broad number of administrative and policy changes.

The Florida Legislature and AHCA have in recent years shifted healthcare reimbursement methods away from facility-specific cost-based rates to prospective payment methods. The newer prospective payment methods primarily use standardized rates (the same rate for multiple facilities) and limit correlation with individual facility costs. Applying this trend to ICF/IIDs is worthy of consideration when considering updates to Florida Medicaid's ICF/IID payment method.

The newer payment methods recently implemented by Florida Medicaid for hospitals and nursing facilities create greater incentives for healthcare providers to manage their costs by offering greater margin to facilities who are more successful in controlling costs of providing healthcare. In addition, the new prospective payment systems reduce administrative burden by removing the need for post-payment cost settlement with individual facilities.

In contrast, Florida Medicaid's current ICF/IID payment method uses per diems that are calculated separately for each facility and are based on facility costs. The current ICF/IID payment method contains ceilings on per diem amounts, but otherwise offers few incentives for facilities to carefully manage healthcare costs. Facilities with higher costs are generally paid more and facilities with lower costs are generally paid less. Reductions in cost by individual facilities are "rewarded" with lower reimbursement from Medicaid.

Florida Medicaid's current ICF/IID payment method is very similar to an older Florida Medicaid nursing facility payment method that was in effect through September of 2018. For nursing facilities, the Florida Legislature and AHCA removed these adverse incentives through implementation of a prospective payment system that was implemented in October 2018. The new nursing facility prospective payment system uses standardized rates (common across facilities) to distribute 80 percent of Medicaid reimbursements. For the standardized rates, two peer groups have been implemented to account for the generally higher cost of healthcare in certain geographic areas within the State of Florida. The other 20 percent of reimbursement is split between multiple facility-specific parameters – for example, one facility-specific parameter is based on facility property costs and another is based on facility-specific quality of care measurements. Thus, the full per diem amount for each facility is based on a combination of standardized rates and facility-specific rates.

In addition, the new nursing facility prospective payment system includes an add-on payment for a specific category of patients whose healthcare costs are unusually high. These are patients who require use of a mechanical ventilator. Similarly, within an ICF/IID, patients with significant behavioral needs require unusually high costs of care for which an add-on payment could be provided within an ICF/IID prospective payment system to more fairly reimburse facilities for care of these recipients. As it relates to individuals with severe behavioral needs, examining

other states' methods of reimbursing ICF/IIDS may be helpful for designing and potentially establishing tiers based on severe behavior. In particular, as previously discussed in Section 4 the District of Columbia provides a model for establishing a separate tier for individuals with the most severe behavioral needs.

### *Industry Acceptance*

Even with possible add-on payments and peer groups, any shift of rates from facility-specific values to standardized values will result in some facilities receiving higher reimbursement and others receiving lower reimbursement. This is because the standardized portion(s) of the rate are based on averages across all facilities within a rate setting peer group. When shifting to standardized rates, those ICF/IIDs with a facility-specific cost-based rate above the average would experience a reduction in reimbursement and those with a rate below the average within the peer group would experience an increase in reimbursement.

This potential shift in reimbursement levels is a significant drawback to the option of moving to a prospective payment system with standardized rates. ICF/IIDs generally rely on Medicaid as the sole payer for healthcare services and many ICF/IIDs are very small. Some facilities have as few as six beds. As a result, reductions in Medicaid reimbursement might be catastrophic for some facilities and for this reason, we expect a conversion to a prospective payment system with standardized rates would be opposed by Florida ARF and others within the industry.

## *Additional Considerations*

All the options just discussed would require changes in the following three areas:

1. The Medicaid state plan,
2. Agency administrative rules and procedures, and
3. Florida Medicaid statutes.

The following subsections discuss potential changes required in each of these areas.

### *Impact to Medicaid State Plan and Rule*

AHCA will need to change the state plan and associated promulgated rules for every option to include the new definition developed to describe "severe behavioral needs." Depending on which option is chosen, this may also include updated descriptions on reimbursement levels, governance regarding mid-year changes in individual recipient level of care, and description of rate calculations (particularly if converting to a fully prospective payment system). Federal reimbursement for Medicaid payments cannot be made until updates to the state plan are made and approved by CMS, thus this is a critical step.

To modify the state plan, AHCA would submit a State Plan Amendment (SPA) to CMS with changes in the section entitled *Florida Title XIX Reimbursement Plan for Services in Facilities Not Publicly Owned and Not Publicly Operated for Intermediate Care Facilities for Individuals with Intellectual Disabilities* (Attachment 4.19-D).

In addition, implementation of any of the three options presented in this study would require updates to Florida administrative code, particularly section *59G-6.045, Florida Administrative Code Payment Methodology for Services in Facilities Not Publicly Owned and Not Publicly Operated.*[36]

[36] Florida Administrative Code. Rule 59G-6.045. Payment Methodology for Services in Facilities Not Publicly Owned and Not Publicly Operated. March 11, 2018. Available online. https://www.flrules.org/gateway/ruleNo.asp?id=59G-6.045

### *Developing and Implementing New Policies*

As discussed in Section 4, the first step AHCA must take to implement any option is to develop a clear definition of "severe behavioral needs." Under the purview of the Bureau of Medicaid Policy (Medicaid Policy), the newly created reimbursement level would need to be defined and all assessment staff would need to be trained on the new assessment category criteria. Medicaid Policy would also be responsible for disseminating, monitoring, and evaluating the programmatic changes and their application in partner state agencies, such as APD.

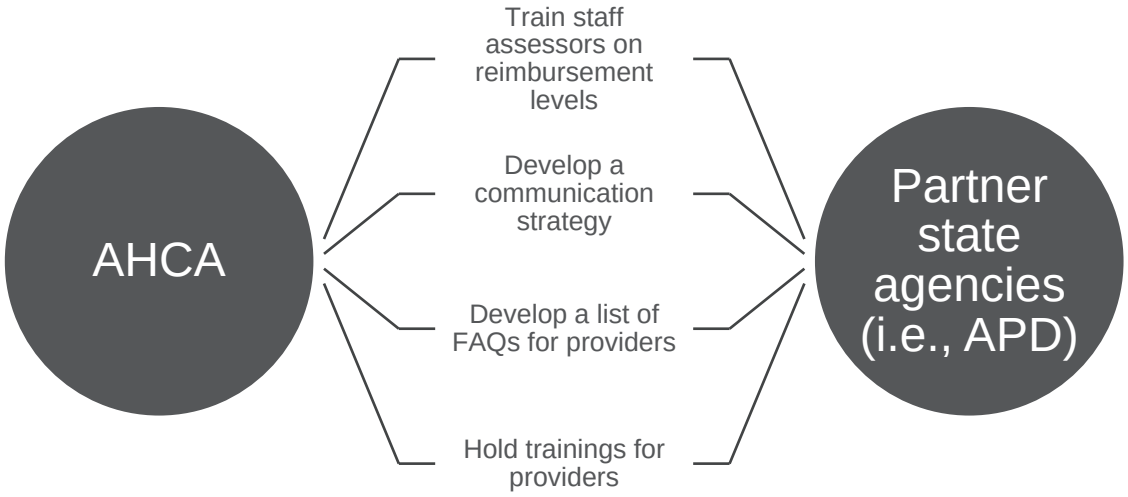
Policy changes needed under this option would require multiple levels of coordination both for internal agency stakeholders (i.e., all applicable AHCA Bureaus), external state agencies (i.e., APD, etc.), and external stakeholders (i.e., ICF/IID providers, Florida ARF, etc.).

To aid in coordination and policy adoption, other beneficial activities for Medicaid Policy or its designee to undertake regarding the new reimbursement level are:

1. Train assessors on policies within the new reimbursement level
2. Develop a communication strategy for all stakeholders (i.e., with AHCA, other state agencies, providers, etc.)
3. Develop a list of FAQs for providers in the ICF/IID industry
4. Provide training on the policy changes for providers in the ICF/IID industry

Navigant suggests a culture of open communication between AHCA, APD, and the ICF/IID industry to ensure a solution can be developed that is acceptable to all stakeholders and enables ICF/IIDs to become a viable option in which recipients with severe behavioral needs may receive high quality healthcare. Figure 6.4 highlights some recommended activities for AHCA, in conjunction with other state agencies, where needed, to facilitate smooth transition of administrative and policy changes. AHCA would also benefit from convening with their partner state agencies to discuss the proposed changes prior to submitting to CMS. This discussion should help AHCA reach agreement with APD, for example, regarding the assessment process and policies requiring a memorandum of understanding (MOU) to execute the re-assessment process.

**Figure 6.4 – AHCA Activities to Aide Coordination of Transition**




As previously described, each option would require effort from AHCA to make changes to the reimbursement methodology. When moving from Option One to Option Three on the continuum,

the level of coordination and initial level of effort needed within AHCA increases. Regardless of the option, it's critical to deploy strategies to aid in communication, training, and delegation of new responsibilities under a re-structured reimbursement methodology. In addition, partner state agencies have the potential to provide key aid to enact the changes effectively and efficiently.

### *Impact to Legislation*

Any increase in aggregate Medicaid reimbursement to ICF/IIDs would require legislative approval for use of additional state funds. In addition, implementation of a prospective payment system with standardized rates would likely require description of the new ICF/IID payment method to be added within section 409.908, *Reimbursement of Medicaid Providers*, of the Florida Statutes. This section does not include a description of the current ICF/IID payment method for non-public facilities. Thus, a less significant change, such as a change in the definition of Reimbursement Level 2 or addition of a Reimbursement Level 3 could likely be implemented with little or no changes to Florida Statutes.

## *Facility Expansion*

Although not directly tied to any of the three reimbursement options, expanding the number of ICF/IIDs in Florida is something that has been raised by the provider community. Florida has not approved a new facility since 1984.

In response to the Carlton Palms closure and an occupancy rate for existing ICF/IIDs above 95 percent as of April 2018, Sunrise Community, Inc. submitted a certificate of need (CON) application to open a new ICF/IID. The proposed facility would be a cluster facility with 24 additional beds that would be specifically designed to serve recipients with severe behavioral needs. Ultimately, AHCA denied Sunrise's application, in part citing Section 408.035(1)(f), Florida Statute, which requires a new ICF/IID facility to be able to demonstrate long-term financial feasibility. Since the new facility would increase capacity and accordingly the total ICF/IID population in the State, and since the facility (like all other ICF/IIDs in the state) would derive nearly 100 percent of its revenues from Medicaid, the Legislature would need to appropriate additional funding for ICF/IIDs for Sunrise to demonstrate long-term financial feasibility of the new facility. Rule 59C-1.034, Florida Administrative Code states that for an ICF/IID proposal to be approved, current legislative appropriations must be made for placements into the facility. In other words, without a budget increase, there would be no funding available to pay for services provided by the new facility.

## Section 7: Conclusion

The Florida ICF/IID Rate Study was intended to provide AHCA with options to modify the ICF/IID reimbursement methodology to address individuals with "severe behavioral needs." This report offers a continuum of options for changes to the current Florida Medicaid reimbursement methodology, context regarding Florida's and other states' ICF/IID landscapes, and insights into providers' perspective on the obstacles in the current ICF/IID reimbursement system.

Our major findings are summarized below:

- **Behavioral Needs Addressed in Rate Setting**
    - Several states use ICAP or SIS assessment tools, which include a behavioral component in the assessment. The tools are then used in determining the level of need, which is part of the overall reimbursement level rate.
- **Reimbursement Options**
    - Options One and Two are directly related to the Florida ARF's original request for AHCA to create either an "add-on" reimbursement rate, or a new reimbursement level. Option Three offers AHCA considerations should the Agency want to convert to a fully prospective payment system. Today, most states use a cost-based prospective payment system for ICF/IIDs. However, the Florida Legislature has demonstrated a preference in recent years to move away from cost-based reimbursement.
    - Depending on what AHCA chooses to modify in the ICF/IID reimbursement methodology, if anything, each option may be enacted in either a budget neutral manner or through an increase in Medicaid reimbursement to ICF/IIDs.

### *Next Steps*

Based on the rate study findings, one or more of the following next steps are suggested:

1. Develop a definition of "severe behavioral needs." This is a pre-requisite to choosing any of the options and should be the first step following AHCA's review of the report.
2. Meet with partner state agencies (i.e., APD) to aid in coordination and policy adoption.
3. Engage and debrief key external stakeholders, including agencies and individuals within the ICF/IID industry.
    - The Florida ARF should be included, as they represent provider organizations.
    - It would also be beneficial to include case managers, direct support workers, and other ancillary support staff to gauge and build support for the proposed changes to the payment structure and rate methodology, since they will be serving the recipients residing in ICF/IIDs and may provide additional considerations.

*Next Steps:*

1. *Develop a definition of "severe behavioral needs"*
2. *Meet with partner state agencies*
3. *Meet with key external stakeholders*
4. *Meet with key legislators and legislative staff*
5. *Conduct a brief ICF/IID provider study*

4. Meet with key legislators and legislative staff to discuss options for changes to reimbursement policy and to facilitate alignment across other state-level entities.
5. Confirm the Florida ARF's survey findings of the 88 private (non-public) ICF/IID providers by performing site visits to determine how many individuals with "severe behavioral needs" are currently receiving care within ICF/IIDs. This would determine how many individuals would be addressed by this new reimbursement rate and help AHCA to ultimately decide which option will be most appropriate to pursue.

# Appendix A – Florida ARF Provider Survey

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Suzanne Sewell
President & CEO

Jon Fisher
Board Chair

Zach Wray & Jim Weeks
Co-Chairs, ICF/IID Forum

**ICF/IID Survey**

On October 1, 2018, Florida ARF surveyed its ICF/IID member agencies to ask if the Level Two classification for ICF/IID levels of reimbursement was amended, or if there were a new level of reimbursement, to address the specific needs of individual ICF/IID recipients who have severe behavioral needs, how many individuals would meet the following criteria: Individuals with Intellectual Disabilities who are under the care of a Psychiatrist, are receiving Psychotropic Medications, and have Support Plans that indicate a need for behavioral analysis services to control or minimize self-injurious and/or aggressive behaviors?

In addition to the number of individuals currently served, we asked how many individuals sought placement within the last year who met the proposed criteria but were denied admission because the facility could not meet their behavioral needs? We explained it is understood many individuals who seek admission to ICF/IIDs take Psychotropic medications; however, Psychiatric diagnoses and Psychotropic medications alone would not qualify individuals for the new definition. We also explained the intent was to identify the number of individuals/referrals to ICF/IIDs who were not served because of their behavioral needs, ***but*** could be served if an overlay of additional services and staffing were available. Further, we explained that while rates have not been determined for a new level of reimbursement, early projections indicate the costs would probably run about $525 per day for cluster models and as high as $598 per day for six-bed facilities.

The responses to the survey are shown on the next page.

Florida ARF also contacted the ICF/IID consultant for the American Network of Community Options and Resources (ANCOR), Mark Dorio) who indicated that several states are struggling with this issue and several are looking at community options. And, we requested responses from other state ICF/IID programs who are ANCOR members. We received one response from the State of Maine who replied: "In Maine, our ICF's are cost-reimbursed with a prospective rate system. You can request an increase in staffing for individuals with high behaviors which may or may not be granted (Catherine Thibedeau, CEO, Independence Advocates of Maine, Orono, ME, (207) 866-3769, Ext. 103)."

**ICF/IID Survey on Severe Behavior Requests for ICF/IID Placement**

| Facility Name | No. of Beds | Residents Meeting Criteria | Severe Behavior Referrals - Denied | Facility Accepts Behaviors |
|---|---|---|---|---|
| Ann Storck | 72 | | | |
| ARC Broward | 36 | 25 | 0 | Yes |
| Care Centers of Nassau | 72 | 2 | 3 | Yes |
| Central FL Communities | 192 | 14 | 2 | Yes |
| Florida Mentor | 234 | 19 | 13 | Yes |
| Sandy Park | 64 | 3 | 2 | Yes |
| MACTown | 56 | 12 | 5 | Yes |
| New Vue – New Horizons | 48 | | | |
| PARC | 64 | | | |
| Pensacola Care | 316 | 44 | 20 | Yes |
| Fern Park | 64 | 10 | 2 | Yes |
| Quest | 72 | 0 | 0 | No |
| Res Care | 72 | | | |
| St. Augustine Ctr for Living | 60 | 0 | 2 | Yes |
| Sunrise | 396 | 11 | 4 | Yes |
| Woodhouse | 24 | | | |
| Salem Villages - RHA | 102 | 8 | 4 | Yes |
| UCO | 96 | 1 | 2 | Yes |
| New Horizons of N FL | 30 | | | |
| **Total** | 2070 | 149 | 59 | 12 |

Based on the above analysis, 12 of 19 ICF/IID provider groups would accept individuals with severe behaviors if an additional overlay of services were available that allowed for adequate services and supports. All ICF/IIDs were asked to respond to the survey and were contacted twice; six did not respond.

From the responses above, it appears about 10% of the population would meet the criteria for the definition we provided. Please note, the Arc Broward program is a predominantly behavior focused program.

# Appendix B – State Comparison Table

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**Appendix B: State Comparison Table – Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)**
*(Florida, Hawaii, New York, North Dakota, Texas, West Virginia, District of Columbia)*

| State | Summary of Rates & Behavioral Enhancements | Reimbursement Methodology[1] | Assessment Tool(s) | Behaviors Accounted for in Rates? (Y/N) |
|---|---|---|---|---|
| **Florida** | Florida ICF/IID Rate Sheet – Non-Public (Rates Effective as of July 1, 2018)[2]<br><br>**Calculating Rate:**<br>• Determine total allowable cost by reimbursement class for property cost, resident care cost, operating cost, and return on equity (ROE).<br>• Calculate per diems for each of the four cost components for the two reimbursement classes by dividing the component's cost by the appropriate number of resident days. | Prospective cost based per diem with limits, full per diem paid for leave days. | Comprehensive Functional Assessment (CFA) | No |
| **Hawaii** | Hawaii ICF/IID Rate Sheet – Appendix F: Long Term Care Rates (Rates Effective as of June 6, 2018) [3]<br><br>**Calculating Rate:** the sum of the applicable per diem amounts for the direct nursing, capital, and G&A components for each Provider and for the level of care that the provider is certified to provide. | Prospective cost based per diem with limits, full per diem paid for leave days. | ePASRR (Electronic Preadmission Screening and Resident Review) | No |
| **New York** | New York ICF/IID Rate Sheets (Rates Effective as of April 1, 2018)[4]<br><br>**Calculating Rate:**<br>ICF/IID funding is based on the net of day services and tax assessment reimbursement. Adjustments are incorporated for inflationary or other changes authorized pursuant to State law, including the salary and salary related fringe benefit increases for direct care, support and clinical staff that took effect (most recently, i.e., using the 4/1/18 rates).<br><br>**Behavioral Assessment / Enhancements:**<br>There is an option to indicate whether there are severe behavior problems on the LCED form. | Prospective cost based per diem with limits, full per diem paid for leave days. | ICF/MR-Level of Care Eligibility Determination (LCED) | Yes |
| **North Dakota** | North Dakota ICF/IID Rate Sheet (Rates Effective as of April 1, 2018)[5]<br><br>**Calculating Rate:**<br>• The rate established for ICF/IIDs is an all-inclusive rate for routine services. Routine services include supplies, therapies, nursing supplies, equipment, transportation, and non- | Cost based payment, full per diem paid for leave days. | • Supports Intensity Scale (SIS) for adults<br>• Inventory for Client and | Yes |

[1] Kaiser Family Foundation. *Medicaid Benefits: Intermediate Care Facility Services for Individuals with Intellectual Disabilities, 2012.* Available online. https://www.kff.org/medicaid/state-indicator/intermediate-care-facility-services-for-the-mentally-retarded/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[2] Florida Agency for Health Care Administration. Office of Medicaid Cost Reimbursement Planning and Finance. ICF/IID Planning Sheet. July 2018. Available online. http://ahca.myflorida.com/medicaid/cost_reim/pdf/ICF_Not_Public_Calc_July_2018.pdf
[3] Hawaii Department of Human Services. *Medicaid Fee-For-Service Rates Effective July 1, 2018.* Available online. https://medquest.hawaii.gov/content/dam/formsanddocuments/provider-memos/qi-memos/qi-memos-2018/QI-1809.pdf
[4] New York Department of Health. *Mental Hygiene Services Rates.* April 2018. Available online. https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/
[5] North Dakota. *ICF/IID Rate Matrix.* April 1, 2018. Available online.https://www.nd.gov/dhs/services/disabilities/docs/rate-matrix.pdf

**Appendix B: State Comparison Table – Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)**
*(Florida, Hawaii, New York, North Dakota, Texas, West Virginia, District of Columbia)*

| State | Summary of Rates & Behavioral Enhancements | Reimbursement Methodology[1] | Assessment Tool(s) | Behaviors Accounted for in Rates? (Y/N) |
|---|---|---|---|---|
| | legend drugs. Separate billings for these items will not be paid. Ancillary charges that are not included in the ICF/IID facility rate, such as x-ray, lab, drugs, etc. must be billed by the provider furnishing the service.<br><br>**Behavioral Assessment / Enhancements:**<br>• The SIS and ICAP assessments have behavioral components.<br>• ICAP Service Score (used for children) considers adaptive and behavior support needs.<br>• There is also an "ICF-ID Medically Intensive" Service Component in the rate sheet. | | Agency Planning (ICAP) for children | |
| **Texas** | Texas ICF/IID Facilities Rate Sheet (Rates Effective as of September 1, 2017)[6]<br><br>**Calculating Rate:**<br>• Each provider's total reported allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost-reporting period to the prospective reimbursement period as described in §355.108 of this title (relating to Determination of Inflation Indices).<br><br>**Behavioral Assessment / Enhancements:**<br>Individuals with a Level of Need (LON) of 1, 5, or 8 may be assigned to the next higher LON category if they have dangerous behaviors that require a behavior support plan (BSP) that includes preventive actions by additional provider staff. | • Private facilities paid acuity adjusted cost based per diem that varies by facility size.<br>• Cost based per diem for public facilities. | Inventory for Client and Agency Planning (ICAP) | Yes |
| **West Virginia** | Rate Sheet: WV ICF/IID-specific rate sheet inaccessible.<br><br>**Calculating Rate[7]**<br>• Individual facility client specific rates are established on a prospective basis, considering cost to be expected and allowable during the rate period. The rate is not subject to retrospective revision. This does not exclude corrections for errors or omissions of data, or reconciliation of audit findings related to falsification of data or overstatement of costs.<br><br>**Behavioral Assessment / Enhancements:**<br>• The accepted WV service level score (from the ICAP) determines the rate of reimbursement for the member. | • Private facilities paid prospective cost related and acuity adjusted per diem with limits based on operating costs plus capital.<br>• Leave days paid at the rate for lowest level of acuity. | Inventory for Client and Agency Planning (ICAP) | Yes |

[6] Texas Health and Human Services. *Intermediate Care Facilities Payment Rates.* September 1, 2017. Available online. https://rad.hhs.texas.gov/sites/rad/files/documents/long-term-svcs/2017/2017-09-icf-rates.pdf
[7] West Virginia Health & Human Resources. Bureau for Medical Services. June 6, 2016. Available online. https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20511%20-%20Intermediate%20Care%20Facilities%20for%20Individuals%20with%20Intellectual%20Disabilities%20%28ICF%20IID%29.pdf

**Appendix B: State Comparison Table – Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)**
*(Florida, Hawaii, New York, North Dakota, Texas, West Virginia, District of Columbia)*

| State | Summary of Rates & Behavioral Enhancements | Reimbursement Methodology[1] | Assessment Tool(s) | Behaviors Accounted for in Rates? (Y/N) |
|---|---|---|---|---|
| **District of Columbia** | District ICF/IID Rate Sheet (pages 20-22) (Rates Effective as of March 9, 2018) [8]<br><br>**Calculating Rate:**<br>• The rates for ICF/IID services are developed based on Fiscal Year (FY) cost data reported by providers of different sizes serving individuals at varying acuity levels. The rates vary based on staffing ratios, facility size, and beneficiary acuity level.<br>• The reimbursement methodology does tier based on acuity-factors of the resident and not just facility-size.<br><br>**Behavioral Assessment / Enhancements:**<br>• Acuity Level 3 (Extensive – Behavioral) – severe behavioral needs<br>• Acuity Level 5 (Pervasive) – severe behavioral needs plus 1:1 staffing | • Prospective cost based per diem with efficiency incentives, up to Medicare limits.<br>• Full per diem paid for leave days less one-to-one services. | Level of Need Assessment and Risk Screening Tool (LON) | Yes |

[8] District of Columbia Federal Register. Department of Health Care Finance. Medicaid Reimbursement for Intermediate Care Facilities. Volume 65, No. 10. March 9, 2018. Available online. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Medicaid%20Reimbursement%20for%20Intermediate%20Care%20Facilities%20for%20Individuals%20with%20Intellectual%20Disabilities%20Notice%20of%20Final%20Rulemaking_0.pdf

# Appendix C – District of Columbia ICF/IID Rate Calculation and Behavioral Tiers

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## DEPARTMENT OF HEALTH CARE FINANCE

## NOTICE OF FINAL RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02 (2017 Supp.)) and Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2013 Repl.)), hereby gives final notice of the intent to adopt amendments to Chapter 9 (Medicaid Program) and Chapter 41 (Medicaid Reimbursement for Intermediate Care Facilities for Individuals with Intellectual Disabilities) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), respectively entitled "Medicaid Program" and "Medicaid Reimbursement for Intermediate Care Facilities for Individuals with Intellectual Disabilities."

These final rules update the reimbursement methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). Each ICF/IID may be reimbursed when the Medicaid beneficiary is hospitalized or on a therapeutic leave of absence. The rules governing reserved bed days for nursing facilities and ICFs/IID are set forth in § 950 (Payment for Reserved Beds) of Chapter 9. These proposed rules repeal the reserve bed day sections governing ICFs/IID in section 950. These sections are now included as a new § 4117 to ensure that all the rules governing reimbursement for ICFs/IID are included in one chapter. In addition, the "hospitalization" and "therapeutic leave of absence" categories of reserved bed days have been combined to afford increased flexibility in the utilization of reserved bed days.

The reimbursement methodology is amended as follows: (1) in § 4101.14 the frequency of acuity level assessments has been extended for low-acuity beneficiaries from once every twelve (12) months to once every three (3) years to lessen the administrative burden on providers and beneficiaries; (2) in § 4107 the requirements to spend a certain percentage of Medicaid reimbursement funds on direct service delivery have been modified to require providers to expend ninety-five percent (95%) of funds in the Direct Service cost center and one-hundred percent (100%) of funds in the Active Treatment cost center, allowing providers to shift unspent reimbursement funds among certain other cost centers to cover over-expenditure in those cost centers; and (3) in § 4105 the rebasing timeline has been changed from FY17 to FY18 due to the length of time to complete the audit process for provider cost reports and ongoing provider appeals associated with the cost report audit process. The aggregate impact of these changes is $ 260,647.85 in FY18 and $ 269,509.88 in FY19.

A Notice of Emergency and Proposed Rulemaking was published in the *D.C. Register* on October 27, 2017 at 64 DCR 011222. DHCF received no comments. DHCF is making technical corrections in §§ 4105 and 4107 to clarify that certain changes to ICFs/IID provider reimbursement methodology are effective November 1, 2017, the effective date of the corresponding State Plan Amendment (SPA). Finally, DHCF is proposing a technical change to § 4105.2, to clarify that updated rates for ICF/IID services, effective January 1, 2018, are included in the Medicaid Fee Schedule located on the DHCF website at https://www.dc-

medicaid.com/dcwebportal/nonsecure/feeScheduleDownload. A public notice of the Medicaid Fee Schedule update was published in the *D.C. Register* on at 64 DCR 012357 on December 1, 2017.

The corresponding amendment to the District of Columbia State Plan for Medical Assistance (State Plan) was approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) and the Council of the District of Columbia (Council). The Council approved the corresponding SPAs through the Fiscal Year 2018 Budget Support Emergency Act of 2017, on July 20, 2017 (D.C. Act 22-104). CMS approved the corresponding SPA on November 6, 2017 with an effective date of November 1, 2017.

This final rule was adopted on February 26, 2018, and shall become effective on the date of publication of this notice in the *D.C. Register.*

**Chapter 9, MEDICAID PROGRAM, of Title 29 DCMR, PUBLIC WELFARE, is amended as follows:**

**Section 950, PAYMENT FOR RESERVED BEDS, is amended to read as follows:**

**950 PAYMENT FOR RESERVED BEDS**

950.1 Vendor payment for reserved bed days for hospitalization or therapeutic leaves of absence, for a resident of a nursing facility, when provided in the resident's plan of care, shall not exceed eighteen (18) days during any fiscal year, if there is a reasonable expectation that the resident will return to the nursing facility.

950.2 **[REPEALED]**

950.3 **[REPEALED]**

950.4 Payment for reserved bed days authorized in accordance with section 950.1 shall equal one hundred (100) percent of the facility's per diem rate.

950.5 **[REPEALED]**

950.6 Each resident shall reside in the nursing facility for at least one (1) day as a condition of vendor payment for reserved bed days.

950.7 Each provider shall require the family member or caregiver to sign a leave and request form upon exit and return to the facility. The provider shall ensure that each family member or caregiver provide contact information.

950.8 Each provider shall discuss the resident's medical regimen with the family member or caregiver. The provider shall ensure that each family member or

caregiver is provided a sufficient quantity of the resident's medication for the leave period.

950.9 Each provider shall report to DHCF any unusual incident that occurred during any therapeutic leave of absence.

**Chapter 41, MEDICAID REIMBURSEMENT FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES, of Title 29 DCMR, PUBLIC WELFARE, is amended to read as follows:**

**Section 4101, ACUITY LEVEL ASSIGNMENTS, is amended as follows:**

**4101 ACUITY LEVEL ASSIGNMENTS**

4101.1 Reimbursement rates shall be differentiated based on the individual's acuity level, as recommended by DDS, through the Level of Need Assessment and Risk Screening Tool (LON), and interdisciplinary teams of health and habilitation professionals, pursuant to the Individual Service Plan (ISP).

4101.2 Acuity levels higher than Acuity Level 1 (Base), specific to the medical and health needs of each qualified individual, shall be requested by the ICF/IID, recommended by DDS, and approved by DHCF.

4101.3 Reimbursement under this chapter shall be governed according to the following acuity levels:

(a) Acuity Level 1 (Base) shall represent the health, habilitation, and support needs of a beneficiary whose level of care determination (LOC) reflects a need for ICF/IID services. Acuity Level 1 shall be the base acuity level.

(b) Acuity Level 2 (Moderate) shall represent the health, habilitation, and support needs of a beneficiary who:

(1) Meets the requirements of § 4101.3(a); and

(2) Requires moderate levels of services in order to effectively support functional impairments, as described in § 4101.6.

(c) Acuity Level 3 (Extensive – Behavioral) shall represent the health, habilitation, and support needs of a beneficiary who:

(1) Meets the requirements of § 4101.3(a); and

(2) Requires services and interventions that can address conditions associated with an extensive intellectual and developmental

disability and significant behavioral challenges as described in § 4101.7.

(d) Acuity Level 4 (Extensive – Medical) shall represent the health, habilitation, and support needs of a beneficiary who:

(1) Meets the requirements of § 4101.3(a); and

(2) Requires services and interventions that can address conditions associated with a significant intellectual and developmental disability and significant medical and support challenges as described in § 4101.8.

(e) Acuity Level 5 (Pervasive) shall represent the health, habilitation, and support needs of a beneficiary who:

(1) Meets the requirements of § 4101.3(a);

(2) Requires services and interventions that can address conditions associated with a pervasive intellectual and developmental disability; and

(3) Exhibits dangerous behaviors or conditions that require one-to-one (1:1) supervision for twenty-four (24) hours per day or less, as described in § 4101.9.

(f) Acuity Level 6 (Pervasive Plus Skilled Nursing) shall represent the health, habilitation, and support needs of a beneficiary who:

(1) Meets the requirements of § 4101.3(a);

(2) Requires services and interventions that can address conditions associated with a pervasive level of care to accommodate individuals with dangerous behaviors or conditions that require one to one (1:1) supervision twenty-four (24) hours per day; and

(3) Requires extensive skilled nursing services as described in § 4101.10.

4101.4 For purposes of reimbursement, a beneficiary admitted on or after October 1, 2012, shall be assumed to be at Acuity Level 1 (Base). An ICF/IID may request through, and with supporting documentation by, DDS that DHCF assign a beneficiary to a higher acuity level. This request must be accompanied by documentation submitted by the ICF/IID that justifies the higher acuity level.

4101.5 In order for a beneficiary to qualify at an acuity level above Acuity Level 1 (Base), the ICF/IID shall ensure that qualified health and habilitation practitioners assess each beneficiary using the LON.

4101.6 A beneficiary shall qualify for Acuity Level 2 (Moderate) when assessed to have at least one (1) of the following characteristics:

(a) Is unable to perform two (2) or more activities of daily living (ADL);

(b) Is non-ambulatory;

(c) Is unable to evacuate self without assistance in the event of a fire or other emergency situation;

(d) Is assessed to lack life safety skills to ensure self-preservation; or

(e) Has a diagnosis of one (1) of the following conditions:

(1) Blindness;

(2) Deafness;

(3) Autism Spectrum Disorder; or

(4) Epilepsy.

4101.7 A beneficiary shall qualify for Acuity Level 3 (Extensive – Behavioral) when he or she is dually diagnosed with an intellectual and developmental disability and with one (1) or more behavioral disorders that:

(a) Are assaultive, self-abusive, including pica, or aggressive;

(b) Require a Behavior Support Plan (BSP) which shall be based on current data and targets the identified behaviors; and

(c) Require intensive staff intervention and additional staff resources to manage the behaviors set forth in § 4101.8(a).

4101.8 A beneficiary shall qualify for Acuity Level 4 (Extensive – Medical) when he or she requires skilled nursing and extensive health and habilitation supports on a daily basis. Skilled nursing and extensive health and habilitation supports shall be prescribed by the individual's primary care physician or advanced practice registered nurse (APRN).

4101.9 A beneficiary shall qualify for Acuity Level 5 (Pervasive) when he or she requires one-to-one (1:1) staffing and exhibits one (1) or more of the following characteristics:

(a) Has a history of, or is at high risk for, elopement resulting in risk to the beneficiary or others;

(b) Exhibits behavior that is life-threatening to the beneficiary or others;

(c) Exhibits destructive behavior that poses serious property damage, including fire-setting;

(d) Is a sexual predator; or

(e) Has a history of, or is at high risk for, falls with injury and a primary care physician or advanced practice registered nurse order for one-to-one (1:1) supervision.

4101.10 A beneficiary shall qualify for Level 6 (Pervasive Plus Skilled Nursing) if the beneficiary requires at least one (1) type of skilled nursing that shall be ordered by a primary care physician or advanced practice registered nurse and provided, at a minimum, on an hourly basis.

4101.11 For a beneficiary who requires services at or above Acuity Level 4, the prescription of the physician or advanced practice registered nurse, shall specify the type, frequency, scope, and duration of the skilled nursing and health and habilitation support services required.

4101.12 The number of one-to-one (1:1) staffing hours shall be approved by DHCF using results from assessments conducted by ICFs/IID. Under Levels 5 and 6 (Pervasive and Pervasive Plus Skilled Nursing), DHCF's approval shall be based on having staff member(s) assigned to the beneficiary who have no other duties while assigned to the beneficiary.

4101.13 Each ICF/IID shall have responsible direct care staff on duty and awake on a twenty-four (24) hour basis when residents are present in the facility to ensure prompt, appropriate action in the event of injury, illness, fire, or other emergency.

4101.14 Acuity level assignments shall be recertified every three (3) years for beneficiaries assigned Acuity Level 1 through 4, and annually for beneficiaries assigned Acuity Level 5 or 6. Each ICF/IID shall be responsible for requesting recertification of the beneficiary's acuity level assignment by compiling and submitting the beneficiary's information in the required format(s) at least twenty (20) days before the ISP effective date. Each ICF/IID shall ensure that the individual has an approved acuity level assignment by the ISP effective date. At minimum, the ICF/IID shall provide DHCF with the following:

(a) Level of Need Assessment and Risk Screening Tool (LON); and

(b) Current ISP document including medical, psychological, occupational or physical therapy assessment, or in the absence of a current ISP document, evidence of consensus by a majority of the members of the beneficiary's interdisciplinary team for the proposed acuity level assignment.

4101.15 Late submission of the documentation required for recertifications as set forth in § 4101.14 shall result in payment at the rates that correspond to Acuity Level 1 (Base) beginning on the first day following the expiration of the assignment. DHCF shall not make retroactive adjustments to the reimbursement rates for late submissions of recertification documentation.

4101.16 Additional documentation shall be required to support the acuity level assignment for a beneficiary. Depending on acuity level, additional documentation shall be required as follows:

(a) For Acuity Level 3 (Extensive – Behavioral) the following additional documentation is required:

(1) A BSP addressing the targeted behaviors;

(2) A written behavior plan that shall be based on current data and which targets the identified behaviors; and

(3) A concise statement that summarizes thirty (30) days of behavioral data prior to the date of the request and justification of the need for intensive staff intervention and additional staff resources to manage targeted behaviors.

(b) For Acuity Level 4 (Extensive – Medical) documentation that includes an order for daily skilled nursing and extensive health supports prepared by the beneficiary's primary care physician or an advance practice registered nurse is required.

(c) For Acuity Level 5 (Pervasive) the following additional documentation is required:

(1) A concise statement setting forth the presenting problem that necessitates one to one (1:1) supervision and the number of requested one to one (1:1) hours;

(2) Evidence of a history or risk of elopement that results in risk to the beneficiary and/or others;

(3) Evidence of behavior that is life threatening to self and/or others;

(4) Evidence of destructive behavior causing serious property damage, including fire starting;

(5) Evidence of sexually predatory behavior;

(6) Evidence of a history of, or risk of, falls with injury, and an order from the beneficiary's primary care physician or APRN;

(7) A BSP that shall be based on current data and targets the behaviors identified;

(8) A job description for one to one (1:1) staff based on the beneficiary's individual needs; and

(9) Thirty (30) days of behavioral data prior to the date of the request in support of the targeted behaviors.

(d) For Acuity Level 6 (Pervasive plus Skilled Nursing) the following additional documentation is required:

(1) An order for skilled nursing services prepared by the beneficiary's primary care physician or APRN;

(2) A concise statement setting forth the presenting problem that necessitates one to one (1:1) supervision and skilled nursing and the number of requested one to one (1:1) hours; and

(3) A job description for one to one (1:1) staff based on the beneficiary's individual needs.

4101.17 Documentation required to review a beneficiary's acuity level shall be submitted to DHCF within sixty (60) days of the event that necessitates assignment to a higher acuity level.

4101.18 On a case-by-case basis, DHCF shall consider requests for retroactive adjustment to a beneficiary's acuity level that may result in a change to the reimbursement rate. DHCF decisions shall be based on the facility's submission of required documentation as set forth below:

(a) A concise statement setting forth the situation that necessitates retroactive adjustment;

(b) Evidence of the higher acuity level for the specified period of time for which the change in acuity level is requested. This evidence shall include

the LON and other clinical and professional documentation such as discharge planning notes, physician's notes, other clinician's notes, interdisciplinary team meeting notes, and healthcare reports for the same defined period of time; and

(c) Evidence that a higher level of service was delivered for the defined period and that the higher level of service delivered is that required for the higher acuity level. This evidence shall include documentation of staffing levels detailing hours and types of services delivered for each day in the defined period of time. Evidence shall also include the identity of the specific staff delivering the higher acuity services and an attestation from the staff of the higher acuity service they delivered.

4101.19 Any retroactive adjustment based on § 4101.18 shall be limited to the time that has lapsed since the date of the beneficiary's last continuous stay review, as set forth in § 4109.

4101.20 DHCF, or its designee, shall have access to all approved ISP documents.

4101.21 Each ICF/IID shall notify DHCF of the transfer or death of a beneficiary at least seven (7) business days after the date of the event.

**Section 4102, REIMBURSEMENT METHODOLOGY, is amended as follows:**

**4102 REIMBURSEMENT METHODOLOGY**

4102.1 The rates for ICF/IID services were developed based on Fiscal Year (FY) 2010 cost data reported by providers of different sizes serving individuals at varying acuity levels. The rates shall vary based on staffing ratios, facility size, and beneficiary acuity level.

4102.2 For the purposes of rate-setting, and independent of the classification used by the Department of Health for licensing, DHCF shall classify ICFs/IID as follows:

(a) Class I - A facility with five (5) or fewer licensed beds; and

(b) Class II - A facility with six (6) or more licensed beds.

4102.3 The residential component of the rate, as described in § 4100.5(a), shall be based on a model that includes the following seven (7) cost centers:

(a) The "Direct Service" cost center, which shall include expenditures as follows:

(1) Nurses, including registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs);

(2) Qualified Intellectual Disabilities Professionals (QIDPs);

(3) House managers;

(4) Direct Support Personnel;

(5) Allocated time of staff with administrative duties and who are also utilized in direct service support, subject to the results of a time study or time sheet process that has been approved by DHCF; and

(6) Fringe benefits, including but not limited to required taxes, health insurance, retirement benefits, vacation days, paid holidays, and sick leave.

(b) The "All Other Health Care and Program Related" cost center, which shall include expenditures for:

(1) Pharmacy co-pays and over-the-counter medications;

(2) Medical supplies;

(3) Therapy costs, including physical therapy, occupational therapy, and speech therapy;

(4) Behavioral health services provided by psychologists or psychiatrists;

(5) Nutrition and food;

(6) Medical record maintenance and review;

(7) Insurance for non-direct care health staff;

(8) Quality Assurance;

(9) Training for direct care staff;

(10) Program development and management, including recreation;

(11) Incident management; and

(12) Clothing for beneficiaries.

(c) The "Non-Personnel Operations" cost center, which shall include expenditures for:

(1) Food service and supplies related to food service;

(2) Laundry;

(3) Housekeeping and linen; and

(4) Non-capital repair and maintenance.

(d) The "Administration" cost center which shall include expenditures for:

(1) Payroll taxes;

(2) Salaries and consulting fees to non-direct care staff;

(3) Insurance for administrators and executives;

(4) Travel and entertainment;

(5) Training costs;

(6) Office expenses;

(7) Licenses;

(8) Office space rent or depreciation;

(9) Clerical staff;

(10) Interest on working capital; and

(11) Staff transportation.

(e) The "Non-Emergency Transportation" cost center, which shall include expenditures for:

(1) Vehicle license, lease, and fees;

(2) Vehicle maintenance;

(3) Depreciation of vehicle;

(4) Staffing costs for drivers and aides not otherwise covered by, or in excess of costs for, direct support personnel;

(5) Fuel; and

(6) Vehicle insurance.

(f) The "Capital" cost center, which shall include expenditures for leased, owned, or fully depreciated properties, less all amounts received for days reimbursed pursuant to the "Policy on Reserved Beds," as set forth on page 2 of Attachment 4.19C of the State Plan for Medical Assistance, for the following:

(1) Depreciation and amortization;

(2) Interest on capital debt;

(3) Rent;

(4) Minor equipment;

(5) Real estate taxes;

(6) Property insurance;

(7) Other capital; and

(8) Utilities, including electricity, gas, telephone, cable, and water.

(g) The "Stevie Sellows Intermediate Care Facility for the Intellectually and Developmentally Disabled Quality Improvement Fund Assessment" cost center shall include only the allowable share of the Assessment expenditure consistent with 42 U.S.C. § 1396(b)(w) and 42 C.F.R. §§ 433.68, 433.70 and 433.72.

4102.4 Fiscal Year (FY) 2013 rates shall be based on FY 2010 cost data reported by providers, legal requirements, and industry standards, and shall be paid for services delivered beginning on October 1, 2012 through September 30, 2013. FY 2013 rates, and all rates thereafter, shall be set forth in this Chapter. FY 2013 rates were developed based upon the following assumptions:

(a) FY 2013 Non-Personnel Operations per diem rates shall be based on FY 2010 costs, inflated twelve percent (12%);

(b) FY 2013 Capital per diem rates shall be based on FY 2010 costs, inflated fifteen percent (15%);

(c) FY 2013 rates for the cost centers described in §§ 4102.4(a) and (b) shall be calculated as the quotient of total industry expenditures divided by the total number of industry licensed bed days as reported for FY 2010;

(d) The FY 2013 rate for Non-Emergency Transportation shall be eighteen dollars ($18) per person, per day; and

(e) Capital expenditures for Class I and Class II facilities shall be calculated separately.

4102.5 FY 2014 rates shall be based on the reported FY 2013 cost reports, adjusted for inflation, in accordance with the index described in § 4102.13. In establishing the rates for FY 2014, DHCF shall use FY 2013 rates as a baseline to compare to the FY 2013 cost reports. After inflationary adjustments, DHCF may make operational adjustments as described in this section to each cost center based on the provider's actual reported costs. These adjustments may increase or decrease the per diem rates for each cost center. For services rendered on or after January 1, 2014, DHCF shall also incorporate the following rate setting principles:

(a) Effective January 1, 2014, and on October 1, annually thereafter, DHCF may make appropriate outlier adjustments when the entire ICF/IID provider community experiences uncharacteristically low or high costs (*e.g.*, wage increases) experienced by the entire ICF/IID provider community and supported by legislative or other unanticipated changes. With respect to the Capital cost center, market induced fluctuations in the cost of items comprising that rate (*e.g.*, property appreciation/depreciation, significant increase in the cost of utilities, etc.) shall be documented and confirmed using information from the Bureau of Labor Statistics, the Consumer Price Index, the District of Columbia Office of Tax and Revenue, and other relevant indices or reports;

(1) All adjustments shall be limited to one (1) time in any given fiscal year.

(2) Except for the Capital cost center, operational adjustments shall be subject to a five percent (5%) maximum. Operational adjustments to the Capital cost center shall be subject to a maximum of ten percent (10%);

(3) An outlier adjustment shall not exceed the amount of the rebased cost center, subject to the upper payment limit;

(4) Except for inflationary adjustments, all other adjustments under this section shall be supported through provider documentation and data reflecting the economic landscape of the Washington, D.C. Metropolitan area;

(5) All adjustments described in § 4102.5 shall be limited to fiscal years when rebasing does not occur;

(6) "Operational Adjustment" shall refer to an adjustment made to any cost center based on information reflected in an ICF/IID's cost report (*i.e.*, actual reported costs). These reported costs will be compared to the actual reported aggregate costs for all ICF/IIDs. An operational adjustment provides a mechanism for DHCF to address under- or over-payments that are identified after comparing the projections used to determine the rate with the provider's actual costs; and

(7) "Outlier Adjustment" shall refer to an adjustment made after the ICF/IID submits a cost report and the actual reported costs reflect uncharacteristically low or high costs. In order to qualify for an outlier adjustment, the unexpected expense must impact all of the District's ICF/IIDs.

(b) Effective January 1, 2014, the rate for Non-Emergency Transportation shall be twelve dollars and sixteen cents ($12.16).

4102.6 For dates of service on or after October 1, 2016 through September 30, 2017, final reimbursement rates for the residential component will be based on providers' FY 2014 cost reports subject to audit and adjustment by DHCF.

4102.7 Direct Service cost center reimbursement rates shall be calculated based on staffing ratios, facility size, and individuals' acuity levels. All rates shall accommodate the following staffing patterns:

(a) Two (2) Direct Support Personnel (DSP) at three (3) shifts per day for three hundred sixty-five (365) days per year, at the following staffing ratios:

(1) Class I Facilities: One (1) DSP to every two (2) individuals (1:2); and

(2) Class II Facilities: One (1) DSP to every three (3) individuals (1:3).

(b) One (1) LPN for each facility at one (1) shift per day for three hundred sixty-five (365) days per year, for all ICFs/IID;

(c) One (1) additional LPN for each ICF/IID at one (1) shift per weekend day (Saturday and Sunday) for fifty-two (52) weeks per year. This staffing pattern shall apply only to Class II facilities;

(d) One (1) RN, one (1) QIDP, and one (1) house manager, each at one (1) shift per day for two hundred sixty (260) days per year, at a ratio of one (1) staff person to every twelve (12) individuals (1:12) for all ICFs/IID;

(e) For services provided to individuals assigned to acuity levels higher than Acuity Level I, an ICF/IID shall be paid rates that can accommodate additional staffing needs as follows:

(1) Acuity Level 2 (Moderate) rates shall also include one (1) additional DSP at three (3) shifts per day for three hundred sixty-five (365) days per year, at a staffing ratio of one (1) DSP for every two (2) individuals (1:2) for all ICFs/IID;

(2) Acuity Level 3 (Extensive – Behavioral) rates shall also include costs associated with two (2) additional DSPs. The rates for Acuity Level 3 shall include one (1) DSP at three (3) shifts per day for three hundred sixty-five (365) days per year, at a staffing ratio of one (1) DSP staff member for every two (2) individuals for all ICFs/IID. The rate shall also include one (1) DSP at two (2) shifts per day for three hundred sixty-five (365) days per year, at a staffing ratio of one (1) DSP staff member for every two (2) individuals for all ICFs/IID;

(3) Acuity Level 4 (Extensive – Medical) rates shall also include costs associated with one (1) additional LPN at two (2) shifts per day for three hundred sixty-five (365) days per year, for all ICFs/IID. Class II facilities shall also receive a rate that includes one (1) certified nurse aide (CNA) at two (2) shifts per day for three hundred sixty-five (365) days per year;

(4) Acuity Level 5 (Pervasive) rates shall vary based on the number of one-to-one services prescribed for a beneficiary. Acuity Level 5 rates shall also include one (1) DSP at two (2) or three (3) shifts per day, for five (5) or seven (7) days per week for fifty-two (52) weeks per year, at a staffing ratio of one (1) DSP to one (1) beneficiary (1:1); and

(5) Acuity Level 6 (Pervasive Plus Skilled Nursing) rates shall vary based on the number of one-to-one services prescribed for a beneficiary. Acuity Level 6 rates shall also include one (1) LPN at one (1), two (2), or three (3) shifts per day for seven (7) days per week for fifty-two (52) weeks per year, at a staffing ratio of one (1) LPN to one (1) beneficiary (1:1).

(f) The base salaries used in the development of FY 2013 rates for direct care staff wages and salaries, subject to adjustment for inflation using the Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Market Basket Index, shall be as follows:

(1) DSP: Twelve dollars and fifty cents ($12.50) per hour;

(2) LPN: Twenty one dollars ($21.00) per hour;

(3) CNA: Sixteen dollars and eighty-three cents ($16.83) per hour;

(4) House Manager: Forty-five thousand dollars ($45,000) per year;

(5) RN: Seventy thousand dollars ($70,000) per year; and

(6) QIDP: Sixty thousand dollars ($60,000) per year.

(g) Salaries set forth in Section 4102.7(f) shall be treated as follows:

(1) "Paid time off" shall include the addition of eighty (80) hours of paid leave. Holiday pay shall include the addition of forty-four (44) hours to ensure that the rate includes the rate of pay plus one-half (1/2) the rate of pay (time and one-half) for holidays worked;

(2) Salaries shall be inflated by twenty percent (20%) and paid leave and holiday pay shall be inflated by twelve percent (12%), to accommodate fringe benefits; and

(3) All rates shall include paid time off and holiday pay for all hourly full-time equivalents (FTEs).

(h) Effective October 1, 2013 through September 30, 2016, Direct Care Staff Compensation shall be inflated by the greater of any adjustment to the living wage or the associated costs of benefits and inflation based on the CMS Skilled Nursing Facility Market Basket Index or other appropriate index if the CMS Skilled Nursing Facility Market Basket Index is discontinued.

(i) Effective October 1, 2016, Direct Care Staff Compensation shall be inflated only by any adjustment to the living wage.

4102.8 The "All Other Health Care and Program Related Expenses" cost center reimbursement rates shall be calculated based on the facility size and the "Direct Care" cost center rate, which varies by staffing ratios and individuals' acuity levels. The rate for this cost center shall be calculated as a fixed percentage of the rate for direct services, at twelve percent (12%) for Class I facilities and at seventeen percent (17%) for Class II facilities.

4102.9 The "Non-Personnel Operations" cost center reimbursement rates shall be calculated based on industry average reported costs. The Non-Personnel Operations reimbursement rate shall be equal to the industry average reported

expenses per licensed bed day for the line items included in the cost center, and shall be uniformly set for all providers.

4102.10 During FY 2013, the "Administration" cost center reimbursement rates shall be calculated based on the staffing ratios, facility size, and individuals' acuity levels. The Administration reimbursement rate shall vary based on the nature of ownership of the physical premises where the ICF/IID is housed. The Administration rate shall be a uniform percentage of the sum of the rates for all other cost centers and acuity levels. Beginning January 1, 2014, and on October 1, 2014 and annually thereafter, reimbursement rates for the Administration cost center shall be uniform for Class I and Class II facilities. The Administration rate shall be a uniform percentage of the sum of the Acuity Level I (Base) rates comprising the Residential cost center for leased, Class I facilities, as set forth in this Chapter.

4102.11 The "Non-Emergency Transportation" cost center reimbursement rates shall be based on the industry average expenses divided by the total number of licensed bed days. Beginning January 1, 2014, and on October 1, 2014 and annually thereafter, Non-Emergency Transportation cost center reimbursement rates shall be based on actual, reported costs.

4102.12 The "Capital" cost center reimbursement rates shall be determined in accordance with 42 C.F.R. § 413.130 and based on the industry average reported expenses per licensed bed day for the line items included in this cost center as described in § 4102.3. The rate shall vary based on the nature of ownership of the physical premises where the ICF/IID is housed. The Capital rate for leased premises shall be equal to the industry average reported expenses per licensed bed day for the line items included. The Capital rate for provider-owned premises shall be equal to fifty percent (50%) of the rate for leased premises. The Capital rate for fully depreciated premises shall be equal to fifty percent (50%) of the rate for provider owned premises. The Capital rate shall also be subject to the following principles:

(a) When a sale/leaseback of an existing ICF/IID facility occurs, the ICF/IID's allowable capital related cost may not exceed the amount that the seller/lessor would have recorded had the seller/lessor retained legal title;

(b) Depreciation shall incorporate the following principles:

(1) When depreciated buildings and building improvements are acquired, the cost basis of the depreciable asset shall be the lesser of the cost or acquisition value of the previous owner(s) less all reimbursement attributable to the asset as determined by DHCF or the fair market value of the asset at time of acquisition. Notwithstanding, if the seller makes the full payback in accordance

with § 4102.12(b)(6), the cost basis to the new owner shall be the lesser of the fair market value or the purchase price;

(2) Facilities shall employ the straight-line method for calculating depreciation subject to the limits set forth in §§ 4102.12(b)(3)-(6) below. Accelerated methods for calculating depreciation shall not be allowed. Subject to the limits set forth in §§ 4102.12(b)(3)-(6), the annual depreciation expense of an asset shall be determined by dividing the basis of the asset reduced by any estimated salvage or resale value by the estimated years of useful life of the asset at the time it is placed in service;

(3) Depreciation expense of buildings and building improvements shall be limited to the basis of each asset and shall not exceed the basis of such assets less the aggregate amount received in reimbursement for such assets in the current and prior years;

(4) Fully depreciated buildings and building improvements subsequently sold or disposed of shall be subject to payback by the owner to the program of all depreciation expense paid to the owner and all previous owners when such assets are no longer used to provide ICF/IID services or have been transferred to new owners in an arm's length transaction, provided that such payback shall be reduced by all amounts previously paid back, if any, by prior owners;

(5) ICFs/IID shall estimate assets' years of useful life in accordance with the most recent edition of "Estimated Useful Lives of Depreciable Hospital Assets" published by the American Hospital Association, or if not applicable, relevant guidance issued by the U.S. Internal Revenue Service. Subject to the limits set forth in paragraphs (d) and (e), depreciation expense for the year of disposal can be computed by using either the half-year method or the actual time method;

(6) Assets shall be recorded using historical cost, except for donated assets which shall be recorded at fair market value at the time received and based on the lesser of at least two (2) bona fide appraisals. Costs during the construction of an asset, consulting and legal fees, interest, and fund raising, should be capitalized as a part of the cost of the asset;

(7) When an asset is acquired by a trade-in, the cost of the new asset shall be the sum of the book value of the old asset and any cash or issuance of debt as consideration paid;

(8) Facilities that previously did not maintain fixed asset records and did not record depreciation in prior years shall be entitled to any straight-line depreciation of the remaining useful life of the asset. The depreciation shall be based on the cost of the asset or fair market value of a donated asset at the time of purchase, construction or donation over its normal useful life. Fully depreciated assets shall not be included in the Capital cost center, except for the costs associated with utilities and relevant leasehold improvements. No depreciation may be taken on an asset that would have been fully depreciated if it had been properly recorded at the time of acquisition;

(9) Leasehold improvements made to rental property by the lessor shall be depreciated over the lesser of the asset's useful life or the remaining life of the lease;

(c) On a case by case basis, DHCF may reimburse an ICF/IID by providing an offset to capital costs that shall be equal to the daily amount computed under this subsection in situations when DDS has not filled vacant bed space(s). The ICF/IID shall receive the product of the capital cost multiplied by the administrative rate anytime this payment is made;

(d) The daily cost described in § 4102.12(c) shall be computed as the capital component of the daily per-diem rate, multiplied by the number of vacant bed space(s); and

(e) ICFs/IID shall incur costs and provide DHCF with proof of the vacant bed space in order to be eligible.

4102.13 Effective October 1, 2013 through September 30, 2016, the per diem rates for "Non-Personnel Operations," "Non-Emergency Transportation," "Capital," and "Active Treatment" cost centers shall be adjusted for inflation on an annual basis in accordance with the Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Market Basket Index or other appropriate index if the CMS Skilled Nursing Facility Market Basket Index is discontinued.

4102.14 Effective October 1, 2016, the annual inflation adjustment in the per diem rates for "Non-Personnel Operations," "Non-Emergency Transportation," "Capital," and "Active Treatment" cost centers shall be eliminated.

4102.15 The Stevie Sellows Intermediate Care Facility for the Intellectually and Developmentally Disabled Quality Improvement Fund Assessment shall be a broad based assessment on all ICF/IID providers in the District of Columbia at a uniform rate of five and one-half percent (5.5%) of each ICF/IID's gross revenue. The allowable cost of the Assessment shall be calculated consistently with 42 U.S.C. § 1396(b)(w) and 42 C.F.R. §§ 433.68, 433.70, and 433.72.

4102.16 Beginning October 1, 2016, ICF/IID reimbursement rates, shall be as follows:

| | Beds | Facility | Direct care staffing FY 17 | Other health care & program FY 17 | Non-Pers Oper FY 17 | Transp. FY 17 | Capital FY 17 | Admin FY 17 | Active Tx FY 17 | Tax FY 17 | Total Rate FY 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Base | 4 - 5 | Leased | $320.02 | $41.60 | $19.77 | $12.57 | $61.30 | $59.19 | $90.14 | $33.25 | $637.85 |
| | | Owned | $320.02 | $41.60 | $19.77 | $12.57 | $30.65 | $59.19 | $90.14 | $31.57 | $605.51 |
| | | Depreciated | $320.02 | $41.60 | $19.77 | $12.57 | $15.33 | $59.19 | $90.14 | $27.47 | $589.34 |
| | 6 | Leased | $240.73 | $43.33 | $19.77 | $12.57 | $55.99 | $59.19 | $90.14 | $28.69 | $550.41 |
| | | Owned | $240.73 | $43.33 | $19.77 | $12.57 | $28.00 | $59.19 | $90.14 | $27.15 | $520.88 |
| | | Depreciated | $240.73 | $43.33 | $19.77 | $12.57 | $14.00 | $59.19 | $90.14 | $26.38 | $506.11 |
| Moderate | 4 - 5 | Leased | $320.02 | $41.60 | $19.77 | $12.57 | $61.30 | $59.19 | $90.14 | $33.25 | $637.85 |
| | | Owned | $320.02 | $41.60 | $19.77 | $12.57 | $30.65 | $59.19 | $90.14 | $31.57 | $605.51 |
| | | Depreciated | $320.02 | $41.60 | $19.77 | $12.57 | $15.33 | $59.19 | $90.14 | $30.72 | $589.34 |
| | 6 | Leased | $312.05 | $56.17 | $19.77 | $12.57 | $55.99 | $59.19 | $90.14 | $33.32 | $639.20 |
| | | Owned | $312.05 | $56.17 | $19.77 | $12.57 | $28.00 | $59.19 | $90.14 | $31.78 | $609.67 |
| | | Depreciated | $312.05 | $56.17 | $19.77 | $12.57 | $14.00 | $59.19 | $90.14 | $31.01 | $594.90 |
| Extensive behavioral | 4 - 5 | Leased | $391.35 | $50.87 | $19.77 | $12.57 | $61.30 | $59.19 | $90.14 | $37.69 | $722.87 |
| | | Owned | $391.35 | $50.87 | $19.77 | $12.57 | $30.65 | $59.19 | $90.14 | $36.00 | $690.54 |
| | | Depreciated | $391.35 | $50.87 | $19.77 | $12.57 | $15.33 | $59.19 | $90.14 | $35.16 | $674.37 |
| | 6 | Leased | $359.60 | $64.73 | $19.77 | $12.57 | $55.99 | $59.19 | $90.14 | $36.41 | $698.40 |
| | | Owned | $359.60 | $64.73 | $19.77 | $12.57 | $28.00 | $59.19 | $90.14 | $34.87 | $668.86 |
| | | Depreciated | $359.60 | $64.73 | $19.77 | $12.57 | $14.00 | $59.19 | $90.14 | $34.10 | $654.09 |
| Extensive medical | 4 - 5 | Leased | $431.59 | $56.11 | $19.77 | $12.57 | $61.30 | $59.19 | $90.14 | $40.19 | $770.85 |
| | | Owned | $431.59 | $56.11 | $19.77 | $12.57 | $30.65 | $59.19 | $90.14 | $38.50 | $738.51 |
| | | Depreciated | $431.59 | $56.11 | $19.77 | $12.57 | $15.33 | $59.19 | $90.14 | $37.66 | $722.34 |
| | 6 | Leased | $374.71 | $67.45 | $19.77 | $12.57 | $55.99 | $59.19 | $90.14 | $37.39 | $717.21 |
| | | Owned | $374.71 | $67.45 | $19.77 | $12.57 | $28.00 | $59.19 | $90.14 | $35.85 | $687.67 |
| | | Depreciated | $374.71 | $67.45 | $19.77 | $12.57 | $14.00 | $59.19 | $90.14 | $35.08 | $672.90 |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| Pervasive 8 h / 7 d | 4 - 5 | Leased | $462.67 | $60.15 | $19.77 | $12.57 | $61.30 | $59.19 | $90.14 | $42.12 | $807.90 |
| | | Owned | $462.67 | $60.15 | $19.77 | $12.57 | $30.65 | $59.19 | $90.14 | $40.43 | $775.56 |
| | | Depreciated | $462.67 | $60.15 | $19.77 | $12.57 | $15.33 | $59.19 | $90.14 | $39.59 | $759.40 |
| | 6 | Leased | $383.38 | $69.01 | $19.77 | $12.57 | $55.99 | $59.19 | $90.14 | $37.95 | $727.99 |
| | | Owned | $383.38 | $69.01 | $19.77 | $12.57 | $28.00 | $59.19 | $90.14 | $36.41 | $698.46 |
| | | Depreciated | $383.38 | $69.01 | $19.77 | $12.57 | $14.00 | $59.19 | $90.14 | $35.64 | $683.69 |
| Pervasive 8 h / 5 d | 4 - 5 | Leased | $417.33 | $54.25 | $19.77 | $12.57 | $61.30 | $59.19 | $90.14 | $39.30 | $753.86 |
| | | Owned | $417.33 | $54.25 | $19.77 | $12.57 | $30.65 | $59.19 | $90.14 | $37.61 | $721.52 |
| | | Depreciated | $417.33 | $54.25 | $19.77 | $12.57 | $15.33 | $59.19 | $90.14 | $36.77 | $705.35 |
| | 6 | Leased | $338.04 | $60.85 | $19.77 | $12.57 | $55.99 | $59.19 | $90.14 | $35.01 | $671.56 |
| | | Owned | $338.04 | $60.85 | $19.77 | $12.57 | $28.00 | $59.19 | $90.14 | $33.47 | $642.02 |
| | | Depreciated | $338.04 | $60.85 | $19.77 | $12.57 | $14.00 | $59.19 | $90.14 | $32.70 | $627.25 |
| Pervasive 16 h | 4 - 5 | Leased | $605.32 | $78.69 | $19.77 | $12.57 | $61.30 | $59.19 | $90.14 | $50.98 | $977.96 |
| | | Owned | $605.32 | $78.69 | $19.77 | $12.57 | $30.65 | $59.19 | $90.14 | $49.30 | $945.62 |
| | | Depreciated | $605.32 | $78.69 | $19.77 | $12.57 | $15.33 | $59.19 | $90.14 | $48.45 | $929.45 |
| | 6 | Leased | $526.02 | $94.68 | $19.77 | $12.57 | $55.99 | $59.19 | $90.14 | $47.21 | $905.58 |
| | | Owned | $526.02 | $94.68 | $19.77 | $12.57 | $28.00 | $59.19 | $90.14 | $45.67 | $876.04 |
| | | Depreciated | $526.02 | $94.68 | $19.77 | $12.57 | $14.00 | $59.19 | $90.14 | $44.90 | $861.27 |
| Pervasive 24 h | 4 - 5 | Leased | $747.96 | $97.24 | $19.77 | $12.57 | $61.30 | $59.19 | $90.14 | $59.85 | $1,148.02 |
| | | Owned | $747.96 | $97.24 | $19.77 | $12.57 | $30.65 | $59.19 | $90.14 | $58.16 | $1,115.68 |
| | | Depreciated | $747.96 | $97.24 | $19.77 | $12.57 | $15.33 | $59.19 | $90.14 | $57.32 | $1,099.51 |
| | 6 | Leased | $668.67 | $120.36 | $19.77 | $12.57 | $55.99 | $59.19 | $90.14 | $56.47 | $1,083.16 |
| | | Owned | $668.67 | $120.36 | $19.77 | $12.57 | $28.00 | $59.19 | $90.14 | $54.93 | $1,053.62 |
| | | Depreciated | $668.67 | $120.36 | $19.77 | $12.57 | $14.00 | $59.19 | $90.14 | $54.16 | $1,038.85 |
| Nursing 1:1 8 h / 7 d | 4 - 5 | Leased | $543.15 | $70.61 | $19.77 | $12.57 | $61.30 | $59.19 | $90.14 | $47.12 | $903.85 |
| | | Owned | $543.15 | $70.61 | $19.77 | $12.57 | $30.65 | $59.19 | $90.14 | $45.43 | $871.51 |
| | | Depreciated | $543.15 | $70.61 | $19.77 | $12.57 | $15.33 | $59.19 | $90.14 | $44.59 | $855.34 |
| | 6 | Leased | $463.86 | $83.49 | $19.77 | $12.57 | $55.99 | $59.19 | $90.14 | $43.18 | $828.18 |
| | | Owned | $463.86 | $83.49 | $19.77 | $12.57 | $28.00 | $59.19 | $90.14 | $41.64 | $798.65 |
| | | Depreciated | $463.86 | $83.49 | $19.77 | $12.57 | $14.00 | $59.19 | $90.14 | $40.87 | $783.88 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Nursing 1:1 8 h / 5 d | 4 - 5 | Leased | $472.24 | $61.39 | $19.77 | $12.57 | $61.30 | $59.19 | $90.14 | $42.71 | $819.31 |
| | | Owned | $472.24 | $61.39 | $19.77 | $12.57 | $30.65 | $59.19 | $90.14 | $41.03 | $786.97 |
| | | Depreciated | $472.24 | $61.39 | $19.77 | $12.57 | $15.33 | $59.19 | $90.14 | $40.18 | $770.80 |
| | 6 | Leased | $392.94 | $70.73 | $19.77 | $12.57 | $55.99 | $59.19 | $90.14 | $38.57 | $739.91 |
| | | Owned | $392.94 | $70.73 | $19.77 | $12.57 | $28.00 | $59.19 | $90.14 | $37.03 | $710.37 |
| | | Depreciated | $392.94 | $70.73 | $19.77 | $12.57 | $14.00 | $59.19 | $90.14 | $36.26 | $695.60 |
| Nursing 1:1 16 hours | 4 - 5 | Leased | $766.28 | $99.62 | $19.77 | $12.57 | $61.30 | $59.19 | $90.14 | $60.99 | $1,169.85 |
| | | Owned | $766.28 | $99.62 | $19.77 | $12.57 | $30.65 | $59.19 | $90.14 | $59.30 | $1,137.51 |
| | | Depreciated | $766.28 | $99.62 | $19.77 | $12.57 | $15.33 | $59.19 | $90.14 | $58.46 | $1,121.34 |
| | 6 | Leased | $686.98 | $123.66 | $19.77 | $12.57 | $55.99 | $59.19 | $90.14 | $57.66 | $1,105.96 |
| | | Owned | $686.98 | $123.66 | $19.77 | $12.57 | $28.00 | $59.19 | $90.14 | $56.12 | $1,076.42 |
| | | Depreciated | $686.98 | $123.66 | $19.77 | $12.57 | $14.00 | $59.19 | $90.14 | $55.35 | $1,061.65 |
| Nursing 1:1 24 hours | 4 - 5 | Leased | $989.41 | $128.62 | $19.77 | $12.57 | $61.30 | $59.19 | $90.14 | $74.85 | $1,435.85 |
| | | Owned | $989.41 | $128.62 | $19.77 | $12.57 | $30.65 | $59.19 | $90.14 | $73.17 | $1,403.51 |
| | | Depreciated | $989.41 | $128.62 | $19.77 | $12.57 | $15.33 | $59.19 | $90.14 | $72.33 | $1,387.34 |
| | 6 | Leased | $910.11 | $163.82 | $19.77 | $12.57 | $55.99 | $59.19 | $90.14 | $72.14 | $1,383.73 |
| | | Owned | $910.11 | $163.82 | $19.77 | $12.57 | $28.00 | $59.19 | $90.14 | $70.60 | $1,354.19 |
| | | Depreciated | $910.11 | $163.82 | $19.77 | $12.57 | $14.00 | $59.19 | $90.14 | $69.83 | $1,339.42 |

**Section 4103, ACTIVE TREATMENT SERVICES, is amended as follows:**

**4103 ACTIVE TREATMENT SERVICES**

4103.1 An individual residing in an ICF/IID shall receive continuous active treatment services, consistent with the requirements set forth in 42 C.F.R. § 483.440. Active treatment services shall vary depending on the needs of the beneficiary, as determined by the interdisciplinary team.

4103.2 An ICF/IID shall ensure that a beneficiary receives active treatment services on a daily basis. The ICF/IID may affiliate with outside resources to assist with program planning and service delivery or the facility may provide active treatment services directly.

4103.3 A program of active treatment services shall include aggressive, consistent implementation of a program of specialized training, treatment, health services, and other related services that is directed towards:

(a) The acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible; and

(b) The prevention or deceleration of regression or loss of current optimal functional status.

4103.4 In accordance with 42 C.F.R. §§ 483.440(c) - (d), an interdisciplinary team shall determine the type of active treatment services that a beneficiary needs based on preliminary evaluations, assessments, and re-assessments. Each beneficiary's active treatment requirements shall be described in his Individual Program Plan (IPP), pursuant to 42 C.F.R. § 483.440(c). The ICF/IID shall ensure that each beneficiary receives all of the services described in the IPP.

4103.5 For dates of service on or after January 1, 2014, the per diem reimbursement rate for active treatment shall equal the average of FY13 active treatment rates multiplied by two hundred sixty (260) days of service, to account for the maximum days of service provided, inclusive of holidays, and divided by three hundred sixty-five (365).

**Section 4105, REBASING, is amended as follows:**

**4105 REBASING**

4105.1 Effective November 1, 2017 (FY 2018), and every three (3) years thereafter, reimbursement rates for the residential component shall be updated based on cost reports from the most recently audited year, as determined by DHCF.

4105.2 The rate schedule set forth in § 4102.16 shall be updated after completion of the FY 2018 rebasing. The updated rates for ICF/IID services, effective January 1, 2018, are included in the Medicaid Fee Schedule located on the DHCF website at https://www.dc-medicaid.com/dcwebportal/nonsecure/feeScheduleDownload.

**Section 4107, FISCAL ACCOUNTABILITY, is amended as follows:**

**4107 FISCAL ACCOUNTABILITY**

4107.1 Effective October 1, 2013 through September 30, 2017, except for the Administration, Capital, and Active Treatment cost centers, each facility shall spend at least ninety-five percent (95%) of the rate under each cost center on service delivery to Medicaid individuals. Facilities expending less than ninety-five percent (95%) of each cost center shall be subject to repayment requirements set forth in Subsection 4107.6.

4107.2 Effective October 1, 2013 through September 30, 2017, each ICF/IID shall spend one hundred percent (100%) of the rate for Active Treatment on service delivery to Medicaid individuals. Facilities expending less than one hundred percent (100%) of the rate for Active Treatment shall be subject to repayment requirements set forth in Subsection 4107.6.

4107.3 Effective January 1, 2014 through September 30, 2017, each ICF/IID shall spend one hundred percent (100%) of the rate associated with the Capital cost center. A facility that fails to expend one hundred percent (100%) on capital shall be subject to repayment requirements set forth in Subsection 4107.6.

4107.4 Effective November 1, 2017, each ICF/IID shall spend at least ninety-five percent (95%) of the rate for Direct Service and one-hundred percent (100%) of the rate for Active Treatment on service delivery to Medicaid beneficiaries. Facilities expending less than ninety-five percent (95%) of the rate for Direct Service or one-hundred percent (100%) of the rate for Active Treatment shall be subject to repayment requirements set forth in Subsection 4107.6.

4107.5 Effective November 1, 2017, each ICF/IID shall spend at least ninety-five percent (95%) of the aggregate rate for the All Other Health Care and Program Related, Non Personnel Operations, Non-Emergency Transportation, and Capital cost centers. Facilities expending less than ninety-five percent (95%) of the aggregate rate for these four (4) cost centers shall be subject to repayment requirements set forth in Subsection 4107.6.

4107.6 Repayment amounts shall be as follows:

(a) The repayment amount described in § 4107.1 shall be the difference between ninety-five percent (95%) of the rate for the applicable cost

center(s) and the facility's reported expenses for the applicable cost center(s);

(b) The repayment amount for Active Treatment described in § 4107.2 shall be the difference between one hundred percent (100%) of the payments made for Active Treatment and the facility's reported expenses for Active Treatment;

(c) The repayment amount for Capital described in § 4107.3 shall be the difference between one hundred percent (100%) of the payments made for Capital and the facility's reported Capital expenses;

(d) The repayment amounts described in § 4107.4 shall be as follows:

(1) The difference between ninety-five percent (95%) of the Direct Service rate and the facility's reported Direct Service expenses; and

(2) The difference between one-hundred percent (100%) of the Active Treatment rate and the facility's reported Active Treatment expenses; and

(e) The repayment amount described in § 4107.5 shall be the difference between ninety-five percent (95%) of the aggregate rate for the All Other Health Care and Program Related, Non Personnel Operations, Non-Emergency Transportation, and Capital cost centers and the facility's reported aggregate expenses for these four (4) cost centers.

4107.7 In accordance with D.C. Official Code § 47-1272(c), DHCF, or its designee, has the right to inspect payroll and personnel records to support the Department's obligations pursuant to the Living Wage Act of 2006, effective March 8, 2006 (D.C. Law 16-118; D.C. Official Code §§ 47-1270 *et seq.*), and implementing regulations.

4107.8 DHCF shall evaluate expenditures subject to the requirements in this section through annual review of cost reports. DHCF, or its designee, shall review each cost report for completeness, accuracy, compliance, and reasonableness through a desk audit.

4107.9 On-site audits shall be conducted not less than once every three (3) years. Each ICF/IID shall allow access, during on-site audits or review by DHCF or U.S. Department of Health and Human Services auditors, to relevant financial records and statistical data to verify costs previously reported to DHCF.

4107.10 DHCF shall issue a notice to each ICF/IID that is required to repay as set forth in this section. The notice shall set forth the repayment amount and include language describing the procedure and timeframes for requesting an appeal before OAH.

Filing an appeal with OAH shall not stay any action to recover the amounts prescribed in this section.

**A new Section 4117, PAYMENT FOR RESERVED BEDS, is added to read as follows:**

**4117 PAYMENT FOR RESERVED BEDS**

4117.1 Payment for reserved bed days for hospitalization or therapeutic leaves of absence for a beneficiary who is a resident of an ICF/IID may be authorized for up to sixty (60) days during a District fiscal year, if there is a reasonable expectation that the beneficiary will return to the facility.

4117.2 Payment for therapeutic leaves of absence shall only be authorized if provided for in a beneficiary's plan of care.

4117.3 Payment for reserved bed days authorized in accordance with §§ 4117.1 and 4117.2 shall equal the facility's per diem rate for the beneficiary, based on the beneficiary's approved acuity level assignment.

4117.4 A reserved bed day for purposes of this section is a day in which a beneficiary who is a resident of an ICF/IID receives fewer than eight (8) hours of supports in an ICF/IID beginning at midnight (12:00 am) and ending at 11:59 p.m.

4117.5 Payment for reserved beds is conditioned on each beneficiary residing in an ICF/IID for at least one (1) day.

4117.6 Each provider shall require the family member or caregiver to sign a leave and request form upon exit and return to the facility. The provider shall ensure that each family member or caregiver provide contact information.

4117.7 Each provider shall discuss the resident's medical regimen with the family member or caregiver. The provider shall ensure that each family member or caregiver is provided a sufficient quantity of the resident's medication for the leave period.

4117.8 Each provider shall report to DHCF any unusual incident that occurred during any therapeutic leave of absence.

4117.9 Each provider shall comply with all reporting requirements for reserved bed days set forth in 29 DCMR § 951.

**Section 4199, DEFINITIONS, is amended as follows:**

**4199 DEFINITIONS**

4199.1 For purposes of this chapter, the following terms shall have the meanings ascribed:

**Active Treatment** - A program of specialized and generic training, treatment, health services, and related services designed toward the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status. These services shall be provided consistent with Federal standards.

**Activities of Daily Living** - The ability to bathe, transfer, dress, eat and feed oneself, engage in toileting, and maintain bowel and bladder control (continence).

**Acuity Level** - The intensity of services required for a Medicaid beneficiary residing in an ICF/IID. Individuals with a high acuity level require more care; those with lower acuity levels require less care.

**Administrator** - An individual responsible for the administration or implementation of ICF/IID policies or procedures, and other roles other than delivering services directly related to resident treatment and care, food service, or maintenance of the facility.

**Allowable costs** - Actual costs, after appropriate adjustments, incurred by an ICF/IID, which are reimbursable under the Medicaid program.

**Base year** - The standardized year on which rates for all facilities are calculated to derive a prospective reimbursement rate.

**Behavior Support Plan** - A written document requested by the Individual Support Team that is developed by a psychologist or psychology associate and incorporated into the Individual Support Plan. If developed by a psychology associate, the plan shall be approved by the psychologist.

**Current Individual Support Plan (ISP)** - An Individual Support Plan with a range of effective dates that includes the date on which the plan is being reviewed.

**Depreciation** - The systematic distribution of the cost or other basis of depreciable assets, less salvage value, over the estimated useful life of the assets.

**Direct service costs** - Costs incurred by a provider that are attributable to the operation of providing services to individuals.

**District Fiscal Year** - A twelve (12) month period beginning on October 1 and ending on September 30.

**Elopement** - To run away; abscond.

**Employee** - A worker in an ICF/IID that does not serve as a manager or administrator, and is not under contract to provide professional services.

**Facility** - An intermediate care facility for individuals with intellectual disabilities.

**Habilitation** - The process by which an individual is assisted to acquire and maintain those life skills which enable him or her to cope more effectively with the demands of his or her own person and of his or her own environment, including, in the case of a person committed under D.C. Official Code § 7-1304.06a, to refrain from committing crimes of violence or sex offenses, and to raise the level of his or her physical, intellectual, social, emotional, and economic efficiency.

**Holiday pay** - The term used in a labor agreement, provider policy, or in the absence of either, by the U.S. Department of Labor.

**Individual Support Plan (ISP)** - The document produced through coordinated efforts of ICFs/IID and DDS. The ISP is the successor to the Individual Habilitation Plan as defined in the court-approved *Joy Evans* Exit Plan. For purposes of Medicaid reimbursement, the individual program plan, as described in 42 C.F.R. § 483.440(c), shall be included within the ISP.

**Industry Average** - The sum of total industry expenditures divided by total industry licensed bed days per reported fiscal year costs.

**Interdisciplinary team** - A group of persons, with special training and experience in the diagnosis and habilitation of individuals with intellectual and developmental disabilities, with the responsibility to perform a comprehensive evaluation of each beneficiary and participating in the development, implementation, and monitoring of the beneficiary's individual habilitation plan. The "core team" shall include the individual, the individual's representative, the service coordinator, and relevant clinical staff.

**Level of Care Determination (LOC)** - The assessment used by DDS to determine a beneficiary's eligibility for ICF/IID services.

**Level of Need Assessment and Risk Screening Tool (LON)** - The comprehensive and uniform assessment tool developed by DDS that determines the beneficiary's individual support needs and identifies potential risks to be addressed by the interdisciplinary team.

**Licensed bed days** - Three hundred and sixty-five (365) days or the number of days of that calendar year.

**Life safety skills** - An individual's ability to protect oneself from perceived and apparent risks and life-threatening situations such as fires, evacuation emergencies, traffic, and ingestion of toxic substances.

**Manager** - An individual who is responsible for the administration of an ICF/IID facility inclusive of human resources, maintenance, and policy management.

**Non-ambulatory** - A beneficiary who spends all of his or her time out of bed in a wheelchair or a chair.

**One-to-One** - An altered staffing pattern that allows one staff to provide services to an individual with intellectual disabilities exclusively for an authorized period of time.

**Owner** - A person who is a sole proprietor, partner, or corporate stockholder-employee owning any of the outstanding stock of the contracted provider.

**Per diem rate** - The rate per day established by DHCF.

**Professional services** - Services provided pursuant to any legal arrangement, which include occupational and speech therapies and nursing care services provided by an individual or a corporation.

**Quality of care improvements** - The same definition as set forth in D.C. Official Code § 47-1270, and any subsequent amendments thereto.

**Related organization** - In accordance with 42 C.F.R. § 413.17(b)(1), an organization is related to an ICF/IID when the ICF/IID, to a significant extent, is associated or affiliated with, or has control over, or is controlled by the organization furnishing the services, facilities, or supplies.

**Therapeutic leave of absence** – When a beneficiary leaves the ICF/IID to visit with relatives and friends or to participate in a District-approved therapeutic and rehabilitative program.

# Appendix D – Florida ARF Behavior Descriptors

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**Florida ARF Response on Descriptors to Use for**
**New Level of Reimbursement Based on Behaviors**

Florida ARF members have identified descriptors that could be used to decide if ICF/IID residents with significant behaviors warrant an additional level of care. The consensus was that certain factors such as medication usage, the need for physical restraints, management of inappropriate client behaviors, and, client behavior and facility practices, along with corresponding Federal regulations, can be used to assess individuals who require an additional service level to address severe behaviors.

The new level of care/reimbursement should be about staffing, credentials, training, and monitoring for fidelity rather than the range of "emergency procedures" allowable. ICF/IIDs support treatment that focuses on positive interventions based upon comprehensive assessment. The intent is to develop, strengthen and generalize prosocial and adaptive skills for people to function as independently as possible. Only in emergency situations, then, should the more restrictive interventions be used, there can be a hierarchy of these procedures, from redirection to time-out to forms of restraint. Even so, this part of the management of behavior should not be the focus and should be very small, since that is why they are called reactive strategies that are to be used when planned (least restrictive) interventions fail.

Our members note the primary reason for the additional level of care/reimbursement is the intensity of residents' behaviors. Individuals with intense behaviors need continual revisions to their behavior plans and often exhibit sporadic aggressive behavior that occur at irregular intervals. To address these behaviors facilities will need to provide enhanced staffing and staff training, for ongoing monitoring to ensure the procedures are implemented as described in the plan; monitoring of medications and side effects, adverse reactions and non-pharmacological interventions; and they may have to provide enhanced or one-on-one staffing of residents as appropriate. The enhanced services may in many cases be faded-out once the resident is safe and is not injuring self or others.

The following guidelines could be used for assessment of individuals regarding the need for a new level of care.

1. A score of 3, 4, 5, or 6 on the Global Behavioral Service Need Matrix
2. Have met at least one of the following behavioral characteristics within the past six months:
   - Engaged in behavior that caused injury to self or others that required emergency room or other inpatient care from a physician or other health care professional.
   - Engaged in a behavior that creates a life-threatening situation, such as, excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, or severe insomnia.
   - Engaged in unauthorized fire setting.
   - Attempted suicide.
   - Intentionally cause damage to property in excess of $1,000 in value for one incident.

- Engaged in behavior that was unable to be controlled via less restrictive means and necessitated the use of restraints, either mechanically, manually or by commitment to a crisis stabilization unit, three or more times in a 30-day period, or six times across the applicable six-month period.
- Engaged in behavior that resulted in the recipient's arrest and confinement.
- Engaged in sexual behavior with any person who did not consent or is considered unable to consent to such behavior or engaged in sexual behavior that caused injury to self or others requiring emergency room or other in-patient care from a physician or other health care professional.
- If the supervision and environment is such that the recipient lacks opportunity for engaging in these serious behaviors, a behavior analyst providing services must provide data, probes, or other documented evidence showing that the behavior would likely occur at least every six months if the recipient were without the supervision or environment provided. This might include documentation of the continued prevalence of precursor behaviors which occur with great certainty under certain environmental conditions before the serious behaviors occur.

**Other Examples of Behaviors that would warrant an additional level of care**

- Requires psychiatric oversight due to intense behaviors that impact health and safety
- Presents as a risk for suicide or engages in suicidal threats
- Engages in self-injurious behavior that results in tissue damage
- Engages in behaviors that result in injuries to themselves or others
- Engages in Pica of non-edible and/or noxious material
- Elopement risk target defined in Behavior Support Plan
- Engages in inappropriate sexual behavior that impacts others
- Requires one to one supervision per doctor's order due to intense behavioral complications that impact their safety and others
- Required Baker Act due to intense/dangerous behavior within the last 6 months
- Required use of manual, mechanical restraints within the last 6 months due to unsafe/dangerous behavior.

**ICF/IIDs that serve individuals with such behaviors will likely have to meet additional federal standards as outlined below:**

**1. Drug Usage**

Residents are administered multiple medication (polypharmacy) that may include antipsychotic, antidepressant, antianxiety, hypnotic medication, etc. for residents that have diagnoses of psychosis, depression, anxiety, schizophrenia, bipolar disorder, agitation, and/or insomnia.

- Continual monitoring is needed to ensure the benefit of the psychotropic medication outweighs the risk.
- Documentation of rationale for continued use of the medication is present.
- Continual documented review for possible gradual drug/dose reduction to determine the optimum level is ongoing. (APD commented this should be evident on the graphs maintained by the Behavior Analyst but could be integrated into a case review led by the Behavior Analyst.)
- Monitoring of the resident is required to ensure the medication is effective; appropriate doses are being given; drug interactions are not problematic; staff interventions are required to ensure the

resident's quality of life (cognitive ability, mobility, etc.) has not diminished; diet, weight loss, dehydration or acute illness that may have been attributed to the medication are being monitored; and, progress or regression on goals as described on the Individual Program Plan is not being negatively affected by the medication.

- Monitoring is required to ensure an acceptable clinical indication for use (wandering, restlessness or mild anxiety; poor self-care or inattention or indifference; impaired memory; insomnia; sadness or crying that is not related to depression or other psychiatric disorder; fidgeting or nervousness; uncooperativeness (e.g. refusal/difficulty receiving care).
- Tracking of appropriate behaviors for all psychoactive medications is in place (Hypnotics, causes for insomnia, hours of sleep (day and night); Antidepressants, duplicative therapies, effectiveness).

**Drug Usage tags:**

**Section 483.450 Client Behavior & Facility Practices**

- §483.450(e)(1) The facility must not use drugs in doses that interfere with the individual client's daily living activities. (W 310)

- §483.450(e)(2) Drugs used for control of inappropriate behavior must be approved by the interdisciplinary team and be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. (W310 & W312)

- §483.450(e)(3) Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs. (W313)

- §483.450(e)(4) - (i)(ii) Drugs used for control of inappropriate behavior must be monitored closely, in conjunction with the physician and the drug regimen review requirement at §483.460(j), for desired responses and adverse consequences by facility staff; and gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. (W314, W315, W316 &W317)

**2. Physical Restraints**

Residents receive a physical restraint that is used as an emergency intervention only in situations where the resident is exhibiting behaviors which: 1) the client has not exhibited before; 2) were not identified in the functional analysis of behavior; 3) are harming other people or themselves; or, 4). In those cases where the prescribed behavioral interventions are not effective in diffusing the dangerous behavior.

Ongoing monitoring of the use of physical restraints will be implemented as specified in the resident's Individual Program Plan (IPP) to ensure it addresses:

- The specific type of client behavior to be managed by the plan;
- The less restrictive behavioral approaches which were previously used, but were unsuccessful;
- The hierarchy of measures that must be utilized prior to the application of physical restraint;
- The type of physical restraint used;

- The type of client behavior that would indicate that the patient is calm and can be released from the restraint; and
- The replacement behavior being taught to the client to reduce the need for future restraints.

**Physical Restraint Tags**

- §483.450(d)(1),(d)(1)(i),( d)(1)(ii), (d)(1)(iii) The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied; as an emergency measure, but only if absolutely necessary to protect client or others from injury; or as a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists. (W295, W296, & W297)

- §483.450(d)(2), (d)(2)(i), (d)(2)(ii) Authorizations to use or extend restraints as an emergency measure must be in effect no longer than 12 consecutive hours and obtained as soon as the client is restrained or stable. (W298 & W299)

- §483.450(d)(3) The facility must not issue orders for restraint on a standing or as needed basis. (W300)

- §483.450(d)(4) A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints, released from the restraint as quickly as possible, and a record of these checks and usage must be kept. (W301, W302, & W303)

- §483.450(d)(5) Restraints must be designed and used so as not to cause physical injury to the client and so as to cause the least possible discomfort. (W304 & W305)

- §483.450(d)(6) Opportunity for motion and exercise must be provided for a period of not less than 10 minutes during each two-hour period in which restraint is employed, and a record of such activity must be kept. (W306 & W307)

- §483.450(d)(7) Barred enclosures must not be more than three feet in height and must not have tops. (W308 & W309)

**3. Management of inappropriate client behavior**

Behavior plans/programs are to include interventions for undesirable behavior and procedures to encourage desirable or functional replacement behaviors. Behavior Plans are to be continually reviewed to ensure positive client outcomes and that staff are monitored to ensure consistent implementation of the least restrictive intervention and procedures called for in these plans. Interventions are employed and removed as soon as the resident is no longer an immediate threat to self or others. (APD prefers that another level of care should be about staffing, credentials, training, and monitoring for fidelity rather than the range of “emergency procedures” allowable.)

**Management of Inappropriate Client Behavior Tags**

§483.450(b)(1), (b)(1)(i), (b)(1)(ii), (b)(1)(iii), (b)(1), (iv A-F) The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior, as well as formal skill training procedures that will reduce the need for procedures to manage inappropriate behavior. These policies and procedures must be consistent with the provisions of paragraph (a) of this section. These procedures must specify all facility approved interventions to manage inappropriate client behavior; designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least restrictive or most intrusive; insure prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective; and address the following: A. The use of time-out rooms; B. The use of physical restraints; C. The use of drugs to manage inappropriate behavior; D. The application of painful or noxious stimuli (APD indicates they thought this was prohibited); E. The staff members who may authorize the use of specified interventions; F. A mechanism for monitoring and controlling the use of interventions. (W274, W275, W276, W277, W278, W279, W280, W281, W282, W283, & W284) APD prefers that ICF/IIDs adhere to Rule 65G-8.003)

§483.450(b)(2) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. (W285)

§483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for disciplinary purposes, for the convenience of staff, or as a substitute for an active treatment program. (W286, W287, W288)

§483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. (W289)

§483.450(b)(5) Standing or as needed programs to control inappropriate behavior are not permitted. (W290)

**4. Client Behavior and Facility Practices**

The facility has trained staff and provides ongoing monitoring regarding the conduct between staff and residents relating to their language, actions, discipline, rules, order and other types of interactions exchanged between staff and clients or imposed upon clients by the staff during a client's daily experiences that affect the quality of a client's life. The facility will provide continuous monitoring to ensure:

- The interactions between clients and staff are consistent and positive.
- Staff teach and encourage clients to interact with each other in a manner that promotes social integration both in the facility and out in the community.
- All opportunities to teach and reinforce skill acquisition are utilized.
- Staff will promptly intervene when any client tries to independently impose discipline upon another client.

**Client Behavior and Facility Practices Tags**

(a.) Standard: Facility practices-- Conduct toward clients.

§483.450(a)(1)(i-iv) The facility must develop and implement written policies and procedures for the management of conduct between staff and clients. These policies and procedures must promote the growth, development and independence of the client; Address the extent to which client choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible; Specify client conduct to be allowed or not allowed; and, Be available to all staff, clients, parents of minor children, and legal guardians. (W267, W268, W269, W270, W271)

§483.450(a)(2) To the extent possible, clients must participate in the formulation of these policies and procedures. (W272)

§483.450(a)(3) Clients must not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy. (W273)

**Conclusion**

In consideration of the information provided, an additional level of care/reimbursement for ICF/IID recipients who present with severe behaviors is warranted.

# Appendix E – ICF/IID Cost and Reimbursement Comparison

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## Appendix E: ICF/IID Cost and Reimbursement Comparison from SFY 2018/19 Rate Setting

| # | Facility Name | Medicaid Number | Cost Report End Date | Total Resident Days | Total Allowable Cost from Cost Report | Total Allowable Cost Inflated to SFY 2018/19 | Estimated SFY 2018/19 Medicaid Reimbursement | Payment Versus Cost (Dollars) | Payment Versus Cost (Percent) |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 107th Place Group Home | 012373500 | 10/31/2016 | 2,130 | $519,097 | $553,869 | $567,271 | $13,402 | 102% |
| 2 | 119th Street Grp Home #11 (Sunrise) | 028062300 | 6/30/2017 | 2,190 | $516,323 | $543,864 | $598,710 | $54,845 | 110% |
| 3 | 138th Court Grp Home #16 (Sunrise | 028548000 | 6/30/2017 | 1,992 | $526,590 | $553,591 | $555,369 | $1,777 | 100% |
| 4 | 145th Street Grp Home (Sunrise) | 028569200 | 6/30/2017 | 2,086 | $635,706 | $668,178 | $721,264 | $53,086 | 108% |
| 5 | 146th Place Grp Home #10 (Sunrise) | 028059300 | 6/30/2017 | 2,190 | $487,981 | $513,353 | $573,495 | $60,143 | 112% |
| 6 | 148th Court Grp Home #20 (Sunrise) | 028557900 | 6/30/2017 | 2,190 | $487,434 | $512,798 | $531,360 | $18,562 | 104% |
| 7 | 157th Terrance (Sunrise) | 028568400 | 6/30/2017 | 2,190 | $536,639 | $564,847 | $608,316 | $43,469 | 108% |
| 8 | 19th Street Group Home | 012375400 | 10/31/2016 | 2,027 | $523,746 | $558,624 | $568,669 | $10,045 | 102% |
| 9 | 22nd Street Grp Home #6 (Sunrise) | 028065800 | 6/30/2017 | 1,930 | $486,671 | $511,995 | $516,713 | $4,718 | 101% |
| 10 | 26th Terrace Grp Home #12 (Sunrise) | 028552800 | 6/30/2017 | 2,037 | $481,212 | $506,253 | $523,617 | $17,364 | 103% |
| 11 | 53rd Court Grp Home #9 (Sunrise) | 028559500 | 6/30/2017 | 2,157 | $529,221 | $557,413 | $545,354 | -$12,058 | 98% |
| 12 | 55th Court Grp Home #15 (Sunrise) | 028560900 | 6/30/2017 | 2,017 | $520,669 | $548,178 | $527,264 | -$20,914 | 96% |
| 13 | 62nd Place Grp Home #17 (Sunrise) | 028547100 | 6/30/2017 | 2,096 | $525,421 | $553,152 | $486,019 | -$67,133 | 88% |
| 14 | Ann Storck Center, Inc. | 028521800 | 9/30/2017 | 16,638 | $5,839,353 | $6,114,956 | $6,662,107 | $547,152 | 109% |
| 15 | Avon Park Cluster (Mentor) | 031256800 | 9/30/2017 | 8,660 | $3,449,583 | $3,612,565 | $4,006,320 | $393,754 | 111% |
| 16 | BARC Housing, Inc. | 028519600 | 9/30/2017 | 13,121 | $4,292,128 | $4,491,777 | $4,830,098 | $338,321 | 108% |
| 17 | Barranger Grp Home (Mentor) | 031262200 | 9/30/2016 | 2,196 | $597,600 | $640,297 | $727,657 | $87,360 | 114% |
| 18 | Bayshore Cluster (Sunrise) | 028031301 | 6/30/2017 | 8,466 | $3,139,180 | $3,308,455 | $3,631,009 | $322,554 | 110% |
| 19 | Bayview (Mentor) | 012037000 | 9/30/2016 | 2,067 | $709,109 | $760,081 | $851,139 | $91,058 | 112% |
| 20 | Bayview Community Care (Res-Care) | 028537400 | 6/30/2017 | 2,096 | $514,474 | $541,095 | $591,994 | $50,899 | 109% |
| 21 | Bessent Road Group Home | 012075700 | 10/31/2016 | 2,196 | $460,606 | $491,224 | $549,351 | $58,127 | 112% |
| 22 | Cape Coral Cluster (Sunrise) | 028533100 | 6/30/2017 | 8,218 | $2,956,840 | $3,110,514 | $3,369,824 | $259,310 | 108% |
| 23 | Caprona Grp Home (Mentor) | 031265700 | 9/30/2017 | 1,962 | $644,250 | $673,316 | $651,794 | -$21,523 | 97% |
| 24 | Claudia Drive Group Home | 012392700 | 10/31/2016 | 1,689 | $562,323 | $600,214 | $531,793 | -$68,421 | 89% |
| 25 | Coletta Drive Group Home | 012074200 | 10/31/2016 | 1,903 | $580,307 | $619,633 | $680,634 | $61,001 | 110% |
| 26 | Country Meadows Grp Home #13 (Sunrise) | 028553600 | 6/30/2017 | 2,190 | $537,668 | $566,170 | $645,130 | $78,960 | 114% |
| 27 | Dorchester Cluster (Sunrise) | 028049601 | 6/30/2017 | 8,084 | $3,301,505 | $3,478,240 | $3,674,242 | $196,002 | 106% |
| 28 | Eagle Watch Cluster (Mentor) | 031257600 | 9/30/2016 | 8,658 | $3,234,984 | $3,470,704 | $3,877,566 | $406,862 | 112% |
| 29 | Frederick Avenue Group Home | 012075900 | 10/31/2016 | 2,196 | $571,051 | $609,924 | $638,842 | $28,917 | 105% |
| 30 | Fern Park Developmental Center | 028427100 | 2/28/2017 | 22,979 | $6,826,054 | $7,240,987 | $7,931,730 | $690,743 | 110% |

## Appendix E: ICF/IID Cost and Reimbursement Comparison from SFY 2018/19 Rate Setting

| # | Facility Name | Medicaid Number | Cost Report End Date | Total Resident Days | Total Allowable Cost from Cost Report | Total Allowable Cost Inflated to SFY 2018/19 | Estimated SFY 2018/19 Medicaid Reimbursement | Payment Versus Cost (Dollars) | Payment Versus Cost (Percent) |
|---|---|---|---|---|---|---|---|---|---|
| 31 | Flamingo Drive Cluster (Mentor) | 031261400 | 9/30/2017 | 7,886 | $3,619,370 | $3,788,943 | $3,953,021 | $164,078 | 104% |
| 32 | Ft. Walton Beach Development Ctr. | 028524200 | 9/30/2017 | 21,844 | $5,773,538 | $6,041,974 | $6,602,620 | $560,646 | 109% |
| 33 | Gainesville 39th Avenue Cluster | 028032101 | 6/30/2017 | 7,380 | $2,303,105 | $2,427,727 | $2,435,998 | $8,271 | 100% |
| 34 | Greenridge Grp Home (Mentor) | 031263100 | 9/30/2016 | 2,196 | $437,401 | $468,352 | $526,466 | $58,114 | 112% |
| 35 | Greentree Court Cluster (Sunrise) | 028028301 | 6/30/2017 | 8,084 | $3,009,255 | $3,171,213 | $3,652,421 | $481,208 | 115% |
| 36 | Gulfview (Mentor) | 012040300 | 9/30/2016 | 2,196 | $807,800 | $864,614 | $815,964 | -$48,650 | 94% |
| 37 | Hendricks | 028539100 | 5/31/2017 | 8,561 | $3,884,882 | $4,078,132 | $4,419,481 | $341,349 | 108% |
| 38 | High Desert Court Group Home | 012410100 | 10/31/2016 | 2,166 | $490,272 | $523,564 | $589,636 | $66,071 | 113% |
| 39 | Hillsborough County Developmental Ctr. | 028530700 | 9/30/2017 | 22,246 | $6,069,175 | $6,359,462 | $6,712,765 | $353,304 | 106% |
| 40 | Hodges Cluster (Mentor) | 031259200 | 9/30/2017 | 8,189 | $3,347,257 | $3,504,682 | $3,835,615 | $330,933 | 109% |
| 41 | Howell Branch Court | 028567600 | 11/30/2016 | 22,528 | $7,552,403 | $8,070,102 | $8,671,038 | $600,936 | 107% |
| 42 | Kinkaid Cluster (Mentor) | 031260600 | 9/30/2016 | 8,216 | $2,977,055 | $3,192,916 | $3,538,166 | $345,249 | 111% |
| 43 | Lake City Cluster | 028030501 | 6/30/2017 | 8,283 | $2,311,750 | $2,434,815 | $2,563,837 | $129,022 | 105% |
| 44 | Lakeview Court | 028565000 | 11/30/2016 | 22,563 | $7,552,615 | $8,068,768 | $8,679,667 | $610,899 | 108% |
| 45 | Laurel Hill Cluster | 028019401 | 9/30/2017 | 8,258 | $4,406,756 | $4,622,191 | $5,121,514 | $499,323 | 111% |
| 46 | Log Cabin Enterprises, Inc (Sunrise) | 015979000 | 6/30/2017 | 43,311 | $14,006,174 | $14,751,287 | $16,267,041 | $1,515,754 | 110% |
| 47 | MACtown, Inc. | 028512900 | 9/30/2015 | 20,276 | $4,955,445 | $5,418,726 | $5,516,297 | $97,571 | 102% |
| 48 | Mahan Cluster (Sunrise) | 028029101 | 6/30/2017 | 8,355 | $3,282,151 | $3,458,513 | $3,746,482 | $287,970 | 108% |
| 49 | McCauley Cluster (Sunrise) | 028020801 | 6/30/2017 | 8,101 | $3,257,424 | $3,432,786 | $3,686,630 | $253,844 | 107% |
| 50 | MCP 2nd Street | 028046101 | 6/30/2017 | 8,434 | $4,240,278 | $4,456,737 | $4,613,988 | $157,252 | 104% |
| 51 | MCP 80th Street | 028041101 | 6/30/2017 | 8,676 | $4,056,092 | $4,261,966 | $4,553,338 | $291,372 | 107% |
| 52 | MCP Braddock | 028045301 | 6/30/2017 | 8,630 | $4,316,599 | $4,537,326 | $4,793,620 | $256,293 | 106% |
| 53 | MCP Sunset | 028048801 | 6/30/2017 | 8,667 | $4,238,762 | $4,455,702 | $4,639,445 | $183,743 | 104% |
| 54 | Miner North | 001069500 | 5/31/2017 | 8,377 | $3,852,532 | $4,047,658 | $4,184,811 | $137,153 | 103% |
| 55 | Minor South | 001071000 | 5/31/2017 | 8,760 | $3,708,065 | $3,817,385 | $3,982,975 | $165,590 | 104% |
| 56 | Naranja Group Home (Sunrise) | 028500500 | 6/30/2017 | 3,931 | $928,008 | $976,861 | $928,988 | -$47,873 | 95% |
| 57 | New Horizons of NW Florida, Inc. | 028513700 | 9/30/2016 | 10,889 | $3,447,502 | $3,704,607 | $3,944,357 | $239,749 | 106% |
| 58 | New Horizons Village | 031345900 | 11/30/2016 | 17,182 | $6,228,564 | $6,639,764 | $7,959,413 | $1,319,649 | 120% |
| 59 | Ocala Cluster | 028038101 | 6/30/2017 | 8,584 | $2,315,454 | $2,439,353 | $2,680,955 | $241,602 | 110% |
| 60 | Panama City Development Ctr. | 028526900 | 9/30/2017 | 20,762 | $6,090,769 | $6,372,360 | $7,063,277 | $690,917 | 111% |

## Appendix E: ICF/IID Cost and Reimbursement Comparison from SFY 2018/19 Rate Setting

| # | Facility Name | Medicaid Number | Cost Report End Date | Total Resident Days | Total Allowable Cost from Cost Report | Total Allowable Cost Inflated to SFY 2018/19 | Estimated SFY 2018/19 Medicaid Reimbursement | Payment Versus Cost (Dollars) | Payment Versus Cost (Percent) |
|---|---|---|---|---|---|---|---|---|---|
| 61 | PARC Center Apartments | 028035600 | 9/30/2017 | 17,088 | $6,953,172 | $7,280,886 | $6,798,090 | -$482,795 | 93% |
| 62 | PARC Cottage | 028505600 | 9/30/2017 | 5,840 | $2,378,628 | $2,491,817 | $2,484,544 | -$7,273 | 100% |
| 63 | Pembroke Pines Cluster | 028037201 | 6/30/2017 | 7,924 | $3,079,713 | $3,247,234 | $3,336,499 | $89,265 | 103% |
| 64 | Pensacola Care, Inc. | 028520000 | 9/30/2017 | 22,708 | $6,045,144 | $6,324,283 | $6,999,369 | $675,086 | 111% |
| 65 | Pensacola Cluster (Mentor) | 031264900 | 9/30/2016 | 8,135 | $3,306,609 | $3,550,393 | $3,811,493 | $261,101 | 107% |
| 66 | Plaza Oval Group Home | 012390800 | 10/31/2016 | 1,856 | $605,306 | $646,897 | $822,783 | $175,885 | 127% |
| 67 | Point West Cluster (Mentor) | 031258400 | 9/30/2017 | 8,133 | $2,990,256 | $3,132,249 | $3,605,328 | $473,080 | 115% |
| 68 | Rich Street Grp Home (Mentor) | 031266500 | 9/30/2017 | 2,190 | $513,279 | $536,706 | $537,915 | $1,209 | 100% |
| 69 | Rosewood Avenue Group Home | 012374400 | 10/31/2016 | 2,196 | $499,774 | $533,466 | $592,329 | $58,863 | 111% |
| 70 | Sandpiper Cluster (Mentor) | 031267300 | 9/30/2016 | 8,524 | $3,002,735 | $3,219,553 | $3,559,832 | $340,279 | 111% |
| 71 | Sandy Park Development Center | 028000300 | 12/31/2016 | 23,263 | $5,871,094 | $6,265,934 | $7,071,708 | $805,774 | 113% |
| 72 | Seaview (Mentor) | 012038000 | 9/30/2016 | 2,196 | $688,576 | $709,667 | $816,918 | $107,251 | 115% |
| 73 | Second Street Group Home | 012374200 | 10/31/2016 | 1,736 | $506,551 | $540,612 | $600,002 | $59,390 | 111% |
| 74 | Skipper Road Cluster | 028036401 | 9/30/2017 | 8,279 | $5,003,305 | $5,238,606 | $5,540,061 | $301,456 | 106% |
| 75 | Spring Street Group Home | 012074800 | 10/31/2016 | 2,196 | $448,359 | $478,368 | $482,820 | $4,452 | 101% |
| 76 | Squire Court Community Care (Res-Care) | 028536600 | 6/30/2017 | 1,825 | $539,374 | $567,558 | $543,416 | -$24,143 | 96% |
| 77 | St. Augustine Center for Living | 000169300 | 11/30/2016 | 21,959 | $4,923,658 | $5,237,812 | $5,926,174 | $688,362 | 113% |
| 78 | St. Petersburg Cluster (Sunrise) | 028018601 | 6/30/2017 | 8,041 | $3,147,069 | $3,315,219 | $3,676,038 | $360,819 | 111% |
| 79 | Suffridge Drive Group Home | 012073200 | 10/31/2016 | 1,830 | $560,463 | $598,758 | $712,127 | $113,369 | 119% |
| 80 | Sunrise Oakmont | 028558700 | 6/30/2017 | 2,150 | $505,152 | $531,281 | $533,114 | $1,833 | 100% |
| 81 | Tallahassee Development Center | 028522600 | 9/30/2016 | 21,054 | $6,213,240 | $6,652,960 | $7,413,692 | $760,732 | 111% |
| 82 | Tunis Street Group Home | 012386400 | 10/31/2016 | 2,196 | $500,745 | $534,701 | $593,578 | $58,876 | 111% |
| 83 | Twin Lane Community Home (Res-Care) | 028541200 | 6/30/2017 | 2,190 | $591,674 | $621,986 | $660,208 | $38,222 | 106% |
| 84 | Walnut Street Group Home | 012075300 | 10/31/2016 | 2,196 | $495,791 | $526,974 | $585,723 | $58,749 | 111% |
| 85 | Washington Square | 028566800 | 11/30/2016 | 22,798 | $7,595,368 | $8,115,867 | $8,957,043 | $841,175 | 110% |
| 86 | Wentworth Drive Grp Home #18 (Sunrise) | 028561700 | 6/30/2017 | 2,188 | $546,293 | $575,378 | $588,447 | $13,069 | 102% |
| 87 | Williams Road Cluster | 028040201 | 9/30/2017 | 7,457 | $4,486,678 | $4,695,849 | $5,237,740 | $541,891 | 112% |
| 88 | Woodhouse, Inc. | 028531500 | 6/30/2017 | 8,147 | $3,409,334 | $3,592,711 | $3,742,571 | $149,860 | 104% |
| | **Total** | | | **720,377** | **$243,867,518** | **$257,628,479** | **$278,084,037** | **$20,455,558** | **8%** |

agency for persons with disabilities
State of Florida

September 30, 2019

The Honorable Bill Galvano
Senate President
409 The Capitol
404 South Monroe Street
Tallahassee, Florida 32399

The Honorable Jose Oliva
Speaker of the House
420 The Capitol
402 South Monroe Street
Tallahassee, Florida 32399

Dear President Galvano and Speaker Oliva:

The Agency for Persons with Disabilities (APD) and the Agency for Health Care Administration (AHCA) are respectfully submitting the following iBudget Florida waiver redesign plan for legislative consideration, pursuant to Section 26, Chapter 2019-116, Laws of Florida.

Thank you for your favorable consideration.

Barbara Palmer
APD Director

Mary C. Mayhew
AHCA Secretary

Attachment


# 2019 iBudget Waiver Redesign

Submitted by:

Agency for Persons with Disabilities

Agency for Health Care Administration

September 30, 2019

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VIII. APPENDICES

# EXECUTIVE SUMMARY

The original intent of the Medicaid program was to provide critical health coverage to extremely low-income families, elderly, and individuals with disabilities. Individuals with intellectual and developmental disabilities are often in need of, and dependent on, state-provided services from shortly after birth and often until their death. This is often referred to as the true long-term care system. For far too long individuals with intellectual and developmental disabilities were largely served in institutional settings. Over the last twenty years states around the country have worked to reduce institutional settings in favor of supporting individuals in their homes and in their communities. In Florida, the Medicaid iBudget waiver is the program that funds and supports those home and community-based services to provide medically necessary supports to individuals with intellectual and developmental disabilities in living, learning, and working in their communities. The iBudget waiver program serves individuals with autism, cerebral palsy, spina bifida, intellectual disabilities, Down syndrome, Prader-Willi syndrome, Phelan-McDermid syndrome, and children age 3-5 who are at a high risk of a developmental disability. The services provided by the iBudget waiver program include support coordination, residential services, personal support services, therapeutic services, and life skills development services. The iBudget waiver program currently serves over 34,500 individuals. There are also over 21,000 individuals on the waiting list. The state general revenue expenditures for Fiscal Year 2017-18 were $448.5 million and the projected expenditures for FY 2018-19 are $483.4 million. Total expenditures and appropriations with the federal Medicaid matching funds for Fiscal Year 2017-18 are $1.17 billion and $1.11 billion, respectively. Total projected expenditures and appropriations with the

federal Medicaid matching funds for Fiscal Year 2018-19 are $1.24 billion and $1.14 billion, respectively.

Since full implementation of the iBudget waiver program in 2013, the expenditures for the program have increased to the point that the expenditures exceed the appropriation. The reason for the increased expenditures is the changing service needs of the waiver clients. The primary causes for changes in waiver client service needs are:

- Aging clients requiring more services
- Aging caregivers no longer able to provide care

The waiver services with the highest expenditure increases are:

- Residential Habilitation (group homes) services (38% of all expenditures)
- Personal Supports (personal care) services (26% of all expenditures)
- Adult Day Training (meaningful day activities) services (7% of all expenditures)

The iBudget waiver program is not included in the Social Services Estimating Conference (SSEC). Therefore, the increase in iBudget waiver program expenditures is not a part of the Medicaid expenditure projections provided to the Legislature by the SSEC.

To address the budget shortfall, the following measures could be taken by the Legislature:

- Fully fund the future growth of the iBudget waiver program
- Immediately implement:
    - Inclusion of the iBudget waiver program in the SSEC
    - A behavior health Intermediate Care Facility service rate
    - Individual caps for waiver clients
    - Budget transfers from the Medicaid State Plan to the iBudget waiver

program for waiver clients turning 21

    - Expansion of the Medicaid Assistive Care Services program to include waiver group homes
    - Service limitations on Life Skills Development services
    - Centralization of the Significant Additional Needs process
    - Restructure support coordination services
- Long-Term:
    - Implement the Next Generation – Questionnaire for Situational Information (NG-QSI) as the waiver assessment tool and budget allocation tool
- Implement significant rate cuts and service cuts

# INTRODUCTION

## From Cradle to Grave:

## A Glance at Developmental Disabilities in Florida

### *The People Behind the Growth in Service Needs*

The success of Florida's iBudget waiver program is strongly supported by empirical evidence. The iBudget waiver program provides tens of thousands of our most vulnerable citizens with the opportunity to lead meaningful and productive lives within their communities. It is also well documented that the iBudget waiver program has experienced increased costs over the years. This programmatic growth is not the result of fraud, mismanagement, or waste but is directly attributable to the changing needs and life circumstances of waiver enrollees. Their increased needs extend from birth to death. Although it may be tempting to look at financial growth solely in terms of dollars and cents, it is important for legislators, policymakers, and the general public to understand that there is a human being with a unique situation behind each and every cost plan increase approved by the Agency for Persons with Disabilities (APD).

The following real-life situations represent just a handful of the tens of thousands of individuals served by APD over the past several years; their stories are told from a first-person perspective to help the reader understand and appreciate the circumstances faced by actual iBudget waiver enrollees with increased service needs.

**Louis**

I am a 46-year-old man with cerebral palsy and a profound intellectual disability. I live alone with my 84-year-old mother. My dad died almost 20 years ago, and my mom has no other family in the area. I use a wheelchair to get around our apartment. My mom has to lift me in and out of my wheelchair every day. Lately, she can no longer lift me on her own, so I have to sit in a dirty diaper all day long until my personal care provider gets here after dinner to change me and give me a bath. I need funding for more personal supports and to make our apartment easier to get around in my wheelchair.

**Robert**

I am a 22-year-old man with autism and an intellectual disability. My father left our family a couple of years ago because he could not deal with my behaviors, so I just live here with my mom and my little brother. When I get angry, I attack everyone around me, which is why my mother and little brother sleep in one room and I sleep by myself. Most of the anti-psychotic medications prescribed by my psychiatrist have caused me to gain lots of weight, so I now weigh around 250 pounds. My mom says that all of her friends and relatives are afraid of me, so no one ever comes by to visit or help us. My mom locks me in my bedroom whenever she needs to go to the bathroom or take a shower, so I don't run away or hurt my little brother. She can't work anymore because I'm too old for school and there is no one around to watch me. I need more funding for behavioral services, personal supports, and a day program.

**Steven**

I am a 32-year-old man with an intellectual disability. For as long as I can remember, I have lived alone with my mom. Three days ago, my mom fell and died in the kitchen. I did not know how to use the phone or call for help. After three days, one of the neighbors was worried about us and called the police to check on us. The police found me in the kitchen trying to wake my mom up. I need more money because I am going to move into a group home.

**Rachel**

I am a 35-year-old woman living with my mother and stepfather. I am totally dependent on others for all activities of daily living. I have severe spasticity in my upper and lower extremities and must be positioned carefully to avoid falls or skin breakdown. My mother has been my primary caregiver, but she also cares for my stepfather who has dementia, is non-ambulatory, and requires total care. My mom has had health issues for several months and is overwhelmed with caring for us. I went into a group home for respite care when my mother was hospitalized and the staff at the group home found me severely underweight with six pressure ulcers. The group home staff also noticed redness and warmth in my leg, for which a CT scan was completed, and it was determined that I had a fracture that occurred several weeks ago. I need more funds in my budget for nursing and personal supports for when I go back home.

**Leah**

I am a 42-year-old woman living with my father. My mother died of a heart attack a few years ago, so my father takes care of me when our personal care provider is not here. However, my father just had a hip replacement and, as he ages, it is becoming more difficult for him to meet all of my needs. I have an intellectual disability, seizure disorder, spastic quadriplegia, scoliosis, am legally blind, and have contractures of the arms and legs. I am totally dependent on others for all self-care. My food must be pureed so I don't choke when I eat. My wheelchair must be propelled by others and I cannot tolerate being in an upright position. I need additional funds for more personal supports, adult dental care, consumable medical supplies, and personal care items.

**Timothy**

I am a 43-year-old man with Down syndrome who has lived in a group home for the past five years. When I first moved into the group home, I could do a lot of things for myself, such as making simple meals, using the bathroom, taking a shower, and working part-time at Publix. About a year ago, I began having problems at work and was forgetting how to do many of my household chores. I was diagnosed with early onset dementia (which is very common for people with Down syndrome). I need more funding for residential habilitation and companion services so that my group home can provide me with the additional support I now need.

***Floridians deserve the opportunity to live their American dream – A success story***

Meet 55-year-old Missy. She enjoys swimming, aerobics, dancing, and going to the theater to watch plays. She also has significant developmental disabilities. Missy is one of the original Floridians who made the groundbreaking decision in 1982 to live in her community by enrolling in Florida's Medicaid waiver, rather than moving to an institution. For more than 30 years, the waiver has allowed her to live in her own home, have a long-standing career with Walmart, and be an active citizen in her Tallahassee community. If she had been born 10 or 20 years earlier, Missy likely would have spent her days in an institution with fewer opportunities to be engaged in her community, costing the state millions of dollars.

There are thousands of similar stories of people with intellectual or developmental disabilities who, because of the waiver, start their own businesses, perform in community theater, live independently, are recognized as star employees at their jobs, and the like.

In short, the waiver allows individuals with developmental disabilities to live their American dream.

## The Waiver Program

***The waiver program is a proven system for better care at a lower cost***

After Florida joined the national trend to move away from institutionalization in the early 1980s, Floridians were given the opportunity to waive their right to an institution and instead receive needed services in their family home, in their own home, or in a group home. These individuals enjoyed a better quality of life with the waiver, and the state saved billions of dollars. Institutional care is a mandatory Medicaid service that must be

provided if requested. Florida set up the infrastructure to deliver services in these varied living settings, but continues to struggle with addressing the growth in service needs.

Florida has been extremely frugal with spending on individuals with disabilities, ranking 50th out of 51 in the nation (including the District of Columbia) in Total Fiscal Effort, spending less than $2 per $1,000 of statewide personal income for Intellectual/Developmental Disability (IDD) services. Florida also spends comparatively less on the annual cost of care in a group home (46th) and supported living (44th)[1]. On average, APD spends about $35,000 per person per year on the waiver, as compared to an institutional cost of about $135,000 per person per year.

As of July 1, 2019, 19,465 (56%) waiver clients lived in the family home, 5,268 (15%) lived in their own home, and 9,999 (29%) lived in a licensed residential facility in the community.

***Floridians say the waiver is working for them***

APD held a public forum on July 17, 2019, to receive input on ways to improve the iBudget waiver program. APD received hundreds of emails and letters regarding the iBudget waiver program. The overwhelming themes were: 1) managed care will not work for this population and 2) core services are different for every individual, so eliminating services is not a realistic option. Parents, self-advocates, Waiver Support Coordinators, and providers shared that the waiver has allowed clients to have a better quality of life. Of the nearly 1,000 people who offered their testimonials, all of them said the waiver should not

[1] The State of the States in Intellectual and Developmental Disabilities: 2017, 11th Edition http://www.stateofthestates.org/

be eliminated. The waiver is working for families, allowing their loved ones to live a full life in their community.

## The Drivers of Increased Growth in Service Needs

### *People with disabilities move to Florida daily, and their caregivers are likely seniors*

"When I had cancer, I wasn't afraid of dying, myself; I was afraid of, 'Who is going to take care of my son?' And that's what I would lay in the hospital thinking about." This heartbreaking sentiment from Susan Wallitsch, parent of an adult with autism, is echoed by many parents of APD clients.

Demand for waiver services is increasing. Florida is home to more caregivers over age 60 who are caring for people with developmental disabilities than any other state in the country[2]. Parents who are losing the ability to care for themselves are still trying to take care of their adult children with serious medical and behavioral issues.

The state of Florida promotes itself as a great place to live. As a result, families are moving to Florida at an increasing rate, many with children with disabilities. APD receives calls virtually every day from families who have moved to Florida with a child with a disability and are requesting services.

### *The service needs of people with disabilities are rising dramatically*

The life expectancy of Florida's population is increasing, which includes individuals with disabilities. Unlike many other populations, the needs of someone with a developmental disability are lifelong and will increase as they age; the need for services and the

[2] The State of the States in Intellectual and Developmental Disabilities: 2017, 11th Edition http://www.stateofthestates.org/

associated costs will never go away. More children are being born with autism and other developmental disabilities than ever before. Between 2016 and 2018, the prevalence of autism increased by 15%.[3] These individuals need significant services and supports from state government, which has a legal and moral responsibility to ensure their health and safety. The need for services continues to increase because of the increasing number of children with developmental disabilities who will need services and have yet to reach the adult system, and because of aging caregivers who will no longer be able to take care of their adult children.

As individuals with developmental disabilities and their caregivers become less able to provide natural supports, programmatic costs increase every year, just like other Medicaid-funded programs. Their ongoing service needs span a lifetime.

[3] Centers for Disease Control and Prevention https://www.cdc.gov/media/releases/2018/p0426-autism-prevalence.html

## GOALS

The 2019 Implementing Bill requires the redesign of the iBudget waiver program to:

- Improve budget predictability;
- Maintain or improve the services needed for health and safety;
- Ensure flexibility of clients to select services that meet their needs; and
- Improve the support coordination services that promote management of service utilization.

## CURRENT SITUATION

The Florida iBudget waiver program for individuals with intellectual and developmental disabilities provides a community-based alternative to institutional care. These services not only enable individuals to remain in their communities, they are also less expensive to the state. On average the annual individual cost of waiver services ($35,000) is considerably lower than institutional care ($135,000). The iBudget waiver program serves individuals with autism, cerebral palsy, spina bifida, intellectual disabilities, Down syndrome, Prader-Willi syndrome, Phelan-McDermid syndrome, and children age 3-5 who are at a high risk of a developmental disability. The services provided by the iBudget waiver program include support coordination, residential services, personal support services, therapeutic services, and life skills development services. The iBudget waiver program currently serves over 34,500 individuals. There are also over 21,000 individuals on the waiting list.

*All 34,500 waiver clients are eligible for institutional care.*
*If all 34,500 invoked their entitlement to institutional care, it would be an additional cost to the state of **$3.4 billion** annually.*

The Florida waiver program has gone through several changes since its inception in 1982. The changes have usually been made in response to court rulings or to address deficit spending. The changing service needs of waiver clients over time, due to clients aging, caregivers aging, and other life events, are the primary reasons for the growth in waiver program expenditures.

Although enrollment on the waiver is not an entitlement, once enrolled on the waiver, federal regulations and court rulings have established that clients are entitled to those services that have been determined medically necessary for them to be able to continue to reside in the community. These requirements have effectively prevented APD from containing waiver costs. The result has been iBudget waiver program deficits in recent years. Even though the iBudget waiver program is not included in the Social Services Estimating Conference (SSEC), APD has been able to project future waiver expenditures and has submitted Legislative Budget Request (LBR) issues to address the projected deficits.

# HISTORY OF WAIVER

***We have come too far to return to an antiquated model***

The implementation of Florida's Medicaid waiver in 1982 marked a new era in caring for people with developmental disabilities. Before that landmark decision, Floridians born with "mental retardation" were herded into archaic institutions.

Thankfully, in the early 1960s President John F. Kennedy and others recognized these conditions as inhumane and backwards. Medical professionals and advocates worked for decades to shift from a one-size-fits-all institutional warehouse approach to seeing each individual as worthy of being treated with respect and dignity and provided an opportunity to remain in the community.

The state entered into a Home and Community-Based Services (HCBS) waiver agreement in 1982 with the federal Centers for Medicare & Medicaid Services (CMS), then called the Health Care Financing Administration, to provide community options in lieu of building more institutional placements for individuals with developmental disabilities. As part of the waiver, Florida agreed to provide 26 services to eligible Floridians. While the waiver is not an entitlement program, the waiver agreement requires the state to continually provide medically necessary services to all individuals on the waiver.

The purpose of the Florida waiver as defined in the approved waiver agreement is "to promote and maintain the health of eligible recipients with developmental disabilities; to minimize the effects of illness and disabilities through the provision of needed supports and services to delay or prevent institutionalization; and to foster the principles of self-

determination as a foundation for supports and services. The intent of the waiver is to provide an array of services from which eligible recipients may choose, which allow them to live as independently as possible in their own home or in the community and to achieve productive lives as opposed to residing in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) or other institutional settings."

Since 1982, the waiver program has gone through many changes. During the 1990s, the waiver was expanded to serve more individuals and to provide more service options to individuals on the waiver. The 1999 Prado-Steinman settlement agreement resulted in offering waiver enrollment to everyone on the waiting list, providing full funding for medically necessary services requested, and due process rights for individuals.

During the 2000s, the Consumer-Directed Care Plus program was launched to allow individuals to have more flexibility in how to spend budgeted funds and to be able to hire family members to be caregivers. A standard rate structure was implemented, and thousands of individuals were enrolled on to the waiver. The waiver began running a deficit and service rates were reduced, services were eliminated or reduced, and a four-tier waiver system was implemented to contain costs.

During the 2010s, funds were provided to address past deficits and the iBudget waiver program was implemented to provide more flexibility to waiver clients on the use of their allocated funds and as a cost containment measure. The iBudget waiver program introduced an allocation methodology and algorithm to determine the iBudget amount to be provided to each waiver client based upon the budget amount appropriated for the program. Using this methodology, the iBudget waiver program was to remain within appropriation. The iBudget waiver program was fully implemented in 2013. Since then,

there have been multiple court cases and rule challenges that have resulted in more funding for more clients. The 2013 Moreland ruling[4] required the iBudget amounts of 6,000 individuals be restored to pre-iBudget levels. The 2013 Wheaton settlement[5] agreement required the timely processing of requests for additional funding amounts. The 2014 iBudget rule challenge required that 14,000 individuals have their iBudget amounts increased to the individuals' algorithm amounts. In addition, each year thousands of existing waiver clients request additional funding to address their changing service needs. The majority of the requests are granted because medical necessity can be established for the services.

Because of court decisions and requests for additional funds for medically necessary services, the iBudget allocation methodology and algorithm have not been successful in containing costs as originally envisioned.

Medicaid was created to serve people with disabilities, the elderly, and those living in extreme poverty. We cannot forget how far we've come. We must make the commitment to effectively meet the needs of these vulnerable individuals in the community today, tomorrow, and beyond.

[4] Moreland, et all. v. Palmer (U.S.N.D.FL. Case No. 4:12-cv-00585-MW/CAS)
[5] Wheaton v. Palmer (U.S.N.D.FL. Case No. 4:13cv179-MW/CAS)

# WAIVER OVERVIEW

There are over 34,500 individuals in the iBudget waiver program and there are over 21,000 on the waiting list for the iBudget waiver program. The purpose of the iBudget waiver program is to provide medically necessary services to individuals that allow them to live in their communities rather than in institutions. Waiver services should augment the natural supports available to the individual through family members and the community. Each individual on the waiver must select a Waiver Support Coordinator, paid through the waiver, to assist them in fully utilizing the natural supports and community resources available to them. Individuals enrolled in the iBudget waiver program should receive services that enable them to:

- Have a safe place to live;
- Have a meaningful day activity;
- Receive medically necessary medical and dental services;
- Receive medically necessary supplies and equipment; and
- Receive transportation required to access necessary waiver services.

Seventy-one percent (71%) of all individuals enrolled in the iBudget waiver program live with their families or in their own homes. Twenty-nine percent (29%) live in community residential facilities licensed by APD. Living in the community is not only beneficial to the client and their family, on average it is also more cost effective than institutional care.

APD was directed by the Legislature to design and implement the current iBudget waiver program because “improved financial management of the existing home and community-based Medicaid waiver program is necessary to avoid deficits.” The key budgetary components of the iBudget waiver program are a statistically valid algorithm for “the equitable allocation of available funds based on the client’s level of need” and a reserve

amount of the waiver appropriation for “needs that cannot be accommodated within the funding determined by the algorithm and having no other resources, supports, or services available to meet the need.” APD uses a Significant Additional Needs (SAN) process to provide additional funding to individuals who cannot fund their medically necessary services within their existing allocation[6]. The premise of the iBudget waiver program is that the appropriation will be distributed among the waiver clients based upon level of need and they will have the flexibility to use the funds to choose which services would best meet their needs. Implicit in the statute is the agency will deny additional funding to clients once all of the appropriated funds are distributed among the waiver clients. However, federal regulations[7] prohibit states from denying coverage of “medically necessary” services that fall under a category covered in their Medicaid plans. Further, court rulings[8] have held that states may not deny “medically necessary” services to waiver clients solely based on budget availability.

The primary reason waiver expenditures rise each year is over time individuals with developmental disabilities and their caregivers become less able to provide natural supports, thus more waiver services are needed for the individual to continue living in their community. The cost of the increased service needs of waiver clients has always outpaced funding allocations. Most Medicaid-funded programs have annual increased costs. In Florida, the SSEC provides the Legislature and others with projections of future spending for the Medicaid-funded programs; however, the iBudget waiver program is not included in the conference.

[6] Section 393.0662(1)(a), Florida Statutes, and Rule 65g-4.0214, Florida Administrative Code
[7] See Appendix F
[8] See Appendix F

Because of this exclusion, there is no formal method, other than Legislative Budget Request issues and the Surplus/Deficit report, to communicate to the Legislature the projections of future waiver spending. Another difference between the iBudget waiver program and the other Medicaid programs is enrollment in the iBudget waiver program is not an entitlement. However, once on the waiver, clients are entitled to those services that have been determined medically necessary for them to continue to reside in the community. The primary reasons for the growth in iBudget waiver program expenditures are changing service needs due to clients aging, caregivers aging, and other life events.

Because of the increased need for medically necessary services for existing waiver clients, the iBudget waiver program had a deficit for the 2018-2019 fiscal year. In the event of a deficit, the 2019 Implementing Bill directs APD to work with AHCA to develop a plan to redesign the iBudget waiver program.

# WAIVER REDESIGN PLAN

The plan to redesign the iBudget waiver program will address the budgetary challenges of the current iBudget waiver program, while retaining services and flexibility for waiver clients and improving support coordination services. The plan changes some existing processes, introduces some cost limitations, utilizes other funding sources, and expands services in other agencies to better serve APD clients.

The changes in existing processes should result in better understanding and prediction of the growth in client services and costs. The cost limitations should reduce the level of growth in waiver expenditures. The utilization of other funding sources will reduce waiver expenditures but may not reduce expenditures at the state level. Expanding some services of other agencies will provide needed services to APD clients and avoid the need for some waiver services.

Key elements of the plan are:

1. Include the iBudget waiver program in the Social Services Estimating Conference to better project and communicate future waiver expenditures;

2. Eliminate the iBudget algorithm and allocation process, and replace them with an assessment tool capable of determining client service needs and funding based upon assessment results (Note: This element can only be implemented when the revised assessment tool has been adopted);

3. Centralize the process of determining medical necessity for significant additional needs requests for services to ensure consistency in application of criteria;

4. Restructure support coordination services to improve management of service utilization, increase use of natural supports, increase accountability and responsiveness by implementing a robust training and certification process;

5. Implement an individual cap that is consistent with the new intermediate care facility (ICF) rate (institutional care) for individuals with severe behavioral needs;

6. Implement service limitations for Life Skills Development services;

7. Expand the number of APD group homes that qualify for the AHCA Medicaid Assistive Care Services (ACS) to reduce iBudget waiver program residential costs;

8. Allow for the transfer of budget authority from AHCA to APD for individuals enrolled on the waiver turning 21 who previously received services through the Medicaid State Plan;

9. Implement an ICF service and rate in the AHCA Medicaid program to serve individuals with severe behavioral needs who require services beyond the limits of the iBudget waiver program;

10. Increase the resources available to the Department of Children and Families (DCF) Florida Assertive Community Treatment (FACT) and Community Action Team (CAT) programs in order to serve individuals with comorbid mental health and developmental disabilities to address issues early and avoid the need for more costly services; and

11. Appropriate funding sufficient to provide medically necessary services in the most appropriate setting for all enrolled waiver clients.

***Description of Key Plan Elements***

**1. Include the iBudget Waiver Program in the Social Services Estimating Conference**

Including the iBudget waiver program in the Social Services Estimating Conference will have Legislative and Governor's Office economists analyzing waiver service utilization and expenditures. This will add a level of rigor that has not been available previously and should provide decision-makers with an assurance of the validity of the figures.

This change will require action by the conference principals.

**2. Replace iBudget Algorithm with New Assessment Tool**

The allocation methodology and algorithm are not serving their intended purpose because of federal regulations and court rulings that services cannot be denied based on budgetary constraints.

The Next Generation – Questionnaire for Situational Information (NG-QSI) is a comprehensive assessment tool that has been developed for APD and is currently being updated and validated. The NG-QSI will replace APD's current assessment tool, the Questionnaire for Situational Information (QSI). The functional, physical, behavioral, and demographic information collected by the NG-QSI assessment tool will be used to identify needs on an individual basis and assist with budget predictability and service identification while maintaining the flexibility that is part of the existing iBudget waiver program. The

NG-QSI will also assess the level of natural supports available to clients, including the age of the caregiver, living situations, and other support needs. The NG-QSI will enable waiver support coordinators (WSCs) to better coordinate services that address health and safety risks of clients.

A comprehensive needs assessment is the first step in identifying client needs and correlating those needs to waiver service delivery. According to the Human Services Research Institute, the use of assessment-informed budgeting promotes equity in services for individuals with unique needs and is used in thirty-one (31) other states[9].

Implementation of the NG-QSI will enhance budget predictability of current service needs and future service needs using the data collected.

This change will require statutory and rule changes.

### 3. Centralize the Significant Additional Needs Determination Process

Centralizing the process of making medical necessity determinations of services requested through the SANs process will allow for more consistent application of medical necessity criteria. Currently the SANs process is decentralized in local APD offices, making it difficult to ensure consistent application of medical necessity criteria for requested services. Having all of the SANs reviewers in one location will allow for targeted training, quality assurance, and inter-rater reliability. Centralization will also allow all requests for medical and behavior-related services to be reviewed by a nurse or behavior analyst.

[9] Making Self-Direction a Reality by Human Services Research Institute

Centralization of the SANs process will ensure that waiver clients receive the medically necessary services they need to remain in the community. APD has the statutory authority to make this change and is currently in the process of implementing.

### 4. Restructure Support Coordination Services

Restructuring support coordination services will improve training and increase accountability. Waiver Support Coordinators (WSCs) serve a critical role in the iBudget waiver program. WSCs are independent, enrolled service providers who are responsible for guiding waiver clients through the iBudget waiver program to ensure that they fully utilize their natural supports and only receive those waiver services that are medically necessary for the client to remain in the community.

APD will implement a comprehensive and standardized competency-based curriculum to promote quality support coordination services. Although WSCs are required to complete training prior to rendering support coordination services, there is no specific authority for APD to require WSCs to demonstrate minimum competency to perform the job or pass a competency-based assessment before providing services. Additionally, although there are certain training topics that are required before support coordination services can be provided, WSCs are able to obtain training outside of APD and there are no standards to measure the qualifications of trainers nor to assess the value in the content delivered. A comprehensive and standardized competency-based curriculum for WSCs will help APD ensure that WSCs have a clear understanding of the job they perform and that they have the knowledge and skills to appropriately serve APD clients.

APD will implement a rating system for WSCs based upon established objective performance measures. APD will seek broader authority to sanction poor performing WSCs. This change will require statutory and rule changes.

### 5. Implement Individual Caps on Waiver Costs

Implement an individual cap that is consistent with the new proposed intermediate care facility (ICF) rate (institutional care) for individuals with severe behavioral needs ($205,000 annually). There is a federal requirement[10] that the average per person cost of waiver programs be cost neutral as compared to the average per person cost of providing services in institutional settings. States may choose to apply an "individual cost limit" through the waiver. To date, Florida has chosen to apply cost neutrality using the average per person cost.

By changing to individual cost limits at the institutional level, waiver clients with costs above the $205,000 annual amount will either need to reduce their waiver expenditures to come within the cap, possibly by leveraging community natural supports, or they will need to seek services from another source such as entering an ICF by invoking their entitlement. If the cost of an individual's waiver services exceeds this amount, then the community may not be the most appropriate setting for them to receive their services.

Clients Impacted: 85 based upon FY 2017-18 waiver expenditures

Estimated Waiver Savings:

$2.4 million if all 85 were able to reduce expenditures to the cap

[10] Section 1915(c)(2)(D) of the Social Security Act

$19.9 million if all 85 withdrew from the waiver and entered an ICF

NOTE: AHCA would incur additional costs for any individual that chose to enter an ICF.

This change will require CMS approval, rule changes, and statutory changes.

**6. Impose Service Limitations on Life Skills Development Services**

Imposing service limitations on Life Skills Development services (Companion services, Supported Employment services, and Adult Day Training services) will restrict any combination of the services to 1,440 hours annually or the equivalent of 30 hours per week for 48 weeks. This is a reasonable annual amount of these services and was the limit in place prior to implementation of the iBudget waiver program.

Clients Impacted: 1,557 based upon FY 2017-18 waiver expenditures

Estimated Savings: $2.6 million

This change will require rule changes and possible statutory changes.

**7. Allow APD Group Homes to Qualify for Assistive Care Service Payments**

Allowing APD group homes to qualify for the AHCA Medicaid Assistive Care Services (ACS) will reduce iBudget waiver program residential costs. ACS under the Florida Medicaid State Plan provides health support and assistance with activities of daily living and self-administration of medication. At this time, APD licensed group homes are not included in the list of providers who can bill for ACS. Amending the requirements to allow APD group homes to bill for ACS services will allow shifting a portion of residential habilitation costs from the waiver to AHCA without impacting clients or their services. The

iBudget waiver residential habilitation rates would be reduced by the ACS amount (currently $12.25 per client/day), and the providers will bill the waiver and the ACS program for the residential services rendered.

Clients Impacted: No impact on waiver clients

Estimated Waiver Savings: $40 million

NOTE: AHCA would incur additional costs.

This change will require rule changes and statutory changes.

**8. Transfer Budget Authority from AHCA to APD for Waiver Clients Turning 21**

Transfer of budget authority from AHCA to APD for individuals enrolled on the waiver turning 21 will address a cost driver of the iBudget waiver program. All waiver clients under age 21 qualify for the AHCA Early and Periodic Screening Diagnosis and Treatment (EPSDT) program. EPSDT requires AHCA to offer a robust service package to meet all of the medically necessary service needs of Medicaid recipients under the age of 21. When individuals on the waiver turn 21, these services are still needed for their health and safety but are no longer available through the general Medicaid program and the cost shifts to iBudget waiver program. These costs include expensive services such as nursing, personal care, therapies, behavioral services, medical supplies, etc.

Annually transferring budget authority from AHCA to APD for these individuals will address the increased waiver costs.

Clients Impacted: 800 annually

Estimated Savings: $4.5 million annual additional budget authority

Statutory changes and appropriations changes are required.

9. **Implement an Intermediate Care Facility Payment Rate for Individuals with Severe Behavioral Needs (AHCA)**

Implementing an ICF service and rate in the Medicaid program to serve individuals with intensive maladaptive behaviors will provide another residential option for individuals with a developmental disability and maladaptive behaviors.

The current reimbursement methodology for ICFs is based on medical and physical needs and is not inclusive of individuals with intensive behavioral needs. Many people with severe behavioral needs may require constant one-on-one and sometimes two-on-one staffing. Therefore, many ICF providers are unable to serve individuals with intensive maladaptive behaviors because they do not have the capacity to appropriately provide the care they need. This lack of ICFs able to meet the needs of some individuals with developmental disabilities limits their choice of residential settings. Creating a new ICF payment rate will provide individuals with an additional option from which to choose.

APD will collaborate with AHCA and submit LBRs as necessary to develop additional capacity, which will increase the number of available choices for this population. This change will require CMS approval, rule changes, and statutory changes.

10. **Increase Resources for DCF Florida Assertive Community Treatment and Community Action Team Programs**

Increase the resources available to the Department of Children and Families (DCF) Florida Assertive Community Treatment (FACT) and Community Action Team (CAT) programs in order to serve individuals with comorbid mental health and developmental

disabilities. FACT and CAT teams provide a 24-hour-a-day, seven-days-a-week, multidisciplinary approach to deliver comprehensive care to people where they live, work or go to school, and spend their leisure time. APD recommends expansion of these existing DCF programs to serve APD clients with co-occurring mental health issues and severe maladaptive behaviors to avoid duplication of services across agencies.

The FACT and CAT teams are self-contained clinical units that assume responsibility for directly providing the majority of treatment, rehabilitation, and support services to identified individuals with serious psychiatric disabilities such as schizophrenia, schizoaffective disorder, bipolar disorder, major depression, and personality disorders. These individuals are at high risk of repeated psychiatric admissions and have typically experienced prolonged inpatient psychiatric hospitalization or repeated admissions to Baker Act[11] facilities. Many are involved in the criminal justice system and face the possibility of incarceration.

In order to prevent and reduce the number of Baker Act admissions, extended hospitalizations, and encounters with law enforcement, APD proposes revisions to the existing eligibility criteria for the FACT and CAT programs to include individuals with developmental disabilities who also have a co-occurring mental health diagnosis. It is also recommended that the teams be expanded to include members with training and experience working with individuals with developmental disabilities.

[11] The Baker Act (sections 494.451 through 494.47892, Florida Statutes) allows for an individual to be involuntarily committed for examination for possible mental illness; or is in danger of becoming a harm to self or others. Commitment may be ordered by law enforcement officials, physicians, mental health professionals, or judges.

Providing these services to waiver clients during their mental health episodes will reduce the need for more costly waiver services. This change will require rule changes and statutory changes.

### 11. Appropriate Sufficient Funding to Provide Medically Necessary Services

Funding should be appropriated at a level sufficient to provide medically necessary services in the most appropriate setting for all clients. Although the elements of this waiver redesign plan address a portion of the growth in services and costs, they do not address the entire estimated amount. Providing additional funding for medically necessary services is an investment by the state of Florida in individuals with developmental disabilities to allow them to continue to live, learn, and work in their communities. The return on investment is the quality of life provided to the waiver recipients and the cost avoidance of providing their services in much more costly institutional settings.

This change will enhance budget predictability while preserving services and client flexibility.

# Appendix A

## Waiver Redesign Plan

## Key Components

***Redesign Key Components***

| | Redesign Key Components | Change to Consider | Maximum Service Limits | Total Number of Clients * | Total Clients Affected * | Potential Waiver Savings * | Cost Shift | Implementation Timeline |
|---|---|---|---|---|---|---|---|---|
| 1 | Social Services Estimating Conference (SSEC) | Include the iBudget Waiver program in SSEC to provide the Legislature with projections for the program | N/A | N/A | N/A | N/A | N/A | FY 2020-21 |
| 3 | Medical Necessity Determination/ Significant Additional Needs (SAN) | Centralize the process of SANs determination of medically necessary services to ensure consistency in application of criteria | N/A | 34,500 | 34,500 | Unknown | N/A | ▪ Implement inter-rater reliability and peer review process by Jan 2020 |
| 4 | Support Coordination | Improve performance and increase accountability for Waiver Support Coordinators | N/A | 34,500 | 34,500 | N/A | N/A | ▪ Handbook Rule amendment: Approximately 6 months<br>▪ Amend Florida Statute: FY 2020-21 |
| 5 | Individual Cost Limit at Institutional Level | Implement an annual cap at the individual level for all living settings | Individual cap at the level of the AHCA Proposed Specialized Intermediate Care Facility (ICF) rate:<br><br>100% = $205,130 | 34,500 | 85 | $19,870,370 if all left waiver for an ICF<br><br>$2,434,320 if all remained on waiver with cap limitation | Possible | ▪ Waiver amendment: Approximately 6 months<br>▪ Handbook Rule amendment: Approximately 6 months<br>▪ Amend Florida Statute: FY 2020-21 |
| 6 | Life Skills Development | Combination of companion, supported employment, and adult day training services not to exceed 1,440 hours annually | 1,440 hours annually | 18,593 | 1,557 | $2,570,210 | N/A | ▪ Waiver amendment: Approximately 6 months<br>▪ Rate Rule amendment: Approximately 6 months<br>▪ Handbook Rule amendment: Approximately 6 months<br>▪ Amend Florida Statute: FY 2020-21 |
| 7 | Residential Habilitation | Expand the number of agency group homes that qualify for the AHCA Medicaid Assistive Care Services (ACS) to reduce waiver program residential costs | N/A | 9,000 | No client impact | $40,000,000 | Cost shift to AHCA | ▪ Assistive Care Services Rule amendment: Approximately 6 months<br>▪ State Plan amendment: Approximately 6 months<br>▪ iBudget Rate Rule Change: Approximately 6 months |
| 8 | Medicaid State Plan (MSP) Services Budget Transfer for Aging Out | Allow budgetary transfer from AHCA to APD for waiver clients aging out of MSP services upon turning 21 | N/A | Approx. 800 Annually | Approx. 800 Annually | Approx. $4-5 Million Each Year | Fund transfer from AHCA to APD | FY 2020-21 |
| 10 | Florida Assertive Community Treatment (FACT) and Community Action Team (CAT) Pilot | Increase the resources available to the DCF FACT and CAT teams in order to serve individuals with comorbid mental health and developmental disabilities to address issues early and avoid more costly services in the future | N/A | 34,500 | 34,500 | Unknown | N/A | Implementation can occur once the FACT and CAT teams have the training and/or resources to serve individuals with comorbid mental health and developmental disabilities |

*Client Counts and Potential Savings Amounts are based upon Fiscal Year 2017-18 expenditure data.

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***Redesign Key Components - Require Legislative Budget Request Issue***

| | Redesign Key Components | Change to Consider | Maximum Service Limits | Total Number of Clients | Total Clients Affected | LBR Issue | Cost Shift | Implementation Timeline |
|---|---|---|---|---|---|---|---|---|
| 2 | Next Generation-Questionnaire for Situational Information (NG-QSI) | Eliminate iBudget algorithm and allocation process. Implement the NG-QSI assessment tool capable of determining client needs and funding based on assessment results | N/A | 34,500 | 34,500 | $120,000<br>APD<br>FY 2020-21 LBR<br>Non-Recurring | N/A | • Waiver amendment: Approximately 6 months<br>• Rule amendment: Approximately 6 months<br>• Amend Florida Statute: FY 2020-21<br>• Fully implement by FY 2023-24 |
| 9 | Specialized ICF Rate | Implement an ICF service and rate in the Medicaid program to serve individuals with intensive maladaptive behaviors | $562 per person per day | 187 | 187 | $38,363,421<br>AHCA<br>FY 2020-21 LBR<br>Recurring | Possible | FY 2020-21 |

# Appendix B

Next Generation –

Questionnaire for Situational Information

Assessment tools are a federal requirement of waiver programs.[12] Assessment tools are used by states to assess the functional, physical, and behavioral levels of individuals with intellectual and developmental disabilities to determine what services the individual may require for daily living. The Agency for Persons with Disabilities' (APD) current assessment tool is the Questionnaire for Situational Information (QSI) which was implemented in 2008. The QSI does not collect many important pieces of information that are useful in determining the service needs of individuals, as well as available natural supports and caregiver age. Such information is important in determining current and future needs.

In 2015, APD began the development of a new assessment tool that will address the shortcomings of the current assessment tool. The Next Generation – Questionnaire for Situational Information (NG-QSI) will be the assessment tool for APD once it has been validated and adopted, which is estimated to occur in 2022. The information collected by the NG-QSI assessment tool will be used to identify service needs on an individual basis and assist with budget predictability while maintaining the flexibility that is part of the existing iBudget waiver program. The NG-QSI will also assess the level of natural supports available to clients, including the age of the caregiver, the individuals' living situations, and other support needs. The NG-QSI will enable waiver support coordinators (WSCs) to better coordinate services to address health and safety risks of the individuals served.

The NG-QSI will collect seven groups of information called domains. The domains are:

[12] 42 CFR 441.301(b)(1)

- **Domain 1.0** – **General Information** (e.g., identifying information, eligibility, demographics, and legal information)
- **Domain 2.0** – **Supports and Services** (e.g., living arrangement, anticipated changes in living arrangements, information about a family caregiver, as well as present supports)
- **Domain 3.0** – **Wellness and Health Maintenance** (e.g., any medical condition that requires care and treatment, wellness and health maintenance services, and rating of different aspects of the person's health situation)
- **Domain 4.0** – **Daily Living Skills** (e.g., essential living skills and community living skills the person may have and use, as well as supports the person may require)
- **Domain 5.0** – **Lifestyle, Valued Roles, and Social Integratio**n (e.g., everyday activities, choices, and social integration)
- **Domain 6.0** – **Behavior Concerns** (e.g., maladaptive behaviors that the person may have experienced over the past 12 months. Rates the impact such behaviors may have had on the person's care, treatment, and life choices. Areas assessed are self-injurious behavior, aggression towards others, damage to property, inappropriate sexual behavior, elopement/running away, and other maladaptive behavior(s).
- **Domain 7.0** – **Level of Support** (Contains scoring rubrics for daily living, wellness and health maintenance, and behavior that are used to assign

level of support for the person. All calculations are made electronically based upon information collected in Domains 3.0, 4.0, and 6.0.

Collection of this information is the first step in identifying individual needs and correlating those needs to waiver service delivery. Other states have used assessment-informed budgeting to promote equity in services for individuals with unique needs according to the Human Services Research Institute (HSRI)[13]. In fact, the state of Louisiana has placed in administrative code the allocation of resources using a needs-based assessment[14].

Implementation of the NG-QSI will enhance budget predictability of current service needs and possibly future service needs using the data collected.

[13] Making Self-Direction a Reality by Human Services Research Institute
[14] Title 50, Public Health – Medical Assistance, Louisiana Administrative Code https://www.doa.la.gov/pages/osr/lac/books.aspx

# Appendix C

Centralization of

Significant Additional Needs Process

# Centralization of the Significant Additional Needs (SAN) Process

**Goal**:

Process SAN requests efficiently and consistently with proper consideration for the provision of medically necessary services within allocations.

**Analysis**:

The workgroup evaluated the SAN process and determined that there is no significant benefit from conducting SANs reviews locally. Since the process is essentially a file review, there are more benefits from conducting the reviews centrally.

**Proposal**:

Move the SANs process to the State Office. Encourage regional staff to provide input to the SAN reviewer when appropriate, as is the current practice.

**Action Items**:

For this proposal to be implemented, the following steps are being taken:

1. Specifically define what will be centralized.
2. Determine the number of State Office staff that would be required to complete the SANs process. .
3. Work with HR to develop Position Descriptions and to recruit new employees, potentially using Talent Science in the hiring process.
4. Develop and implement a thorough training program for all SANs reviewers.
5. Work with IT to ensure system and reporting requirements are changed so that workflow is appropriately captured and that the process will be compatible with iConnect.
6. Implement ongoing inter-rater reliability testing and retraining processes.

**Benefits:**

1. Better control and consistency of decisions
2. Consistent training and supervision
3. Reduce subjectivity of SANs reviews
4. Streamlined SANs process, ensuring compliance with time requirements
5. Enable changes in the SANs process as proposed by other work groups to be implemented more quickly and efficiently
6. Enhance the ability to have appropriate clinical staff making medical necessity determinations
7. Enable regional staff to concentrate on other processes
8. Ensure equitable distribution of SANs-related workload
9. Eliminate issue of regional staff defending decisions made by State Office staff in fair hearings, as all witnesses for fair hearings would be drawn from State Office SANs reviewers

# Appendix D

Medical Necessity

*The iBudget Handbook is incorporated by reference into AHCA Rule 59G-13.070, Florida Administrative Code*[15] Pages 1-1 through 1-2 state the following:

**Federally Approved - Purpose of Waiver**

The iBudget waiver provides home and community-based supports and services to eligible persons with developmental disabilities living at home or in a home-like setting. The iBudget waiver program is funded by both federal and matching state dollars.

Individuals enrolled in the iBudget waiver should receive services that enable them to:

- Have a safe place to live,
- Have a meaningful day activity,
- Receive medically necessary medical and dental services,
- Receive medically necessary supplies and equipment, and
- Receive transportation required to access necessary waiver services.

This waiver reflects use of an individual budgeting approach and enhanced opportunities for self-determination. The purpose of this waiver is to:

- Promote and maintain the health and welfare of eligible individuals with developmental disabilities,
- Provide medically necessary supports and services to delay or prevent institutionalization, and
- Foster the principles of self-determination as a foundation for services and supports.

Providing an array of services, from which eligible recipients can choose, allows them to live as independently as possible in their own home or in the community and achieve productive lives. Eligible recipients can choose between the iBudget waiver or an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

The iBudget waiver enhances each recipient's opportunity for participant direction by providing greater choice among services within the limits of an individual budget. To facilitate this, similar services are grouped in service families.

[15] https://ahca.myflorida.com/medicaid/review/specific_policy.shtml

Page 1-8 includes the following requirement:

**MEDICAL NECESSITY – Health and Safety in the Community**

In accordance with Rule 59G-1.010, F.A.C., "[T]he medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which not equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider."

"(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service."

# Appendix E

Federal Requirements

# Federal HCBS Waiver Services Requirements

The State entered into a Home and Community-Based Services (HCBS) Waiver agreement with the Federal Centers for Medicare & Medicaid Services (CMS) to provide 26 services to eligible Florida recipients. The following court rulings require that services be provided to waiver clients if medical necessity is established.

Garrido v. Dudek, 731 F. 3d 1152 (11th Cir. 2013)

The court ruled that federal regulations provide that each service "must be sufficient in amount, duration, and scope to reasonably achieve its purpose;" however, the state Medicaid agency "may place appropriate limits on a service based … on medical necessity." 42 C.F.R. § 440.230. The Medicaid Act and associated implementing regulations grant states the authority to set reasonable standards for the terms "necessary" and "medical necessity." 42 U.S.C. § 1396a(a)(17); 42 C.F.R. § 440.230(d).

The waiver agreement with CMS requires the state to provide medically necessary services to all waiver enrollees; per the provisions found in 42 U.S.C. § 1396a(a)(10), 42 U.S.C. § 1396a(a)(17) and 42 U.S.C. § 440.230(d), states are prohibited from denying coverage of "medically necessary" services that fall under a category covered in their Medicaid plans.

Alvarez v. Betlach 2012, WL10861543 (D. Arizona 2012)

The court ruled that states must provide medically necessary home health services to individuals entitled to those services under 42 U.S.C. § 1396a(a)(10)(D), irrespective of cost.

Moore ex rel. Moore v. Reese 637 F.3d 1220, 1259 (11th Cir. 2011)

The court ruled that "However pressing budgetary burdens may be, we have previously commented that cost considerations alone do not grant participating states a license to shirk their statutory duties under the Medicaid Act."

As defined in 65G-4.0213, F.A.C., a Significant Additional Need (SAN) is a need for additional funding that if not provided would place the health and safety of the individual, the individual's caregiver, or public in serious jeopardy which are authorized under Section 393.0662(1)(b), F.S., and categorized as extraordinary need, significant need for one-time or temporary support or services, or significant increase in the need for services after the beginning of the service plan year. In addition, the term includes a significant need for transportation services as provided in paragraph 65G-4.2018(1)(d), F.A.C.

Wheaton Settlement

The settlement requires APD to adhere to reasonable timeframes for processing requests for additional iBudget waiver services.

# Appendix F

## Improve Waiver Support Coordination Performance and Increase Accountability

# Improve Waiver Support Coordinator Performance and Increase Accountability

The Waiver Support Coordinator (WSC) role is critical to the success of the iBudget waiver program by ensuring that the waiver client fully utilizes community and natural supports, and receives medically necessary services timely. WSCs must interact with families, self-advocates, providers, and the community at large to ensure that the health and safety needs of waiver clients are met. The Agency for Persons with Disabilities (APD) must ensure that the WSCs are fully trained and prepared to perform their duties in order for the iBudget waiver program to be successful.

Consumers, families, and providers are dependent upon WSCs for waiver service authorizations, support, and assistance. Comprehensive and effective competency-based training are required to equip WSCs with the knowledge and information they need to effectively meet the needs of their waiver clients. Also, meaningful consequences are needed for poor performing WSCs and technical assistance must be available for those WSCs who wish to improve.

**Recommendations:**

1. Develop and implement a comprehensive and standardized competency-based curriculum for WSCs to be required statewide to ensure that quality services are provided to consumers served by the iBudget waiver.

2. Establish and implement an objective and easily quantifiable scorecard as a means of providing feedback to WSCs on their performance, and as a tool for self-advocates, families, and guardians to use when selecting a WSC. Examples of measures to consider for the scorecard:

    a. Meeting established timeframes for WSC duties and other assignments, such as Support Plan development, SANs submissions, updates of demographics, etc.
    b. Timely responses to APD requests for information regarding a consumer's health, safety, and wellbeing
    c. Ensuring consumers maintain Medicaid eligibility
    d. Timely follow-up on incident reports

3. Request statutory authority and work with AHCA to expand APD's authority to develop a system of accountability that imposes a range of meaningful consequences for those WSCs who have repeated instances of poor performance.

   Poor performance includes, but is not limited to:

   a. Performance issues addressed in APD Policy/Operating Procedure #4-0014
   b. Performance issues that result in severe disruption for the consumer
   c. Performance issues that result in unnecessary expenditures of Individual and Family Supports funds for covered waiver services

   Recommended sanctions include, but are not limited to, the following:

   a. Required retraining
   b. Plans of Remediation
   c. Fines
   d. Reductions in caseloads
   e. Reductions in counties served
   f. Moratoriums on serving additional clients
   g. Termination of a WSC agency or solo support coordinators from Medicaid for poor performance

4. Establish well-defined criteria for WSCs who are dually employed, including hard limits on various elements, such as the number of hours that are acceptable to be working in another job. It is also recommended that the role of a backup WSC be more clearly defined.

5. Establish specific caseload limits for WSC agency heads so that they are available to provide support, training, and guidance to their WSCs, as well as to address complaints and manage their agencies.

# Appendix G

## 1915(c) I/DD Waiver Research

## 1915(c) I/DD Waiver Research

General waiver information, including how to implement cost limits within a 1915(c) waiver, is located within the *1915(c) Instructions, Technical Guide, and Review Criteria*: http://www.nasuad.org/sites/nasuad/files/Updated%20Waiver%20Instructions.pdf

The Kaiser Family Foundation report on quality and outcomes across all 50 states is available at: https://www.kff.org/report-section/states-focus-on-quality-and-outcomes-amid-waiver-changes-long-term-services-and-supports-reforms/

A comprehensive listing of 1115, 1915(b), and 1915(c) waivers throughout the country is available at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html

A comprehensive review was performed of the waivers serving individuals with intellectual and developmental disabilities throughout the country. In many states, multiple waivers serve this population. Some states have waivers specifically for children with these disabilities and serve adults through a different waiver with different services.

During this review, the goal was to assess whether there are any states that operate waivers for people with intellectual and/or developmental disabilities that impose cost limits. There are 11 states that impose cost limits within at least one 1915(c) waiver. These states are:

1. Montana
2. Missouri
3. North Carolina
4. Ohio
5. Oklahoma
6. Pennsylvania
7. South Carolina
8. Tennessee
9. Texas
10. Washington
11. Wyoming

There are seven states that utilize a managed care approach. These states are:

1. Arizona
2. Iowa
3. Kansas
4. Michigan
5. North Carolina
6. Tennessee
7. Wisconsin

**Oregon's Waivers that serve the DD/ID population:**

1. **OR Children's HCBS**
    - 1915(c)
    - No cost limit
    - Children with DD/ID ages 0 – 17
    - Less than 8,000 participants
    - Services: employment path services, supported employment - individual employment support, waiver case management, discovery/career exploration services, environmental safety modifications, family training - conferences and workshops, specialized medical supplies, supported employment - small group employment support, vehicle modifications

2. **OR Behavioral Model**
    - 1915(c)
    - No cost limit
    - Children with DD/ID ages 0 – 17
    - Less than 200 participants- the state limits the number of participants that it serves at any point in time during the waiver year.
    - Services: waiver case management, environmental safety modifications, family training, individual directed goods and services, special diets, specialized medical supplies, vehicle modifications

3. **OR Adult HCBS**
    - 1915(c)
    - No cost limit
    - Age 18 – no max
    - 7,805 participants
    - Services: employment path services, supported employment - individual employment support, waiver case management, direct nursing, discovery/career exploration services, environmental safety modifications, family training - conferences and workshops, financial management services, special diets, specialized medical supplies, supported employment - small group employment support, vehicle modifications

4. **Comprehensive DD Waiver**
    - 1915(b)(4)
    - No cost limit
    - This waiver provides case management for recipients enrolled in the state's five 1915(c) HCBS waivers.

**New Mexico's Waivers that serve the DD/ID population:**

1. **NM Developmental Disabilities Waiver Program**
    - 1915(c)
    - No cost limit
    - Persons with ID/DD/Autism ages 0 – no max
    - Less than 5,000 participants
    - Services: Provides case management, community integrated employment, customized community supports, living supports, respite, nutritional counseling, occupational therapy for adults, physical therapy for adults, speech and language therapy for adults, supplemental dental care, adult nursing, assistive technology, behavioral support consultation, crisis support, customized in-home supports, environmental modifications, independent living transition service, intense medical living supports, non-medical transportation, personal support technology/on-site response service, preliminary risk screening and consultation related to inappropriate sexual behavior, socialization and sexuality education

2. **NM Mi Via – ICF/MR**
    - 1915(c)
    - No cost limit
    - Self-directed model
    - Persons with ID/DD/Autism ages 0 – no max
    - Less than 2,000 participants
    - Services: Consultant/support guide, customized community group supports, employment supports, home health aide services, homemaker/direct support services, respite, skilled therapy for adults, personal plan facilitation, behavior support consultation, community direct support, emergency response services, environmental modifications, in-home living supports, individual directed goods and services, nutritional counseling, private duty nursing for adults, specialized therapies, transportation

**Tennessee's Waivers that serve the DD/ID population:**

1. **Tennessee Self-Determination Waiver (0427.R03.00)**
   The Self-Determination Waiver Program serves children and adults with intellectual disabilities and children under age six with developmental delays who qualify for and, absent the provision of services provided under the Self-Determination waiver, would require placement in a private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

The Self-Determination Waiver Program affords persons supported the opportunity to directly manage selected services, including the recruitment and management of service providers. Participants and families (as appropriate) electing self-direction are empowered and have the responsibility for managing, in accordance with waiver service definitions and limitations, a self-determination budget affording flexibility in service design and delivery.

The Self-Determination Waiver Program serves persons who have an established non-institutional place of residence where they live with their family, a non-related caregiver or in their own home and whose needs can be met effectively by the combination of waiver services through this program and natural and other supports available to them. The Self-Determination Waiver does not include residential services such as supported living.

The Self-Determination Waiver offers a continuum of services that are designed to support each person's independence and integration into the community, including opportunities for employment and work in competitive integrated settings and engage in community life. A person-centered planning process is used to identify services to be included in each waiver participants Individual Service Plan, based on the waiver participant's individually identified goals and need for specific services to advance toward, achieve or sustain those goals.

Provides respite, nursing services, nutrition services, occupational therapy, physical therapy, specialized medical equipment and supplies and assistive technology, speech, language, and hearing services, adult dental services, behavior services, behavioral respite services, community participation supports, employment and day services, environmental accessibility modifications, facility-based day supports, individual transportation services, intermittent employment and community integration wrap-around, non-residential homebound support services, orientation and mobility services for impaired vision, personal assistance, personal emergency response systems, semi-independent living services, supported employment - individual employment support, and supported employment - small group employment support for individuals w/ID ages 0 - no max age and DD ages 0-5.

Cost Limit Lower Than Institutional Costs.

This cost limit was established at the inception of the Self-Determination Waiver Program. The target population for this waiver is persons who live with their family, a non-related caregiver or in their own home. These are individuals who have support systems in place, and this waiver is intended to support, but not supplant, that natural caregiving system. Because many of the support needs are met by family and other caregivers, based on the state's experience in this program, this level of service is sufficient to meet the needs of this target population.

However, should the person's needs change, or should the natural support system collapse, provisions exist for the individual to transition to the Employment and Community First CHOICES program, which offers a more comprehensive package of benefits, when needed.

**The cost limit specified by the state is**:

Specify dollar amount: $30,000

**2. Tennessee Comprehensive Aggregate Cap (CAC) (0357.R03.00)**

The Comprehensive Aggregate Cap (CAC) Waiver serves individuals with intellectual disabilities who are former members of the certified class in the United States vs. the State of Tennessee, et al. (Arlington Developmental Center), former members of the certified class in the United States vs. the State of Tennessee, et al. (Clover Bottom Developmental Center), persons discharged from the Harold Jordan Center following a stay of at least 90 days, and individuals transitioned from the Statewide Waiver (#0128) upon its renewal on January 1, 2015, because they were identified by the state as receiving services in excess of the individual cost neutrality cap established for the Statewide Waiver. These are individuals who have been institutionalized in a public institution, were part of a certified class because they were determined to be at risk of placement in a public institution, or have significant services/support needs consistent with that of the population served in a public ICF/IID and who qualify for and, absent the provision of services provided under the CAC waiver, would require placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

The CAC Waiver offers a continuum of services that are designed to support each person’s independence and integration into the community, including opportunities for employment and work in competitive integrated settings and engage in community life. A person-centered planning process is used to identify services to be included in each waiver participants Individual Service Plan, based on the waiver participant’s individually identified goals and need for specific services to advance toward, achieve or sustain those goals.

Provides residential habilitation, respite, support coordination, nursing services, nutrition services, occupational therapy, physical therapy, specialized medical equipment and supplies and assistive technology, speech, language, and hearing services, behavior services, behavioral respite services, community participation supports, dental services, employment and day services, environmental accessibility modifications, facility-based day supports, family model residential support, individual transportation services, intensive behavioral residential services, intermittent employment and community integration wrap-around

supports, medical residential services, non-residential homebound support services, orientation and mobility services for impaired vision, personal assistance, personal emergency response system, semi-independent living, supported employment - individual employment support, supported employment - small group employment support, supported living, and transitional case management for individuals w/ID ages 0 - no max age.

**No Cost Limit.** The state does not apply an individual cost limit.

**3. Tennessee Statewide HCBS Waiver (0128.R05.00)**

The Statewide Home and Community-Based Services Waiver serves children and adults with intellectual disabilities and children under age six with a developmental disability who qualify for and, absent the provision of services provided under the Statewide Waiver, would require placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

The Statewide Waiver offers a continuum of services that are designed to support each person's independence and integration into the community, including opportunities for employment and work in competitive integrated settings and engage in community life. A person-centered planning process is used to identify services to be included in each waiver participants Individual Service Plan, based on the waiver participant's individually identified goals and need for specific services to advance toward, achieve or sustain those goals.

Provides residential habilitation, respite, support coordination, nursing services, nutrition services, occupational therapy, physical therapy, specialized medical equipment and supplies and assistive technology, speech, language, and hearing services, adult dental services, behavior services, behavioral respite services, community participation supports, employment and day services, environmental accessibility modifications, facility-based day supports, family model residential support, individual transportation services, intensive behavioral residential services, intermittent employment and community integration wrap-around supports, medical residential services, non-residential homebound support services, orientation and mobility services for impaired vision, personal assistance, personal emergency response systems, semi-independent living, supported employment - individual employment support, supported employment - small group employment support, supported living, and transitional case management for individuals w/DD ages 0 - 5, and w/IID ages 0 - no max age.

**Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services

furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver.

**Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Consistent with the special terms and conditions of the state's approved 1115 demonstration and the June 2015 guidance issued by CMS, Tennessee utilizes tiered standards in its HCBS programs, working to ensure minimum compliance across settings in its Section 1915(c) waivers while closing all new enrollment into these waivers and directing all new HCBS enrollment into the Employment and Community First CHOICES program. For persons currently enrolled in the Statewide Waiver program, prior to entrance into the Statewide Waiver Program, an individualized assessment of need was conducted by the DIDD intake staff. The purpose of this assessment was to identify the service needs and to project the total cost for the services in order to determine whether the person's needs could be satisfactorily met in a manner that assures the individual's health and welfare.

**Other safeguard(s):**
Should a change in the participant's condition or circumstances post-entrance to the waiver require the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, TennCare and DIDD will first work with the Independent Support Coordinator and with the participant's MCO to determine whether additional services and supports needs can be met through covered or cost-effective alternative services available through the managed care program, allowing the person to continue participation in the waiver program. If, following such coordination efforts, it is determined that the participant's health and welfare cannot be assured in the waiver, TennCare and DIDD will work with the individual to facilitate transition to another more appropriate LTSS program or service. This includes the Managed Long-Term Services and Supports Program, Employment and Community First CHOICES. Notice of disenrollment, including the right to fair hearing, would be issued. The applicant would have 30 days to request a fair hearing from TennCare. Fair hearings regarding disenrollment from an HCBS waiver are conducted in accordance with the Uniform Administrative Procedures Act. However, a person enrolled in this waiver shall not be disenrolled if the sole reason the cost cap would be exceeded is a change in the reimbursement methodology that is required under the terms of the Statewide Transition Plan in order to achieve compliance with the federal HCBS Settings Rule.

**Missouri's Waivers that serve the DD/ID population:**

1. **Missouri AIDS (0197.R05.00)**
   Provides waiver personal care, attendant care, private duty nursing, specialized medical supplies for individuals w/HIV/AIDS ages 21 - no max age.

   **No Cost Limit.** The state does not apply an individual cost limit.

2. **Missouri Independent Living (0346.R04.00)**
   Provides case management, personal care, financial management services, environmental accessibility adaptations, and specialized medical equipment and supplies for individuals with physical disabilities ages 18-64.

   **No Cost Limit.** The state does not apply an individual cost limit.

3. **Missouri Children with DD (MOCDD) (4185.R05.00)**

   GOAL: Establish and maintain a community-based system of care for children with developmental disabilities that includes a comprehensive array of services that meets the individualized support needs of children to allow them to remain at home with their families rather than enter an institution, group home, or other out-of-home care.

   OBJECTIVES: 1) provide families choice between ICF/ID institutional care and comprehensive, cost-effective community-based care; 2) maintain and improve a community-based system of care that diverts children from institutional care and residential care; 3) maintain and improve community-based care so services are sufficient to support children living at home with their family; and 4) provide choice and flexibility within a community-based system of care.

   Children in this waiver are living at home with their family but require services and supports so that family members can continue employment and primary caregivers can access relief. This waiver allows certain State MO HealthNet eligibility requirements to be waived so that children targeted for participation may be determined MO HealthNet eligible. In Missouri, the income and resources of a child's parents must be considered in determining the child's financial eligibility for MO HealthNet when the child lives in the home with the parents. This requirement called "deeming parental income to the child: is waived for children who participate in the waiver. For these children, financial eligibility for MO HealthNet is determined solely on the income and resources of the child.

   The waiver is administered by the Division of Developmental Disabilities (DD) through an interagency agreement with the Department of Social Services, the Single State Medicaid Agency. Division of DD has 6 Regional Offices with 5

satellite offices (herein referred to as Regional Offices) that are the gatekeepers for the waiver. The Regional Offices determine eligibility, provide case management, and other administrative functions including quality enhancement, person centered planning, and operation of prior authorization and utilization review processes. Through contracts administered by the Department of Mental Health, SB-40 Boards (public entities) and other Targeted Case Management (TCM) entities provide limited waiver administration functions (case management) in coordination with Regional Offices and oversight from the Division of DD.

Service delivery methods in this waiver include provider-managed (for all waiver services); and there is a self-directed option for personal assistant and community specialist.

Each waiver provider has a contract with the Division of DD. Division of DD Regional Offices authorize services to the providers. Providers must bill through the Division of DDs prior authorization system. The Division of DD submits the qualified bills to the Medicaid claim processing fiscal agent. The Medicaid MMIS pays the providers directly for services provided.

Provides day habilitation, in home respite, personal assistant, support broker, applied behavior analysis, assistive technology, community integration, community specialist, crisis intervention, environmental accessibility adaptations-home/vehicle modification, individualized skill development, out of home respite, person centered strategies consultation, specialized medical equipment and supplies (adaptive equipment), and transportation for children with ID, DD 0-17 yrs.

**Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver.

**Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

In advance of enrollment in the waiver, the needs of the individual and how best to meet the needs are identified. From this assessment, a support plan is developed that specifies the amount, frequency, and duration of all services that are needed to assure health and safety. All potential sources for meeting the needs will be explored such as private insurance, other federal programs, state and local programs as well as non-paid support provided by family and friends. The total

cost of needed services through the waiver will be compared to the average cost of ICF/ID care.

If enrollment in the waiver is denied the applicant is notified writing that they have an opportunity to request a fair hearing.

**Other safeguard(s):**
Participants in this waiver are not eligible for MO HealthNet due to parental income and resources without access to the waiver. Therefore, they will not be eligible for another waiver. Other safeguards: 1) Most have private insurance and are encouraged to keep their private insurance coverage. Children whose parents have or have access to private insurance are encouraged to apply for the DSS Health Insurance Premium Payment Program; and 2) participants are children under the age of 18 whose family members usually assist with some of the care without compensation. If an individual cap was met and additional services were needed, the Regional Office may consider using state funds to meet the additional need, may refer the family to a local County SB-40 Board for funds to meet the additional need, and may refer the individual to other services in the community.

**4. Missouri Partnership for Hope (0841.R02.00)**
PROGRAM PURPOSE: The purpose is to prevent or delay of institutional services for individuals who require minimal services in order to continue living in the community. The waiver will offer prevention services to stabilize individuals primarily living with family members who provide significant support, but are not able to meet all of the individual's needs.

GOALS: To increase access to waiver services for children and adults at the local level in participating counties.

OBJECTIVES: The objectives of the waiver are: 1) to increase the capacity of the State to meet the needs of individuals at risk of institutionalization who require minimal supports to continue living in integrated community settings; 2) to partner with local County Boards through Intergovernmental Agreements in the administration and funding of waiver services; and 3) to implement preventive services in a timely manner in order that eligible participants may continue living in the community with their families.

ORGANIZATIONAL STRUCTURE: The waiver is administered by the Division of Developmental Disabilities (DD) through an interagency agreement with the Department of Social Services, the Single State Medicaid Agency. Through intergovernmental agreements specific waiver administrative tasks are delegated to the boards or other not for profit entities that contract with the Division of DD to provide Targeted Case Management (TCM) services of the participating counties with oversight by the Division of DD, which is the operating agency.

SERVICE DELIVERY METHODS: While traditional service delivery methods will be used, participant-directed services will be an option. As the operational agency for the waiver, the Division of DD's method of service delivery in this waiver is the same as that in 1915(c) waivers operated by this division. Service delivery methods include both provider-managed and participant-directed. Services that may be participant-directed or by an authorized representative are personal assistant, support broker, and community specialist. The state operational agency is responsible eligibility determination, provider credentialing and contracting, prior authorization, claim submission, claim payment, technical assistance and oversight to local agencies, and quality enhancement.

Provides day habilitation, personal assistant, prevocational services, supported employment, dental, support broker, applied behavior analysis (ABA), assistive technology, career planning, community integration, community specialist, community transition, environmental accessibility adaptations-home/vehicle modification, family peer support, individualized skill development, job development, occupational therapy, person centered strategies consultation, physical therapy, professional assessment and monitoring, specialized medical equipment and supplies (adaptive equipment), speech therapy, temporary residential service, and transportation for individuals w/autism, ID, DD ages 0 - no max age.

Cost Limit Lower Than Institutional Costs.

The individual support plan (ISP) must validate the individual's annual need for waiver services can be met at a cost of $12,362 or less, or up to $15,000 if the participant meets criteria..

The basis for the limit is that individuals participating in this waiver live with family members, have a strong and stable system of natural supports, have support needs that do not warrant participation in either the Community Support or Comprehensive waiver, or have funding from other public programs that in combination with waiver services ensures the individuals have sufficient services and supports to assure their health and safety. Individuals in the PfH waiver will be eligible for MO HealthNet State plan services and will be assisted in accessing those services first. More costly residential services are not included in this waiver.

Individuals are assessed prior to entering this waiver and annually to identify their needs and estimate the cost of waiver services necessary to meet the needs. When additional needs may arise that exceed the cost limits of a particular Division of DD waiver (e.g., Partnership for Hope Waiver) the planning team will support the individual to obtain additional waiver resources to meet the need. If the estimated cost of waiver services exceeds the limit initially or after entering the

waiver, the individual is considered for participation in another DD waiver that that can meet their need that does not have a cap.

The regional offices of the operating agency report to the operating agency's central office if the cap becomes too low to meet the needs of a significant number of current participants and/or prospective participants. The cap will be adjusted by amendment if it is determined the cap is not sufficient to meet the needs of a growing number of participants or as a result of system changes such as a statewide provider rate increase.

**The cost limit specified by the state is**:

Specify dollar amount: $12,362

**5. Missouri Medically Fragile Adult (40190.R04.00)**

The Medically Fragile Adult Waiver (MFAW) will provide home and community-based services to participants with serious and complex medical needs who have reached the age of 21 and are no longer eligible for home care services available under Early Periodic Screening Diagnosis and Treatment (EPSDT), known as Healthy Children and Youth (HCY) in Missouri.

Goals are to: 1) Provide for cost-effective home and community-based services for participants as a cost effective alternative to Intermediate Care Facility for Individuals with Intellectual Disabilities(ICF/IID) placement and 2) Ensure that necessary safeguards have been taken to protect the health and welfare of participants receiving services under the Medically Fragile Adult Waiver.

Objectives include: 1) Provide individual choice between ICF/IID institutional care and comprehensive community based care in a cost effective manner, 2) Maintain and improve a community based system of care that diverts participants from institutional care and residential care, 3) Ensure the adequacy of medical care and services provided through case management, 4) Monitor each participant's condition and continued appropriateness of participation through quarterly home visits by Department of Health and Senior Services (DHSS), Bureau of Special Health Care Needs (BSHCN) RN, and 5) Monitor provider provision of service through care plan reviews and documentation that identifies the participant’s progress, the implementation of services, and the appropriateness of the services provided.

The waiver is administered by the BSHCN through an interagency agreement with the Single State Medicaid Agency, Department of Social Services, MO HealthNet Division (DSS, MHD). BSHCN provides service coordination services for participants served by the Waiver.

Waiver services are accessed through referral to BSHCN RN for those participants who reach the age of 21, meet the criteria of the waiver and desire to remain in their homes. Referrals are also accepted from health care providers, families, other state agencies and other sources. The BSHCN RN completes assessments for waiver eligibility. A committee comprised of the BSHCN Bureau Chief and Program Manager makes the final determination of eligibility and services available.

Participants and/or responsible parties are provided with a list of service providers available in the area in which they live. Participants and/or responsible parties may choose their provider and may change providers at any time. Services are prior authorized by the BSHCN RN and are subject to approval by the State Medicaid Agency, MHD. Providers are paid directly through the MO HealthNet MMIS system.

Provides waiver attendant care, private duty nursing, and specialized medical supplies for individuals who are medically fragile ages 21 – no max age and w/DD ages 21 - no max age.

**No Cost Limit.** The state does not apply an individual cost limit.

6. **Missouri Aged and Disabled (0026.R07.00)**
   Provides adult day care, basic respite, homemaker, advanced respite, chore, and home delivered meals for aged individuals ages 65 - no max age and physically disabled ages 63-64.

   **No Cost Limit.** The state does not apply an individual cost limit.

7. **Missouri Adult Day Care (1021.R01.00)**
   Provides adult day care for individuals with physical and other disabilities ages 18-63.

   **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver.

   **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The InterRAI Home Care (HC) assessment is a reliable person-centered assessment that informs and guides comprehensive care and service planning in community-based settings. It focuses on the person's functioning and quality of life by assessing needs, strengths, and preferences. This assessment is a comprehensive assessment that identifies supports and services that may be needed to allow an individual to remain in the community. The InterRAI HC can be used to assess persons with chronic needs for care, as well as with post-acute care needs (e.g., after hospitalization or in a hospital at home situation). The participant would be notified of their right to a fair hearing if enrollment is denied.

**Other safeguard(s):**

DSDS will inform the participant of other options and make referrals to other available services in the community. Other alternatives may also include State Plan Personal Care or nursing home care.

# Appendix H

Report on Managed Care for

Persons with Developmental Disabilities

## MANAGED CARE FOR PERSONS WITH DEVELOPMENTAL DISABILITIES
## A Synthesis of Recent Reports

### WHAT IS MEDICAID MANAGED CARE?

Medicaid Managed Care (MMC) programs have become prevalent in state health systems. In 2017, CMS reported 82% of Medicaid recipients were in managed care programs with 69% in comprehensive managed care plans.[16]

State Medicaid programs use three main types of managed care delivery systems[17]:

> **Comprehensive risk-based managed care.** In such arrangements, states contract with managed care organizations (MCOs) to cover all or most Medicaid-covered services for their Medicaid enrollees. Plans are paid a capitation rate—that is, a fixed dollar amount per member per month—to cover a defined set of services.
>
> **Primary care case management (PCCM).** In a PCCM program, each enrollee has a designated primary care provider who is paid a monthly case management fee to assume responsibility for managing and coordinating his or her basic medical care. Individual providers are not at financial risk and continue to be paid on a fee-for-service basis for delivering services.
>
> **Limited-benefit plans.** Some states contract with limited-benefit plans to manage specific benefits, such as inpatient mental health or substance abuse benefits, non-emergency transportation, oral health, or disease management.

States are increasingly relying on managed care programs approaches inclusive of long-term care and supports (LTSS), however use of managed care for people with intellectual and developmental disabilities is far more limited. **In this summary, programs described are primarily comprehensive risk-based managed care.**

### VARIATIONS OF APPROACHES AMONG STATES

MLTSS programs can operate under several Medicaid authorities[18]. States may pursue different Medicaid authorities based on the different types of flexibility they provide and on other changes a state wishes to make to its Medicaid program. States must get approval from the Centers for Medicare & Medicaid Services (CMS) to deliver services through a managed care program, to provide Home and Community-Based Services (HCBS), or both.

- Section 1115 waiver authority is the most common approach used for MLTSS. States have used this authority to waive comparability and statewideness

[16] 2017 Managed Care Enrollment Data from Medicaid.gov web site
[17] MACPAC.gov
[18] MACPAC (2018), page 56)

requirements related to eligibility, benefits, service delivery, and payment methods. States often use this authority when an MLTSS program is rolled into a broader managed care system that may have many other demonstration components. Section 1115 waivers allow states to receive simultaneous approval for the delivery of services through managed care and to provide HCBS. Currently, most Section 1115 waivers must be renewed every five years.

- States may also implement MLTSS by combining a managed care authority and an HCBS authority. For example, states can combine Section 1915(b) waiver authority, which allows states to achieve certain managed care goals and restrict beneficiary choice of providers, with Section 1915(c) waiver authority, which allows states to develop HCBS waiver services. Currently, Section 1915(b) waivers must be renewed every two years, or every five years if individuals who are dually eligible for Medicare and Medicaid are included. Section 1915(c) waiver authority is used for fee for service (FFS) and MLTSS to provide HCBS. States can also use a combination of Section 1915(a) and Section 1915(c) authorities; the combination allows states to implement voluntary managed care plans that include HCBS.

- Finally, states can use Section 1932(a) authority, which allows states to implement mandatory managed care for all populations except individuals dually eligible for Medicaid and Medicare, American Indians and Alaska Natives, and children with special health care needs (including children eligible for Medicaid on the basis of involvement with the child welfare system) through a state plan amendment (SPA). Section 1932(a) SPAs must be paired with a Section 1915(c) waiver to operate an MLTSS program.

### THE GOALS OF MANAGED CARE FOR PERSONS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

States implement MLTSS for a variety of reasons. In a recent survey of twelve[19] states with MLTSS, states reported that their goals included:

- **Rebalancing Medicaid LTSS Spending**. A key goal for all states was rebalancing Medicaid long-term services and supports spending toward home and community-based settings and providing more options for people to live in and receive services in the community. Many states have specific rebalancing targets, as well as financial incentives for MLTSS plans to meet them. Eight states reported that they were making progress toward their rebalancing goals, which aligns with national trends in MLTSS rebalancing.

- **Improving Member Experience, Quality of Life, and Health Outcomes**. All states wanted to improve consumer health and satisfaction/quality of life. While it

[19] Arizona, Florida, Iowa, Kansas, Massachusetts, Minnesota, New Jersey, New Mexico, Rhode Island, Tennessee, Texas, and Virginia. Dobson (2017) cited in MACPAC (2018) page 55.

can be challenging to attribute improvements in health outcomes solely to MLTSS programs, seven states reported improved consumer health. Nine states said that they collect data on quality of life, and 10 states collect data on consumer and family satisfaction. Among states reporting outcomes, MLTSS consumers had improved quality of life and high levels of satisfaction. One challenge highlighted by states was that fielding the surveys used to collect these data is time and labor-intensive.

- **Reducing Waiver Waiting Lists and Increasing Access to Services**. MLTSS programs may reduce or eliminate waiting lists for waiver services. Six states said they wanted to reduce waiting lists, while others focused on increasing access to services. Some states successfully eliminated waiting lists, while other states addressed waiting lists by prioritizing applicants by level of need. Some states reinvested savings achieved through implementing MLTSS to decrease the number of people on waiting lists.

- **Increasing Budget Predictability and Managing Costs**. MLTSS programs' use of capitated payments can help improve budget predictability. The programs also have the potential to achieve savings by: rebalancing LTSS spending; managing service use; and avoiding unnecessary hospitalizations or institutional placements. Five states identified Medicaid cost containment as a goal and seven states identified budget predictability as a goal. While states report they are "bending the cost curve," inadequate data are a barrier to states' ability to demonstrate these outcomes.[20]

Another recent review of state documents, including waiver applications, fact sheets, contracts, and state websites, identified similar goals. The most frequently cited MLTSS goals were related to improved participant outcomes (67% of MLTSS programs reviewed), followed by increased access to HCBS and improved care coordination (both 46%), increased efficiency (41%), and improved consumer choice (15%). [21]

### USE OF MANAGED CARE FOR PERSONS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

In 2018, Truven Health Analytics produced a 2017 updated inventory of state Medicaid Long-Term Service and Supports (MLTSS) programs[22]. This report updated a series of prior reports by Truven documenting the growth of MLTSS.

A June 2018 report by Health Management Associates (HMA) examined the Truven 2017 update report. The HMA report was prepared for the American Network of Community Options and Resources (ANCOR)[23]. The HMA report noted that of the 25 states identified by Truven as operating a MLTSS program in 2017, only ten states currently enrolled

[20] Dobson (2017) cited in MACPAC (2018) page 55.
[21] Lewis, E. et al (2018) cited in MACPAC (2018) page 55.
[22] Lewis, E. et al (2018)
[23] Lewis, S. et al (2018)

people with Intellectual and Developmental Disabilities (I/DD) in MLTSS, and most use an approach other than mandatory statewide programs contracted to commercial multi-state Managed Care Organizations (MCOs).

**States Serving Adults with Intellectual and Developmental Disabilities through Managed Care from Two Reports**

| State | Truven 2017 Covers Adults with I/DD including ICF and HCBS | Truven 2017 Covers Adults with I/DD including HCBS but not ICF | HMA 2018 States with Current MLTSS-I/DD Programs | HMA 2018 States with Emerging MLTSS-I/DD Efforts |
|---|---|---|---|---|
| Arizona | X | | X | |
| Arkansas | | | | X |
| Iowa | X | | X | |
| Kansas | X | | X | |
| Michigan | | X | X | |
| New York | X | | | X |
| North Carolina | X | | X | |
| Pennsylvania | X | | | |
| Rhode Island | | X | | |
| Tennessee | | X | X | |
| Texas | | | | X |
| Wisconsin | X | | X | |

In addition to coverage of adults, the Truven report indicates that 11 states serve children in MLTSS programs; however, the report does not specify whether this coverage includes children with intellectual and developmental disabilities.

Of the ten states enrolling people with intellectual and developmental disabilities, HMA found that, "***To date, only Kansas and Iowa have contracted with large national commercial managed care plans with mandatory enrollment statewide for nearly all beneficiaries with I/DD for all services, inclusive of Home and Community-Based Services (HCBS).***"

The experiences of Kansas and Iowa underscore the importance of proceeding with caution.

Kansas implemented a fully capitated statewide managed care system (KanCare) in 2013 with people with I/DD delayed until early 2014. The program operates under an 1115 waiver with seven 1915(c) waivers operating concurrently. According to HMA, providers in Kansas report that while they are making some progress in working with MCOs, the program has not achieved the stated goals for people with I/DD. Employment outcome improvements have not been achieved and waiting lists have grown.

Media reports indicated that state audits are unable to come to conclusions regarding the program due to lack of data integrity and reliability. A report in Governing magazine noted

that a recent audit found that, “the state’s data is so bad, there’s no way to know [whether KanCare is working].”

In 2017, CMS denied Kansas’ request to renew their 1115 waiver and issued a corrective action plan. The state subsequently operated under a temporary extension. In December 2017, the state submitted an 1115 renewal titled KanCare 2.0. On June 22, 2018, the Governor’s Office announced that contracts had been awarded to three MCOs. These included two existing MCOs and one new entity, Aetna Better Health of Kansas. The previous contract with Amerigroup ended. Information from the state indicates that the new MCO contracts will provide key improvements including greater oversight and accountability.

CMS approved the state’s section 1115 waiver on December 18, 2018, with technical corrections issued on January 15, 2019. The current waiver approval is for January 1, 2019 through December 31, 2023. The Special Terms and Conditions (STC) continue section 1915(c) waiver authority for Home and Community-Based Services (HCBS).

Iowa implemented Iowa Health Link in 2016. IA Health Link is a statewide, fully integrated, mandatory managed care program for all services and all populations including people with I/DD. The program operates under a 1915(b)/(c) waiver and contracts with multi-state national for-profit MCOs. The stated goals of Health Link included improved quality and access, accountability for outcomes and predictable and sustainable Medicaid budgets. The state pursued aggressive savings targets, projecting $53.1 million in savings in the first six months of operation. The state also sought to rebalance the LTSS system from institutional to community-based services.

HMA reported that the focus on costs savings and lack of stakeholder engagement in system design have halted, if not eroded, progress and harmed the I/DD service system. HMA reported that MCOs, providers and beneficiaries all reported that the transition to managed care, “has been rough”. The three participating MCOs all reported significant losses in 2017 with medical loss ratios above 100% in most quarters. In October 2017, the plan with the largest enrollment, AmeriHealth Caritas, exited largely due to the losses they incurred. Subsequently, a replacement contract was awarded to Centene’s Iowa Total Care Plan. As of July 2019, Amerigroup Iowa and Iowa Total Care Plan are the MCOs remaining, according to the state’s website.[24]

Providers have reported significant issues with billing and payment. Providers reported concerns with low reimbursement rates, reductions in services, and statements from families fearful of long-time providers going out of business. HMA reported that interviewees emphasized that Iowa has lost ground on its efforts to improve community integrated services, including employment.

[24] https://dhs.iowa.gov/iahealthlink.

Iowa's managed care program is so new that outcome data is limited. HMA reports that, after a brief decline, waiver waiting lists have risen above previous levels and rebalancing targets have not materialized.

In April 2019, the HHS Office of Inspector General (OIG) announced that it would be initiating a review to determine whether Medicaid Managed Care Organizations were in compliance with federal requirements when denying access to treatment that required prior authorization[25]. The OIG announcement came after a request from Senator Bob Casey[26], the ranking member of the U.S. Senate Special Committee on Aging. Senator Casey's letter cited examples from media reports from Texas and Iowa of denials of care by large managed care organizations. The organization referenced in the Texas examples is a subsidiary of Centene, whose Iowa subsidiary was recently awarded a contract in that state.

In addition to reviewing the actions of managed care organizations, Senator Casey's letter requests the OIG determine if CMS has conducted sufficient oversight to ensure that Medicaid MCOs are meeting their obligations to provide access to care for people enrolled. The HHS OIG's work plan indicates this review will be completed in FFY 2020.

#### IMPLICATIONS FOR FLORIDA?

It is difficult to draw clear conclusions from the experience of other states. In many of the available descriptions, the primary focus of managed care programs has been on the elderly and physically disabled and the outcomes of these people mask the impact of the programs on people with intellectual and developmental disabilities.

Of the goals pursued in other states, the goals most relevant to Florida are controlling costs without adversely affecting service quality and potentially using cost reduction to reduce the waiting list. The experience of Kansas and Iowa shows that these goals are difficult to achieve, particularly in the initial years of implementation.

Where states have made progress in reducing costs and rebalancing Medicaid spending, this has largely been accomplished through shifting from institutional care (such as nursing homes) to community-based settings. This is not particularly relevant to the situation in Florida for people with developmental disabilities.

It should be noted that much of the information outlined above related to Kansas and Iowa is based on interviews and input from stakeholders including providers of service. Information from the agency websites emphasize more positive aspects of implementation. For example, the press release from The Governor's Office in Kansas announcing the award of contracts to three managed care companies stated, "KanCare has proven an effective and efficient delivery model for Medicaid in Kansas…We have

[25] HHS Office of Inspector General Work Plan, April 2019, Report Number W-00-19-31535.
[26] Letter from Senator Casey to HHS Inspector General of April 4, 2019

achieved cost savings, but more importantly, we've seen greater preventative care access to improve health outcomes for Kansans."[27]

The challenge of mapping the best way to proceed with considering managed care for people with intellectual and developmental disabilities was the subject of recent work by the Council on Quality and Leadership (CQL), the Institute on Public Policy for People with Disabilities and Mosaic. These organizations organized a symposium with thought leaders in the industry and stakeholders in October 2018 followed by a second session in March 2019. The report of these sessions noted that there is little research about quality standards for people with intellectual and developmental disabilities and that the majority of research about managed care for persons with disabilities is about health care services and controlling costs, not about quality[28]. The report notes that not only is the provision of quality managed care understudied, but it may also be implemented without an appropriate evidence-base as a result. Further, the report cautions that it is important to recognize that I/DD services are different from supports for all other populations. For other health conditions or disabilities, services and supports are often time limited. However, what may be adequate for other populations, may not be adequate for people with I/DD. Although service needs may ebb and flow during their lifespan, services and supports are often lifelong.[29]

This observation highlights the difficulty in applying findings from managed care experiences related to the elderly and people with physical disabilities to the likely experience of people with intellectual and developmental disabilities.

## Conclusions

From the review of experience in other states, there are some lessons learned that should be considered:

1. **Adequate Planning Time.** The most effective system transformations are the result of a thoughtful and deliberative planning process.
2. **Consumer, Family, and Stakeholder Engagement**. The experiences of states that have encountered difficulties in implementing managed care show the importance of involving consumers, families and stakeholders. This should include person-centered planning and recognition that self-determination is an essential component of quality.
3. **Experience with People with Intellectual and Developmental Disabilities.** Involvement of organizations and providers with extensive experience in meeting the unique service needs of people with intellectual and developmental disabilities is of critical importance.

[27] Office of Governor Jeff Colyer, M.D. June 22, 2018.
[28] Williamson, et al. (2017) cited in Friedman, C. (2019).
[29] Friedman, C. (2019).

Beyond these considerations, the processes of data analysis, program design, procurement, contract development and development of capitation rates are complex. The experience of Florida in establishing the existing managed care program for the elderly and physically disabled may provide very useful information. However, the service needs of people with developmental disabilities are unique.

To date, there is little evidence that managed care for people with intellectual and developmental disabilities results in reduced cost or increased quality of care. It would be prudent to closely monitor the experience of other states that have implemented managed care and to use their lessons-learned to inform strategies for the future.

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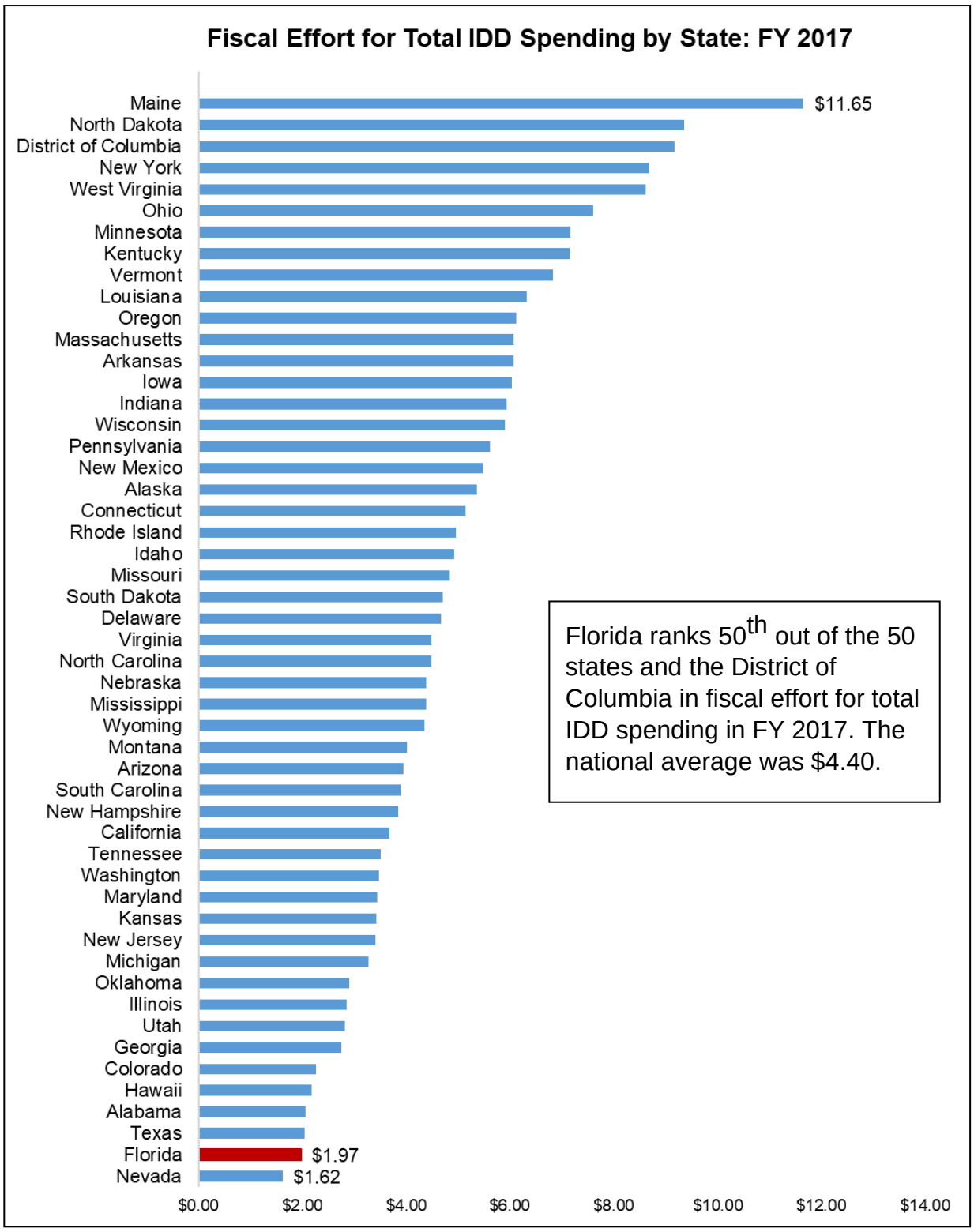
# Appendix I

Data Analysis

# Florida Disability Rankings
## As of 2015[30]

- 1st – Family caregivers over age 60 caring for individuals with developmental disabilities (DD).
    - Caregivers no longer able to provide care is one of the main reasons for waiver clients to require increased services to meet their needs either in their home or in a group home.
    - Caregivers no longer able to provide care is one of the main reasons for individuals with DD not on the waiver to go into crisis requiring either waiver services or institutional care to address their needs.
- 46th – Annual Cost of Care in a Group Home
- 44th – Annual Cost of Care for Supported Living
- 34th – Individual and Family Support Spending per Capita

[30] The State of the States in Intellectual and Developmental Disabilities: 2017, 11th Edition
http://www.stateofthestates.org/

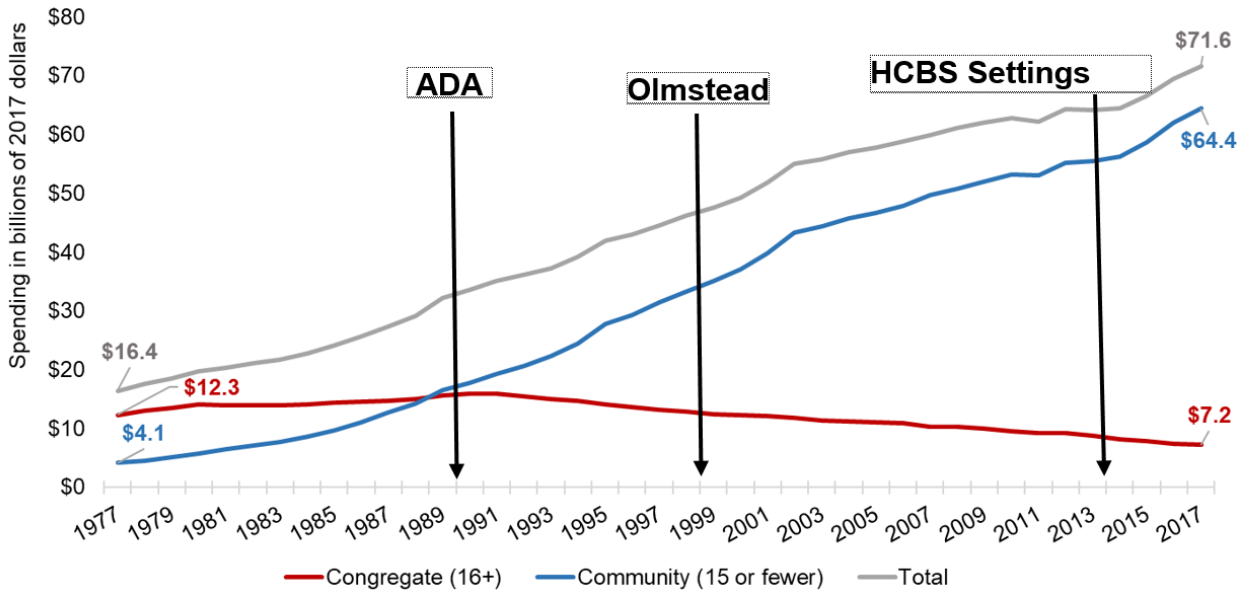

Fiscal Effort for Total IDD Spending by State: FY 2017
Maine $11.65
North Dakota
District of Columbia
New York
West Virginia
Ohio
Minnesota
Kentucky
Vermont
Louisiana
Oregon
Massachusetts
Arkansas
Iowa
Indiana
Wisconsin
Pennsylvania
New Mexico
Alaska
Connecticut
Rhode Island
Idaho
Missouri
South Dakota
Delaware
Virginia
North Carolina
Nebraska
Mississippi
Wyoming
Montana
Arizona
South Carolina
New Hampshire
California
Tennessee
Washington
Maryland
Kansas
New Jersey
Michigan
Oklahoma
Illinois
Utah
Georgia
Colorado
Hawaii
Alabama
Texas
Florida $1.97
Nevada $1.62
$0.00
$2.00
$4.00
$6.00
$8.00
$10.00
$12.00
$14.00
Florida ranks 50th out of the 50 states and the District of Columbia in fiscal effort for total IDD spending in FY 2017. The national average was $4.40.

# *State of the States* Data Highlight

## Public Expenditures on I/DD Community-Based Supports Continue to Outpace Institutional Expenditures

Total public spending on supports and services for individuals with intellectual and developmental disabilities in the United States rose by over four-fold in inflation-adjusted dollars between FYs 1977 and 2017, averaging a 4% increase each year. Spending on community settings (for 15 or fewer individuals) **increased** by nearly 16-fold, while spending on institutional settings (for 16+ individuals) **decreased** by 41% during the same period. Closer examination of institutional expenditures reveal a 54% decrease since the passage of the Americans with Disabilities Act (ADA) in 1990, 42% decrease since the Supreme Court's *Olmstead* decision in 1999, and a 12% decrease since the HCBS Settings Rule was introduced in 2014. [31]

Public Expenditures on I/DD Supports and Services in the US: 1977-2014




Source: Tanis, E.S., Lulinski, A., Wu, J., Braddock, D.L., & Hemp, R. (in preparation). *State of the States in Intellectual and Developmental Disabilities: FY 2017*. University of Colorado.

[31] National Association of State Directors of Developmental Disabilities Services (NASDDDS) VOLUME 26, NUMBER 7 JULY 2019, page 9

## HCBS Waiver Service Utilization - Fiscal Years 2013-14 through 2018-19

| Service Groupings | FY 2013-14 | FY 2014-15 | FY 2015-16 | FY 2016-17 | FY 2017-18 | FY 2018-19 |
|---|---|---|---|---|---|---|
| CDC+Allowance | $ 60,127,933 | $ 70,022,989 | $ 73,855,533 | $ 91,188,155 | $ 104,077,140 | $ 119,996,974 |
| Behavior Analysis | $ 17,407,695 | $ 17,566,946 | $ 18,164,545 | $ 19,206,897 | $ 18,469,225 | $ 18,912,326 |
| Behavior Assistance | $ 6,520,669 | $ 5,604,951 | $ 4,849,156 | $ 3,921,033 | $ 3,260,384 | $ 3,019,699 |
| Diet & Dental Care | $ 2,832,771 | $ 4,473,398 | $ 5,482,776 | $ 5,918,820 | $ 6,339,799 | $ 4,515,923 |
| Employment | $ 4,997,647 | $ 5,214,817 | $ 5,355,648 | $ 5,328,625 | $ 5,268,850 | $ 5,231,315 |
| Home & Environ Access | $ 291,904 | $ 698,170 | $ 1,003,858 | $ 1,023,666 | $ 1,265,449 | $ 1,600,105 |
| In-Home Svs/Companion | $ 194,431,296 | $ 212,202,363 | *$ 240,362,765* | *$ 285,061,074* | *$ 298,378,305* | $ 323,667,703 |
| Live-In Home Staff | $ 225,983 | $ - | $ - | $ - | $ - | $ - |
| Med/Personal Equip | $ 468,466 | $ 813,564 | $ 818,518 | $ 995,584 | $ 1,166,970 | $ 894,054 |
| Medical Supplies | $ 10,803,972 | $ 13,486,089 | $ 13,594,154 | $ 13,416,901 | $ 13,977,898 | $ 14,640,850 |
| Nursing/Spcl Med Care | $ 25,433,045 | $ 31,149,136 | $ 34,397,595 | $ 36,465,073 | $ 41,102,727 | $ 44,272,847 |
| Personal Care | $ 1,109,382 | $ 324 | $ - | $ - | $ - | $ - |
| Residential Habilitation - Behavior Focus | $ 3,124,556 | $ 1,396,235 | $ 1,728,745 | *$ 1,933,480* | *$ 1,880,307* | $ 2,140,892 |
| Residential Habilitation - Intensive Behavior | $ 62,193,444 | $ 63,380,469 | $ 64,889,343 | *$ 70,690,840* | *$ 73,111,244* | $ 78,896,311 |
| Residential Habilitation - Standard or ALF | $ 299,254,141 | $ 320,673,959 | $ 331,552,691 | *$ 351,186,593* | *$ 362,566,856* | $ 385,586,696 |
| Respite | $ 10,929,706 | $ 14,008,877 | $ 15,148,962 | *$ 17,348,457* | *$ 15,950,818* | $ 14,986,089 |
| Support Coach | $ 23,849,936 | $ 24,582,151 | $ 25,273,296 | $ 25,625,334 | $ 24,734,003 | $ 24,815,319 |
| Support Coordination | $ 39,812,514 | $ 41,711,633 | *$ 49,966,714* | $ 53,972,968 | $ 54,287,625 | $ 55,251,330 |
| Therapeutic Svs | $ 8,577,464 | $ 9,035,605 | $ 9,842,243 | $ 10,575,400 | $ 10,762,084 | $ 10,488,599 |
| Training - Facility | $ 65,168,816 | *$ 70,724,217* | $ 74,326,400 | *$ 82,896,178* | *$ 85,282,238* | $ 91,295,225 |
| Training Off Site | $ 568,191 | *$ 795,598* | $ 953,580 | *$ 1,171,456* | *$ 1,231,009* | $ 1,309,653 |
| Transportation | $ 22,379,096 | $ 25,503,245 | $ 28,559,423 | $ 30,779,097 | $ 31,338,518 | $ 34,496,640 |
| **Grand Total** | **860,508,629** | **933,044,734** | **1,000,125,946** | **1,108,705,629** | **1,154,451,450** | **1,236,018,550** |

% Change in service expenditure from previous Fiscal Year

| FY 2014-15 | FY 2015-16 | FY 2016-17 | FY 2017-18 | FY 2018-19 |
|---|---|---|---|---|
| 16.46% | 5.47% | 23.47% | 14.13% | 15.30% |
| 0.91% | 3.40% | 5.74% | -3.84% | 2.40% |
| -14.04% | -13.48% | -19.14% | -16.85% | -7.38% |
| 57.92% | 22.56% | 7.95% | 7.11% | -28.77% |
| 4.35% | 2.70% | -0.50% | -1.12% | -0.71% |
| 139.18% | 43.78% | 1.97% | 23.62% | 26.45% |
| 9.14% | *13.27%* | *18.60%* | *4.67%* | 8.48% |
| | | | | |
| 73.67% | 0.61% | 21.63% | 17.21% | -23.39% |
| 24.83% | 0.80% | -1.30% | 4.18% | 4.74% |
| 22.48% | 10.43% | 6.01% | *12.72%* | 7.71% |
| | | | | |
| -55.31% | 23.81% | *11.84%* | *-2.75%* | 13.86% |
| 1.91% | 2.38% | *8.94%* | *3.42%* | 7.91% |
| 7.16% | 3.39% | *5.92%* | *3.24%* | 6.35% |
| 28.17% | 8.14% | *14.52%* | -8.06% | -6.05% |
| 3.07% | 2.81% | 1.39% | -3.48% | 0.33% |
| 4.77% | *19.79%* | 8.02% | 0.58% | 1.78% |
| 5.34% | 8.93% | 7.45% | 1.77% | -2.54% |
| *8.52%* | 5.09% | *11.53%* | *2.88%* | 7.05% |
| *40.02%* | 19.86% | *22.85%* | *5.08%* | 6.39% |
| 13.96% | 11.98% | 7.77% | 1.82% | 10.08% |

***Source: APD's Allocation, Budget and Contract Control (ABC) System.***

*Provider rate increases contribute to increase in expenditures*
*effective 7/1/2014*
*effective 7/1/2015*
*effective 4/1/2016*
*effective 7/1/2016*
*effective 7/1/2017*

## FY 16-17 TOTAL NUMBER OF SANS STATEWIDE TO DATE

SAN system data as of 10/10/17

| | July | August | Sept. | October | Nov. | Dec. | January | February | March | April | May | June | Total | % | WSC Requested Increase Amount | Final Budget Change Amount |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Approved** | 6 | 33 | 7 | 83 | 114 | 150 | 183 | 369 | 641 | 685 | 597 | 542 | 3,410 | **59.87%** | 23,541,789 | 21,306,716 |
| **Partially Approved** | | 14 | 3 | 55 | 91 | 98 | 121 | 231 | 299 | 329 | 371 | 350 | 1,962 | **34.45%** | 37,064,618 | 18,391,273 |
| **Denied** | 2 | 21 | 22 | 13 | 21 | 20 | 28 | 27 | 30 | 51 | 41 | 48 | 324 | **5.69%** | 4,226,654 | - |
| **Total** | **8** | **68** | **32** | **151** | **226** | **268** | **332** | **627** | **970** | **1,065** | **1,009** | **940** | **5,696** | **100.00%** | **64,833,061** | **39,697,989** |

Electronic SAN submissions began July 1, 2016. Paper submissions prior to July 1, 2016 not captured in this data.

A total of 10,864 SANs were submitted through the electronic SANs submission process identified as FY2016-2017. Not all SANs result in a decision as some are cancelled, withdrawn or re-submitted.

SAN volume increases occurred starting in October as a result of iBudget algorithm implementation.

New algorithms were calculated for consumers with annual Support Plans due January 2017 and forward.

From October 2016 through June 2017, a total of 3,488 SANs were submitted for consumers receiving a new algorithm.

In order to maintain currently approved medically necessary services, a SAN must be submitted when the consumers new algorithm amount is less than the consumers existing iBudget amount.

New algorithms were calculated for consumers with a SAN request whose annual Support Plan was not yet due relative to the algorithm implementation schedule.

From July 2016 through June 2017, a total of 2,208 SANs were submitted for consumers with significant additional needs.

** Unduplicated Consumer Count* *5,513*

## FY 17-18 TOTAL NUMBER OF SANS STATEWIDE TO DATE

SAN system data as of 8/13/2018

| | July | August | Sept. | October | November | December | January | February | March | April | May | June | Total | % | WSC Requested Increase Amount | Final Budget Change Amount |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Approved** | 342 | 380 | 302 | 376 | 330 | 341 | 394 | 338 | 416 | 348 | 319 | 222 | 4,108 | **54.47%** | 87,292,057 | 38,904,394 |
| **Partially Approved** | 240 | 290 | 246 | 274 | 267 | 260 | 261 | 274 | 307 | 262 | 309 | 267 | 3,257 | **43.18%** | 290,697,134 | 33,143,438 |
| **Denied** | 39 | 19 | 10 | 18 | 18 | 16 | 19 | 10 | 6 | 6 | 10 | 6 | 177 | **2.35%** | 2,848,569 | 1,200,296 |
| **Total** | **621** | **689** | **558** | **668** | **615** | **617** | **674** | **622** | **729** | **616** | **638** | **495** | **7,542** | **100.00%** | **380,837,761** | **73,248,128** |

Electronic SAN submissions began July 1, 2016.

A total of 6,906 SANs were submitted through the electronic SANs submission process identified as FY2017-2018. Not all SANs result in a decision as some are cancelled, withdrawn or re-submitted.

SAN volume increases occurred starting in October 2016 as a result of iBudget algorithm implementation.

New algorithms were calculated for consumers with annual Support Plans due January 2017 and forward.

From July 2017 through June 30, 2018, a total of 4,353 SANs notices were issued for consumers whose Waiver Support Coordinator indicated the SAN was the result of an Algorithm Implementation Meeting (AIM).

In order to maintain currently approved medically necessary services, a SAN must be submitted when the consumers new algorithm amount is less than the consumers existing iBudget amount.

New algorithms were calculated for consumers with a SAN request whose annual Support Plan was not yet due relative to the algorithm implementation schedule.

From July 2017 through June 30, 2018, a total of 3,189 SANs notices were issued for consumers with significant additional needs and whose Waiver Support Coordinator indicated the SAN was not the result of an Algorithm Implementation Meeting (AIM).

## FY 18-19 TOTAL NUMBER OF SANS STATEWIDE TO DATE

SAN system data as of 8/1/2019

| | July | August | Sept. | October | November | December | January | February | March | April | May | June | Total | % | WSC Requested Increase Amount | Final Budget Change Amount |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Approved** | 322 | 372 | 484 | 380 | 261 | 200 | 264 | 219 | 194 | 253 | 265 | 215 | 3,429 | **49.66%** | 45,315,793 | 39,690,138 |
| **Partially Approved** | 247 | 311 | 245 | 268 | 266 | 216 | 268 | 299 | 291 | 355 | 362 | 257 | 3,385 | **49.02%** | 109,327,166 | 47,326,896 |
| **Denied** | 8 | 14 | 11 | 4 | 4 | 5 | 8 | 8 | 5 | 8 | 7 | 9 | 91 | **1.32%** | 1,327,570 | (700,756) |
| **Total** | **577** | **697** | **740** | **652** | **531** | **421** | **540** | **526** | **490** | **616** | **634** | **481** | **6,905** | **100.00%** | **155,970,529** | **86,316,278** |

Electronic SAN submissions began July 1, 2016.

A total of 8,002 SANs were submitted through the electronic SANs submission process identified as FY2018-2019. Not all SANs result in a decision as some are cancelled, withdrawn or re-submitted.

SAN volume increases occurred starting in October 2016 as a result of iBudget algorithm implementation.

New algorithms were calculated for consumers with annual Support Plans due January 2017 and forward.

From July 2018 through June 30, 2019, a total of 3,152 SANs notices were issued for consumers whose Waiver Support Coordinator indicated the SAN was the result of an Algorithm Implementation Meeting (AIM).

In order to maintain currently approved medically necessary services, a SAN must be submitted when the consumers new algorithm amount is less than the consumers existing iBudget amount.

New algorithms were calculated for consumers with a SAN request whose annual Support Plan was not yet due relative to the algorithm implementation schedule.

From July 2018 through June 30, 2019, a total of 3,753 SANs notices were issued for consumers with significant additional needs and whose Waiver Support Coordinator indicated the SAN was not the result of an Algorithm Implementation Meeting (AIM).

## Waiver Population by Age Groups
## Fiscal Year 2015-16 to 2018-19

| Age Group | ALL Waiver FY1516 EOY | | ALL Waiver FY1617 EOY | | ALL Waiver FY1718 EOY | | ALL Waiver FY1819 EOY | | Net Change FY1516 vs FY1819 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Count | % | Count | % | Count | % | Count | % | Count | % |
| AGE: 2 TO 10 | 473 | 1.44% | 567 | 1.66% | 592 | 1.73% | 601 | 1.73% | 128 | 6.73% |
| AGE: 11 TO 20 | 4,110 | 12.52% | 3,872 | 11.37% | 3,584 | 10.45% | 3,337 | 9.61% | (773) | -40.64% |
| AGE: 21 TO 30 | 8,985 | 27.37% | 9,495 | 27.88% | 9,764 | 28.48% | 9,887 | 28.47% | 902 | 47.42% |
| AGE: 31 TO 40 | 7,084 | 21.58% | 7,526 | 22.10% | 7,557 | 22.04% | 7,699 | 22.17% | 615 | 32.33% |
| AGE: 41 TO 50 | 5,351 | 16.30% | 5,404 | 15.87% | 5,539 | 16.16% | 5,729 | 16.49% | 378 | 19.87% |
| AGE: 50 TO 60 | 4,423 | 13.47% | 4,576 | 13.44% | 4,523 | 13.19% | 4,558 | 13.12% | 135 | 7.10% |
| AGE: 60 TO 70 | 1,905 | 5.80% | 2,074 | 6.09% | 2,141 | 6.24% | 2,262 | 6.51% | 357 | 18.77% |
| AGE: 70 TO 80 | 447 | 1.36% | 484 | 1.42% | 525 | 1.53% | 594 | 1.71% | 147 | 7.73% |
| AGE: 81 OR OLDER | 52 | 0.16% | 57 | 0.17% | 60 | 0.18% | 65 | 0.19% | 13 | 0.68% |
| Grand Total | 32,830 | 100.00% | 34,055 | 100.00% | 34,285 | 100.00% | 34,732 | 100.00% | 1,902 | 100.00% |

Data includes clients in waiver active status and their age as of the end of each fiscal year period

## Analysis of Top 100 Clients by Expenditure for Fiscal Year 2017-18

- Top 100 Expenditure Average $220,358, Lowest $183,055, Highest $315,909
- 82% are between the ages of 22 and 32

| Age Group | Top 100 | | ALL Waiver | |
|---|---|---|---|---|
| | Count | % | Count | % |
| 03-10 | - | 0.00% | 591 | 1.71% |
| 11-20 | - | 0.00% | 3,375 | 9.79% |
| 21-30 | 75 | 75.00% | 9,832 | 28.51% |
| 31-40 | 19 | 19.00% | 7,618 | 22.09% |
| 41-50 | 3 | 3.00% | 5,676 | 16.46% |
| 51-60 | 3 | 3.00% | 4,534 | 13.15% |
| 61-70 | - | 0.00% | 2,222 | 6.44% |
| 71+ | - | 0.00% | 633 | 1.84% |
| Total | 100 | 100.00% | 34,481 | 100.00% |

- By Living Setting
  - 61% live in the family home
  - 38% live in a group home
  - 1% live in independent/supported living
- By Disability
  - 68% have Intellectual Disabilities
  - 28% have Cerebral Palsy
  - 3% have Autism
  - 1% have Spina Bifida
- By Region

| Region | Top 100 | % | All Waiver | % |
|---|---|---|---|---|
| Central | 25 | 25.00% | 6,459 | 18.73% |
| Northeast | 9 | 9.00% | 5,149 | 14.93% |
| Northwest | - | 0.00% | 2,987 | 8.66% |
| Southeast | 21 | 21.00% | 6,932 | 20.10% |
| Southern | 24 | 24.00% | 5,014 | 14.54% |
| Suncoast | 21 | 21.00% | 7,940 | 23.03% |

- By Service - 6 costliest services
  - Private Duty Nursing – LPN/RN $12,180,293
  - Residential Nursing – LPN/RN $ 5,168,237
  - Residential Habilitation – CTEP $ 1,243,272
  - Personal Supports $ 869,839
  - Residential Habilitation – Standard/ALF $ 845,507
  - Consumable Medical Supplies $ 514,947

## Analysis of Top 100 Clients by Expenditure for Fiscal Year 2018-19

- Top 100 Expenditure Average $238,936, Lowest $206,841, Highest $322,041
- 76% are between the ages of 22 and 32

| Age Group | Top 100 | | ALL Waiver | |
|---|---|---|---|---|
| | Count | % | Count | % |
| 03-10 | - | 0.00% | 598 | 1.73% |
| 11-20 | 1 | 1.00% | 3,335 | 9.64% |
| 21-30 | 71 | 71.00% | 9,872 | 28.52% |
| 31-40 | 21 | 21.00% | 7,685 | 22.20% |
| 41-50 | 4 | 4.00% | 5,716 | 16.51% |
| 51-60 | 2 | 2.00% | 4,528 | 13.08% |
| 61-70 | 1 | 1.00% | 2,234 | 6.45% |
| 71+ | - | 0.00% | 643 | 1.86% |
| Total | 100 | 100.00% | 34,611 | 100.00% |

- By Living Setting
  - 55% live in the family home
  - 44% live in a group home
  - 1% live in independent/supported living
- By Disability
  - 68% have Intellectual Disabilities
  - 27% have Cerebral Palsy
  - 5% have Autism
- By Region

| Region | Top 100 | % | All Waiver | % |
|---|---|---|---|---|
| Central | 19 | 19.00% | 6,484 | 18.73% |
| Northeast | 10 | 10.00% | 5,125 | 14.81% |
| Northwest | - | 0.00% | 2,950 | 8.52% |
| Southeast | 28 | 28.00% | 7,006 | 20.24% |
| Southern | 22 | 22.00% | 5,044 | 14.57% |
| Suncoast | 21 | 21.00% | 8,002 | 23.12% |

- By Service - 6 costliest services
  - Private Duty Nursing – LPN/RN $ 8,838,097
  - Residential/Skilled Nursing $ 6,371,889
  - Residential Habilitation – Standard/ALF $ 3,094,058
  - Residential Habilitation – CTEP $ 453,802
  - Consumable Medical Supplies $ 416,134
  - Personal Supports $ 349,000

# Appendix J

APD/AHCA Meeting Dates and Agendas

The Agency for Persons with Disabilities (APD) and the Agency for Health Care Administration (AHCA) met over the course of several months to discuss topics related to the Waiver redesign plan. Below is a list of the meeting dates and agendas when available.

**March 15, 2019**

**April 4, 2019**

**May 14, 2019**

**May 30, 2019**

| **Topic** |
| --- |
| 1. Introductions |
| 2. Review: Other States Research Comparison of the DD Waiver |
| 3. Discuss: Status of Redesign Options |
| 4. Discuss: Next Steps |

**June 19, 2019**

| Topic |
| --- |
| 1. Introductions & Review of Action Items |
| 2. Review: Comprehensive List of Redesign Options |
| 3. Discuss: Governor's Office Check-in Reminder and What will be Provided |
| 4. Discuss: Scheduling the Next Check-in Meeting with Director Palmer and Secretary Mayhew |
| 5. Discuss: Status of Report |
| 6. Review: APD Budget by Setting for SFY1819 |
| 7. Review: Implementation Process and Timeframe on the Focused Topics:<br>• Reduce Service Rates<br>• Limit Crisis Enrollment<br>• Individual Caps |
| 8. Review: Project Schedule and Report Timeline |
| 9. Discuss: Next Steps |

**June 25, 2019**

| Topic |
| --- |
| 1. Introductions & Review of Action Items |
| 2. Discuss: Building Out Waiver Redesign Options |
| 3. Discuss: Next Steps |

**July 11, 2019**

| Topic |
| --- |
| 1. Introductions & Review of Previous Action Items |
| 2. Prep for APD / AHCA Leadership Meeting on 7/12<br>• Final Report Routing Procedure Options<br>• Status Report Framework<br>• Finalization of Cost Containment Options |
| 3. Review: Cost Containment Options and Managed Care Approaches |
| 4. Review of Project Schedule |

**July 12, 2019**

**July 23, 2019**

| Topic |
| --- |
| 1. Introductions & Review of Previous Action Items |
| 2. Update on APD / AHCA Leadership Meeting on 7/12 |
| 3. Discuss: Research of Waiver Services in Other States |
| 4. Discuss: Managed Care Options |
| 5. Discuss: Public Meeting Outcomes |
| 6. Update on First Status Report Submission |
| 7. Next Steps |
| 8. Review of Project Schedule |

**September 3, 2019**

**September 11, 2019**

# Appendix K

Research Options

**The Agency for Persons with Disabilities has been directed, in conjunction with the Agency for Health Care Administration, to develop a plan to redesign the waiver program and submit such plan to the Legislature for consideration. See Chapter 2019-116, Laws of Florida. The agencies do not necessarily endorse any of these options at this time. Some options, if implemented, will require notifying the affected waiver clients of the change and possible fair hearing rights.**

| | | | | | | | | | Implementation Requirements | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Option Type** | **Service** | **Change to Consider** | **Maximum Service Limits** | **Total Number of Clients** | **Total Clients Affected** | **Overall Financial Impact (Savings)** | **Cost Shift** | **Being Done in Other State(s)** | **Federal** | **State** | **Other** |
| **Rate Reduction** | Provider Service Rates Reduction | Reduction of 1%<br>Reduction of 2%<br>Reduction of 3% | N/A | 34,500 | 34,500 | $11,717,837<br>$23,435,674<br>$35,153,511 | No | N/A | Yes | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•Some private sector service providers may be unwilling or unable to continue doing business in Florida which could create challenges regarding the ability of APD clients to access services within their local communities.<br>•Rate reductions may cause a cost shift to AHCA if community-based providers are no longer willing or able to serve APD clients and those clients subsequently choose to live in ICFs or skilled nursing facilities in order to obtain medically necessary services and supports.<br>•For some providers and services, rate reductions may not support compliance with the United States Department of Labor (USDOL) minimum wage requirements.<br>•A rate reduction would be contrary to rates set through previous rate studies and legislative mandates (which identified and established appropriate costs of care for APD clients). This could result in litigation if the state of Florida knowingly pays inadequate rates for services. | | | | | | | | | |
| | Residential Habilitation | Expand the number of agency group homes that qualify for the AHCA Medicaid Assistive Care Services (ACS) to reduce waiver program residential costs | N/A | 9,000 | No client impact | $40,000,000 | Cost shift to AHCA | N/A | Yes | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>None. | | | | | | | | | |
| **Service Limitation/Service Change** | ADT | •Reduction in number of levels, client shift to next higher ratio<br>•Implement a redesign to promote employment<br>•Introduce a lower rate for "adult day care" | | 13,502<br>11,405 | | $15,000,000<br>$19,000,000 | No | N/A | Yes | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•Less intensive staffing ratios could adversely impact client health and safety and decrease community participation (since less staff would be available to accompany clients on outings).<br>•Providers may not be willing to serve client at lower ratio. | | | | | | | | | |
| | Behavior Services | Limit service to individuals ages 21 and over as Behavior services are available for those under age 21 through Medicaid State Plan | 0 | 76 | 76 | $284,349 | Yes | N/A | Yes | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•None. | | | | | | | | | |

**The Agency for Persons with Disabilities has been directed, in conjunction with the Agency for Health Care Administration, to develop a plan to redesign the waiver program and submit such plan to the Legislature for consideration. See Chapter 2019-116, Laws of Florida. The agencies do not necessarily endorse any of these options at this time. Some options, if implemented, will require notifying the affected waiver clients of the change and possible fair hearing rights.**

| | | | | | | | | | Implementation Requirements | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Option Type** | **Service** | **Change to Consider** | **Maximum Service Limits** | **Total Number of Clients** | **Total Clients Affected** | **Overall Financial Impact (Savings)** | **Cost Shift** | **Being Done in Other State(s)** | **Federal** | **State** | **Other** |
| **Service Limitation/Service Change** | Life Skills Development | Combination of companion, supported employment, and adult day training services not to exceed 1,440 hours annually | 1,440 hours annually | 18,593 | 1,557 | $2,570,210 | No | N/A | Yes | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•Some clients will experience a reduction in services.<br>•Some individuals may increase other waiver services to make up for the loss in Life Skills Development services. For example, if an individual living in the family home or supported living setting requires a set number of hours to ensure their health and safety, some clients may request increases in Personal Supports or other waiver services.<br>•Behavioral issues are often exacerbated by lack of engagement in meaningful day activities and may result in the need for additional services, including more costly behavioral analysis and assistant services. | | | | | | | | | |
| | Occupational Therapy | Limit of 2 hours per week if only therapy service<br><br>If the individual has other therapies (OT, ST, PT) limit is 1 hour per week per therapy<br><br>Limited to 1 hour per week if the individual receives nursing services | 416 QH Annually<br><br>208 QH Annually<br><br>208 QH Annually | 870 | > 416 QH =17<br><br>> 208 QH=475<br><br>>208 QH = 47 | Service Plans = $1,831,109<br><br>Expenditures = $864,677 | Potential | N/A | Yes | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•Significantly limiting therapy hours may result in functional and physical declines for individuals who already have limited capabilities.<br>•Decreasing therapeutic services such as occupational therapy may increase the need for paid staff to perform daily living skills and functions that the clients are learning and maintaining through occupational therapy. This may include daily living skills such as eating, brushing teeth, grasping objects, toileting, etc.<br>•When medically necessary therapies are decreased, some clients may lose job opportunities and the potential for independent living.<br>•Reductions may cause a cost shift to AHCA if community-based providers are no longer willing or able to serve APD clients and those clients subsequently choose to live in ICFs or skilled nursing facilities in order to obtain medically necessary services and supports.<br>•This change increases the likelihood that some clients will choose institutional care to have their needs met if comparable services are not available in the community, which could result in litigation (see Olmstead v. L.C.). | | | | | | | | | |

**The Agency for Persons with Disabilities has been directed, in conjunction with the Agency for Health Care Administration, to develop a plan to redesign the waiver program and submit such plan to the Legislature for consideration. See Chapter 2019-116, Laws of Florida. The agencies do not necessarily endorse any of these options at this time. Some options, if implemented, will require notifying the affected waiver clients of the change and possible fair hearing rights.**

| | | | | | | | | | Implementation Requirements | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Option Type** | **Service** | **Change to Consider** | **Maximum Service Limits** | **Total Number of Clients** | **Total Clients Affected** | **Overall Financial Impact (Savings)** | **Cost Shift** | **Being Done in Other State(s)** | **Federal** | **State** | **Other** |
| **Service Limitation/Service Change** | Personal Supports | Revise definition to exclude "supervision"<br>Require hours beyond 12 hours to be at higher ratios (1:2, 1:3, etc.)<br>the basic areas identified due to physical, medical, or adaptive limitations. Additional hours a month over the 180-hour limit may be requested for intensive physical, medical, or adaptive needs when the hours are essential to maintain the recipient's health and medical status. Any recipient who requires Personal Supports during sleep hours shall provide documentation from a physician stating that services are medically necessary during this time. The support plan shall also explain the duties that the Personal Supports provider will perform. | 6 hours per day = 2,190 H / 8,760 QH Annually<br>8 hours per day Annually<br>12 hours per day = 4,380H / 17,520QH Annually<br>14 hours per day = 5,110H / 20,440QH Annually<br>16 hours per day = 5,840H / 23,360QH Annually<br>18 hours per day = 6,570H / 26,280QH Annually | 13,395 | 2,909<br>650<br>351<br>214<br>119<br>77 | $44,043,512<br>$12,260,352<br>$7,142,561<br>$4,362,000<br>$2,611,256<br>$1,518,580 | Potential | N/A | Yes | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•Some individuals require up to 24 hours per day of Personal Supports because they are unable to complete any activity of daily living without the assistance of someone else. Personal Supports is a life-sustaining service for many APD clients and reducing the amount of personal supports will impact health and safety.<br>•The majority of APD clients live in the family home. The family home is the most cost effective and least restrictive setting for iBudget Waiver clients. The provision of Personal Supports is often the service that allows families to keep APD clients in their homes long term. It includes hands-on care, supervision, community access, and respite for adults who do not access personal care through the Medicaid program. Some APD clients may not be able to remain in their current living setting with reduction of paid support hours. For individuals who live in the family home, parents may not be able to work and meet the housing needs of APD clients. This removes caregivers for individuals who live in supported living settings in their own homes.<br>•This limitation also imposes a health and safety risk for individuals who live in supported living. Individuals require this service so that they can get out of bed, evacuate, eat, and live safely in their homes.<br>•This limitation may result in some clients choosing more costly living settings, including residential care.<br>•Some clients may to choose institutional care to have their needs met if they cannot access Personal Supports which poses a federal litigation risk (see Olmstead v. L.C.) | | | | | | | | |

**The Agency for Persons with Disabilities has been directed, in conjunction with the Agency for Health Care Administration, to develop a plan to redesign the waiver program and submit such plan to the Legislature for consideration. See Chapter 2019-116, Laws of Florida. The agencies do not necessarily endorse any of these options at this time. Some options, if implemented, will require notifying the affected waiver clients of the change and possible fair hearing rights.**

| | | | | | | | | | Implementation Requirements | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Option Type** | **Service** | **Change to Consider** | **Maximum Service Limits** | **Total Number of Clients** | **Total Clients Affected** | **Overall Financial Impact (Savings)** | **Cost Shift** | **Being Done in Other State(s)** | **Federal** | **State** | **Other** |
| **Service Limitation/Service Change** | Physical Therapy | Limit of 2 hours per week if only therapy service<br><br>If the individual has other therapies (OT, ST, PT) limit is 1 hour per week per therapy<br><br>Limited to 1 hour per week if the individual receives nursing services | 416 QH Annually<br><br>208 QH Annually<br><br>208 QH Annually | 1,367 | > 416 QH =83<br><br>> 208 QH=456<br><br>>208 QH = 62 | Service Plans = $1,947,849<br><br>Expenditures = $1,074,622 | Potential | N/A | No | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•Some APD clients have severe physical limitations and require extensive amounts of therapies to prevent contractures, spasticity and to maintain their level of functioning. Significantly limiting therapy hours may result in functional and physical declines for individuals who already have limited capabilities.<br>•Decreasing therapeutic services may increase the need for paid staff to perform daily living skills and functions that the clients are learning and maintaining through therapy.<br>•When medically necessary therapies are decreased, some clients may lose job opportunities and the potential for independent living. | | | | | | | | | | |
| | Residential Habilitation | • Reduce number of levels<br><br>• Revise the annual medical necessity determination process to include a third party for recommendations<br><br>• Res Hab at Moderate/Minimal rate if individual is receiving high levels of nursing through waiver or Medicaid State Plan or personal care through Medicaid State Plan | Where client has Residential Nursing in the Group Home:<br><br>• 0-12 hours of Nursing (17,520 QH max), Res Hab level remains the same<br><br>• 13-16 hours of Nursing (23,360 QH max), Res Hab at the moderate level<br><br>• 17-24 hours of Nursing (35,040 QH max), Res Hab at the minimal level | 134 | 22 | $600,000 | Potential | N/A | Yes | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•Reducing the number of rate levels may require a formal rate study to determine the appropriate cost of care based on client needs.<br>•If payment amounts change, some individuals may have to move out of current stable living arrangement and locate alternate placements.<br>•Rate changes impact private sector providers who may not be able to continue to serve APD clients, thereby creating access-to-care issues. | | | | | | | | | |

**The Agency for Persons with Disabilities has been directed, in conjunction with the Agency for Health Care Administration, to develop a plan to redesign the waiver program and submit such plan to the Legislature for consideration. See Chapter 2019-116, Laws of Florida. The agencies do not necessarily endorse any of these options at this time. Some options, if implemented, will require notifying the affected waiver clients of the change and possible fair hearing rights.**

| | | | | | | | | | Implementation Requirements | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Option Type** | **Service** | **Change to Consider** | **Maximum Service Limits** | **Total Number of Clients** | **Total Clients Affected** | **Overall Financial Impact (Savings)** | **Cost Shift** | **Being Done in Other State(s)** | **Federal** | **State** | **Other** |
| Service Limitation | Respiratory Therapy | Limit of 3 hours per week | 624 QH Annually | 87 | > 624 QH =43 | Service Plans = $261,142<br><br>Expenditures = $120,376 | Potential | N/A | No | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•Respiratory therapy services ensure that individuals with compromised airways get oxygen needed to sustain life. Respiratory therapy is critical for addressing impairments of respiratory function and other deficiencies of the cardiopulmonary system. If there is a reduction in this service, there must be an assurance that a nurses or other caregivers can perform the tasks no longer covered by the respiratory therapist. | | | | | | | | | |
| Service Limitation | [illegible] | Ÿ Limited to 720 Hours / 2880 Quarter Hours for children ages 3-14 Ÿ [illegible] | • Limited to 720 Hours / 2880 Quarter | 703 | 210 | $1,000,000 | Potential | N/A | Yes | Yes | No |
| | | ***Client/Agency Impact and/or Risks*** [illegible] | | | | | | | | | |
| Service Limitation | Skilled Nursing | service as it is available for all ages through Medicaid State Plan | 0 | 40 | 40 | $478,985 | Yes | N/A | Yes | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•AHCA will need to ensure that adequate provider capacity exists to meet APD client needs. | | | | | | | | | |
| Service Limitation | Specialized Mental Health | Limit of 2 hours per month | 96 QH Annually | 294 | > 96 QH =241 | Service Plans = $511,301<br><br>Expenditures = $247,113 | Yes | N/A | No | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•APD has numerous clients who are dually diagnosed with co-occurring mental illness and developmental disabilities. Limiting the availability of mental health services can result in an increase in Baker Acts, extended hospitalizations, and encounters with law enforcement.<br>•Many APD clients are not able to benefit from traditional community mental health services (which are typically geared towards individuals without cognitive impairments). | | | | | | | | | |

**The Agency for Persons with Disabilities has been directed, in conjunction with the Agency for Health Care Administration, to develop a plan to redesign the waiver program and submit such plan to the Legislature for consideration. See Chapter 2019-116, Laws of Florida. The agencies do not necessarily endorse any of these options at this time. Some options, if implemented, will require notifying the affected waiver clients of the change and possible fair hearing rights.**

| | | | | | | | | | Implementation Requirements | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Option Type** | **Service** | **Change to Consider** | **Maximum Service Limits** | **Total Number of Clients** | **Total Clients Affected** | **Overall Financial Impact (Savings)** | **Cost Shift** | **Being Done in Other State(s)** | **Federal** | **State** | **Other** |
| **Service Limitation/Service Change** | Speech Therapy | Limit of 2 hours per week if only therapy service<br><br>If the individual has other therapies (OT, ST, PT) limit is 1 hour per week per therapy<br><br>Limited to 1 hour per week if the individual receives nursing services | 416 QH Annually<br><br>208 QH Annually<br><br>208 QH Annually | 816 | > 416 QH =36<br><br>> 208 QH=252<br><br>>208 QH = 13 | Service Plans = $999,584<br><br>Expenditures = $296,906 | Potential | N/A | No | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•Behavioral issues are often exacerbated by the inability of non-verbal clients to sufficiently communicate their needs in an appropriate manner. Speech therapy assists such clients and restricting access to this service and may result in the need for additional supports, including more costly behavioral analysis and behavior assistant services.<br>•When medically necessary therapies are decreased, some clients may lose job opportunities and the potential for independent living.<br>•Reductions may cause a cost shift to AHCA if community-based providers are no longer willing or able to serve APD clients and those clients subsequently choose to live in ICFs or skilled nursing facilities in order to obtain medically necessary services and supports.<br>•This change increases the likelihood that some clients will choose institutional care to have their needs met if comparable services are not available in the community which could result in litigation (see Olmstead v. L.C.). | | | | | | | | | |
| | Supported Living Coaching | Limit of 20 hours per month | 960 QH Annually | 4,321 | > 960 QH=771 | Service Plans = $2,449,377<br><br>Expenditures = $2,052,941 | Potential | N/A | No | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•Supported Living Coaching services provide training and support to vulnerable adults who live in their own homes. An analysis of incident and abuse/neglect/exploitation data indicates an increasing prevalence in the number of issues adversely impacting the health and safety of APD clients who live in supported living settings. In addition to their own victimization, a number of APD clients in supported living settings (without proper supervision and supports) are increasingly identified as the perpetrators of crimes committed against other community members. | | | | | | | | | |
| | Support Coordination | Improve performance and increase accountability for Waiver Support Coordinators | N/A | 34,500 | 34,500 | N/A | N/A | N/A | No | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•None | | | | | | | | | |

**The Agency for Persons with Disabilities has been directed, in conjunction with the Agency for Health Care Administration, to develop a plan to redesign the waiver program and submit such plan to the Legislature for consideration. See Chapter 2019-116, Laws of Florida. The agencies do not necessarily endorse any of these options at this time. Some options, if implemented, will require notifying the affected waiver clients of the change and possible fair hearing rights.**

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| Waiver Change | Child Waiver | Waiver for children under age 18 with a cap. Doesn't provide res hab to children | N/A | 225 | 225 | TBD | Potential | Yes | Yes | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•APD currently has approximately 2,000 children enrolled on the iBudget waiver who reside in APD-licensed facilities. These children would be required to move or locate other funding for their placement. Requiring unnecessary moves can cause numerous issues, including transfer trauma and adjustment concerns.<br>• Impacts children in foster care.<br>• Provider capacity for non-residential providers would need occur to meet the needs of children who require care 24 hours per day.<br>•Some families may to choose institutional care to have needs met if they cannot access adequate amounts of Respite. There is federal case law regarding institutionalization of individuals with disabilities (see Olmstead v. L.C.). | | | | | | | | | |
| | Crisis Enrollment | Zero crisis enrollment<br><br>Limit monthly crisis enrollment to 30 | 0 crisis enrollees per month<br><br>30 crisis enrollees per month | • FY 17/18 average was 106 p/m, total of 1,272<br>• FY 18/19 average is 97 p/m, total as of 5/31/19 was 1,067 | At zero enrollees per month, estimated average of 1,100 annually<br><br>At 30 enrollees per month, estimated average of 740 annually | **Zero enrollees**<br>Year 1: $12,182,025<br>Year 2: $44,565,319<br>Year 3: $82,871,338<br>Year 4: $125,540,846<br>Year 5: $171,689,035<br><br>**30 pm / 360 py**<br>• Year 1: $8,195,180<br>• Year 2: $29,980,305<br>• Year 3: $55,749,809<br>• Year 4: $84,454,750<br>• Year 5: $115,499,896 | Potential | N/A | No | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•The agency currently enrolls individuals onto the waiver continuously who are in crisis situations. This includes vulnerable individuals who are homeless, a danger to self/others, and their caregiver is unable to provide care who have no other resources to meet these needs.<br>•If crisis enrollment is limited, some individuals will choose institutional care to have needs met if they cannot access community-based services (which could create capacity issues for AHCA)<br>•This change will increase the growth of individuals on the waiting list for services.<br>•APD may spend additional non-waiver/IFS dollars to address crisis situations month-to-month. | | | | | | | | | |
| | Host Home Model | • Host home model (similar to foster care model) instead of a group home | TBD | TBD | TBD | TBD | N/A | Yes | Yes | Yes | Yes |
| | | ***Client/Agency Impact and/or Risks***<br>•TBD - Needs further exploration. | | | | | | | | | |

**The Agency for Persons with Disabilities has been directed, in conjunction with the Agency for Health Care Administration, to develop a plan to redesign the waiver program and submit such plan to the Legislature for consideration. See Chapter 2019-116, Laws of Florida. The agencies do not necessarily endorse any of these options at this time. Some options, if implemented, will require notifying the affected waiver clients of the change and possible fair hearing rights.**

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|---|---|---|---|---|---|---|---|---|---|---|---|
| **Option Type** | **Service** | **Change to Consider** | **Maximum Service Limits** | **Total Number of Clients** | **Total Clients Affected** | **Overall Financial Impact (Savings)** | **Cost Shift** | **Being Done in Other State(s)** | **Federal** | **State** | **Other** |
| **Waiver Change** | Waiver Cap at Individual Level | Implement an annual cap at the individual level for all living settings | Individual CAP at % of ICF Rate:<br>100% = $133,000<br>125% = $166,250<br>150% = $199,500<br>OR At $150,000<br>**Behavioral ICF Rate = $205,130** | 34,500 | <br>460<br>178<br>94<br>272<br>**85** | <br>$16,675,995<br>$7,046,812<br>$2,930,764<br>$10,521,746<br>**$2,434,320** | Potential | Yes | Yes | Yes | Yes |
| | | ***Client/Agency Impact and/or Risks***<br>•The waiver was created to serve people in the community in the most appropriate living setting possible.<br>•At times an individual's service needs and costs may reach a level that their current living setting may not be the most appropriate setting for them to receive services.<br>•For individuals impacted a waiver cap, APD will work with the waiver client to either arrange services within the limits necessary for them to remain in their current settings; or assist them in identifying an alternative living setting better suited to meet their service needs. | | | | | | | | | |
| | Managed Care | •Hybrid managed care model through AHCA for medical services. APD maintains companion, res hab and ADT, etc. | N/A | 34,500 | 14,166 | $66,604,816 | Cost shift to AHCA | Yes | Yes | Yes | Yes |
| | | ***Client/Agency Impact and/or Risks***<br>•This will cause disruption in continuity of care as it will require that clients find new providers who are within a managed care provider's network.<br>•This will cause disruption with existing private sector providers who are currently Medicaid providers but not part of a managed care network.<br>•AHCA and the managed care plans will need to ensure that adequate provider networks exist to meet APD client needs.<br>•AHCA and APD may need to expand the complaint hub processes for mitigating access issues between clients and managed care plans.<br>•This will require new managed care contracts as this changes the scope of existing managed care contracts. | | | | | | | | | |

**The Agency for Persons with Disabilities has been directed, in conjunction with the Agency for Health Care Administration, to develop a plan to redesign the waiver program and submit such plan to the Legislature for consideration. See Chapter 2019-116, Laws of Florida. The agencies do not necessarily endorse any of these options at this time. Some options, if implemented, will require notifying the affected waiver clients of the change and possible fair hearing rights.**

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| **Option Type** | **Service** | **Change to Consider** | **Maximum Service Limits** | **Total Number of Clients** | **Total Clients Affected** | **Overall Financial Impact (Savings)** | **Cost Shift** | **Being Done in Other State(s)** | **Federal** | **State** | **Other** |
| **Waiver Change** | Managed Care | Long Term Managed Care model plan for all services.<br><br>APD contract or AHCA administered? | N/A | 34,500 | 34,500 | TBD | Potential | Yes | Yes | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•This will cause disruption in continuity of care as it will require that clients find new providers who are within a managed care provider's network.<br>•This will cause disruption with existing private sector providers who are currently Medicaid providers but not part of a managed care network.<br>•AHCA and the managed care plans will need to ensure that adequate provider networks exist to meet APD client needs.<br>•AHCA and APD may need to expand the complaint hub processes for mitigating access issues between clients and managed care plans.<br>•This will require new managed care contracts as this changes the scope of existing managed care contracts. | | | | | | | | | |
| | Medicaid State Plan (MSP) Services Budget Transfer for Aging Out | Allow budgetary transfer from AHCA to APD for waiver clients aging out of MSP services upon turning 21 | N/A | Approx. 800 Annually | Approx. 800 Annually | Approx. $4-5 Million Each Year | Fund transfer from AHCA to APD | N/A | No | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•Would result in immediate cost savings upon implementation. When APD clients turn 21, many of their services are no longer available through the Medicaid State Plan Early Periodic Screening and Diagnostic Treatment (EPSDT) coverage. APD has identified this as a major cost driver related to program growth. | | | | | | | | | |
| | Medical Necessity Determination/ Significant Additional Needs (SAN) | Centralize the process of SAN determination of medically necessary services to ensure consistency in application of criteria | N/A | 34,500 | 34,500 | N/A | N/A | N/A | No | No | No |
| | | ***Client/Agency Impact and/or Risks***<br>•Implement inter-rater reliability and peer review process by Jan 2020 | | | | | | | | | |
| | Social Services Estimating Conference (SSEC) | Include the waiver program in SSEC to provide the Legislature with projections for the program | N/A | N/A | N/A | N/A | N/A | N/A | No | No | No |
| | | ***Client/Agency Impact and/or Risks***<br>None. | | | | | | | | | |

**The Agency for Persons with Disabilities has been directed, in conjunction with the Agency for Health Care Administration, to develop a plan to redesign the waiver program and submit such plan to the Legislature for consideration. See Chapter 2019-116, Laws of Florida. The agencies do not necessarily endorse any of these options at this time. Some options, if implemented, will require notifying the affected waiver clients of the change and possible fair hearing rights.**

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|---|---|---|---|---|---|---|---|---|---|---|---|
| **Option Type** | **Service** | **Change to Consider** | **Maximum Service Limits** | **Total Number of Clients** | **Total Clients Affected** | **Overall Financial Impact (Savings)** | **Cost Shift** | **Being Done in Other State(s)** | **Federal** | **State** | **Other** |
| Waiver Change | TeleCare | Independent living technology involves the use of remote monitoring services and/or equipment in conjunction with additional technological support and services | | | | In Ohio - Reduction in support costs for over-night staffing of $15,000 per person | No | Yes - (19 states)<br>Ohio<br>Washington<br>Montana<br>New Mexico<br>South Dakota<br>Minnesota<br>Missouri<br>Arkansas<br>Tennessee<br>Indiana<br>Maine<br>Vermont<br>Connecticut<br>Pennsylvania<br>West Virginia<br>Virginia<br>North Carolina<br>Maryland<br>Washington D.C. | No | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•May be beneficial and appropriate for some higher functioning clients for certain waiver services but not conducive for individuals with significant functional, physical, or behavioral limitations who always require staff to be physically present with them.<br>•Power outages or equipment failures could put clients at risk.<br>•May result in increased access to services and supports (particularly for those individuals in rural parts of the state). | | | | | | | | | |
| | Waiver Support Coordination | APD contract with limited number of Waiver Support Coordination agency(ies) regionally/statewide<br><br>Make Waiver Support Coordination the role of an FTE or contract employee | N/A | TBD | TBD | TBD | TBD | N/A | Yes | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•TBD - Needs further exploration. | | | | | | | | | |
| | Florida Assertive Community Treatment (FACT) and Community Action Team (CAT) Pilot | Increase the resources available to the DCF FACT and CAT teams in order to serve individuals with comorbid mental health and developmental disabilities to address issues early and avoid more costly services in the future | N/A | 34,500 | 34,500 | N/A | N/A | N/A | No | Yes | No |
| | | ***Client/Agency Impact and/or Risks***<br>•Waiver clients will receive mental health services in a more timely manner which may result in a reduced need for more intensive and costly waiver services.<br>•Implementation can occur once the FACT and CAT teams have the training and/or resources to serve individuals with comorbid mental health and developmental disabilities | | | | | | | | | |

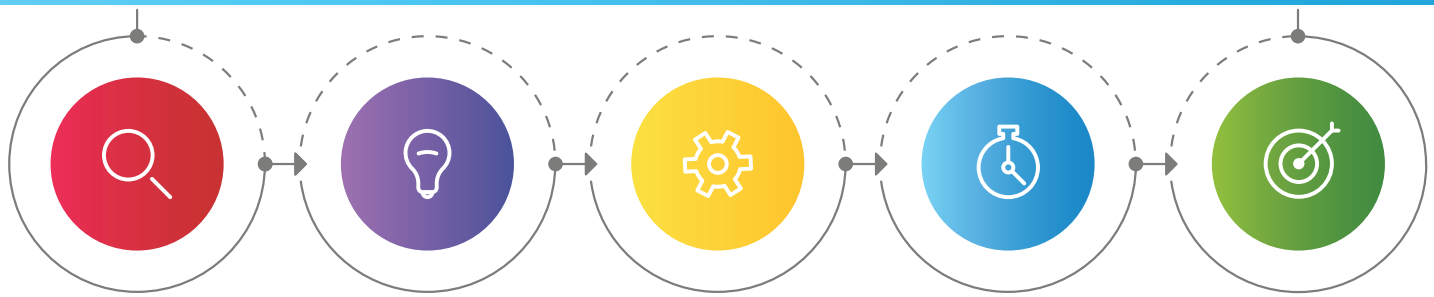
**The Agency for Persons with Disabilities has been directed, in conjunction with the Agency for Health Care Administration, to develop a plan to redesign the waiver program and submit such plan to the Legislature for consideration. See Chapter 2019-116, Laws of Florida. The agencies do not necessarily endorse any of these options at this time. Some options, if implemented, will require notifying the affected waiver clients of the change and possible fair hearing rights.**

| | | | | | | | | | Implementation Requirements | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Option Type** | **Redesign Key Components** | **Change to Consider** | **Maximum Service Limits** | **Total Number of Clients** | **Total Clients Affected** | **LBR Issue** | **Cost Shift** | | **Federal** | **State** | **Other** |
| **Non-Waiver Change** | Next Generation-Questionnaire for Situational Information (NG-QSI) | Eliminate iBudget algorithm and allocation process. Implement the NG-QSI assessment tool capable of determining client needs and funding based on assessment results | N/A | 34,500 | 34,500 | $120,000 APD FY 2020-21 LBR Non-Recurring | N/A | | Yes | Yes | No |
| | | ***Implementation Timeline***<br>• Waiver amendment: Approximately 6 months<br>• Rule amendment: Approximately 6 months<br>▪ Amend Florida Statue: FY 2020-21<br>▪ Fully implement by FY 2023-24 | | | | | | | | | |
| | Specialized ICF Rate | Implement an ICF service and rate in the Medicaid program to serve individuals with intensive maladaptive behaviors | $562 per person per day | 187 | 187 | $38,363,421 AHCA FY 2020-21 LBR Recurring | Potential | | No | Yes | No |
| | | ***Implementation Timeline***<br>FY 2020-21 | | | | | | | | | |

APD-AHCA

# WAIVER redesign

- Include the waiver program in the Social Services Estimating Conference which is the group that projects costs for Medicaid.
- The main change in the approach of the waiver is moving from an algorithm that determines funding to an assessment tool that shows which services each client needs, and funding can be allocated based on need.
- All Significant Additional Needs requests will be centralized at the APD State Office instead of the regions to ensure continuity.
- Ramp up training and accountability for WSCs to make sure they are using APD as the true payor of last resort.
- Work with the few clients who have more than $205,000 in their cost plans to address their needs in a more cost-effective way.
- Provide Life Skills Development services that will provide essential daily services while reducing duplication of services



Help more group homes qualify for the AHCA Medicaid Assistive Care Services funding.

Make it so that the funding follows the individual when they turn 21 from AHCA's Medicaid State Plan to APD.

Start allowing for and paying ICFs to serve people with intensive maladaptive behaviors who have needs beyond the limits of the waiver program.

Increase funding for the Department of Children and Families Florida Assertive Community Treatment and Community Action Team (or FACT and CAT) programs to help better serve people who have both mental health and developmental disabilities.

Increase overall funding so that our agencies can give Florida's most vulnerable population the medically necessary services in the best setting for them.

STATE OF FLORIDA AUDITOR GENERAL

Operational Audit

Report No. 2020-012
August 2019

# AGENCY FOR PERSONS WITH DISABILITIES

## iBudget Florida


Sherrill F. Norman, CPA
Auditor General

## Director of the Agency for Persons with Disabilities

The Agency for Persons with Disabilities is established by Section 20.197, Florida Statutes, as a separate budget entity within the Department of Children and Families for administrative purposes only. The head of the Agency is the Director who is appointed by the Governor and subject to confirmation by the Senate. Barbara Palmer served as Agency Director during the period of our audit.

The team leader was Sabrina Ballew, CPA, and the audit was supervised by Allen G. Weiner, CPA.

Please address inquiries regarding this report to Lisa Norman, CPA, Audit Manager, by e-mail at lisanorman@aud.state.fl.us or by telephone at (850) 412-2831.

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# AGENCY FOR PERSONS WITH DISABILITIES

## iBudget Florida

## SUMMARY

This operational audit of the Agency for Persons with Disabilities (Agency) focused on the administration of iBudget Florida and included a follow-up on finding Nos. 1 through 3 noted in our report No. 2014-056. Our audit disclosed the following:

**Finding 1:** Statutory allowances for additional client funding and differences in client circumstances and needs inhibit the achievement of iBudget Florida financial management goals and the reduction of the number of individuals on the waiting list.

## BACKGROUND

Pursuant to State law,[1] the Agency for Persons with Disabilities (Agency) is responsible for the provision of services to individuals with developmental disabilities and for the programmatic management of Medicaid waivers established to provide services to persons with developmental disabilities. The Agency serves eligible individuals (clients) in the State with autism, cerebral palsy, spina bifida, intellectual disabilities, Down syndrome, Prader-Willi syndrome, and Phelan-McDermid syndrome, as well as children aged 3 to 5 years at high risk of being diagnosed with a developmental disability. For the 2017-18 fiscal year, the Legislature appropriated approximately $1.3 billion to the Agency and authorized 2,702.50 positions.[2]

The Medicaid Home and Community-Based Services (HCBS) waiver program permits the State to provide home and community-based supports and services to clients living at home or in a home-like setting. In 2010, the Legislature found[3] that improved financial management of the State's HCBS waiver program was necessary to avoid deficits that impede the provision of services to individuals on the waiting list for enrollment in the program. The Legislature further found 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. Accordingly, the Agency, in consultation with the Agency for Health Care Administration, established the Florida Developmental Disabilities Individual Budgeting Waiver service delivery system (iBudget Florida) that uses individual budgets as the basis for allocating funds among clients.

The Agency uses iBudget Florida to manage the HCBS waiver program and, among other things, iBudget Florida is to provide:

- Enhanced client choice within a specified service package.
- Appropriate assessment strategies.

[1] Section 20.197(3), Florida Statutes.

[2] Chapter 2017-70, Laws of Florida.

[3] Section 393.0662, Florida Statutes.

- An efficient client budgeting and billing process.
- A mechanism to monitor and control payments.
- Equitable allocation of available funds to clients based on client levels of need.

To assist clients, iBudget Florida offers various supports and services delivered by contracted service providers. These services include residential habilitation, behavioral services, companion services, adult day training, employment services, and physical therapy. In our report No. 2014-056, we noted that Agency expenditures for the HCBS waiver program exceeded annual appropriations for the 2009-10 through 2011-12 fiscal years, which necessitated supplemental legislative appropriations for the 2010-11 and 2011-12 fiscal years. As shown in Table 1, HCBS waiver program expenditures also exceeded appropriations for the 2015-16 through 2017-18 fiscal years.

**Table 1**
**HCBS Waiver Program**
**Appropriations, Expenditures, and Number of Clients Served, on the Waiting List, and Moved Off the Waiting List**
**By Fiscal Year**

| Fiscal Year | Annual Appropriations | Annual Expenditures | Surplus/ (Deficit) | Number of Clients Served | Number of Individuals on Waiting List as of June 30 | Number of Individuals Moved Off Waiting List |
|---|---|---|---|---|---|---|
| 2013-14 | $ 915,250,356 | $ 858,582,751 | $ 56,667,605 | 30,092 | 21,165 | 3,008 |
| 2014-15 | 941,032,259 | 917,529,573 | 23,502,686 | 30,992 | 21,331 | 2,425 |
| 2015-16 | 1,129,176,502 | 1,130,169,476 | (992,974) | 32,715 | 20,486 | 3,189 |
| 2016-17 | 1,097,206,747 | 1,097,462,366 | (255,619) | 33,951 | 20,723 | 2,382 |
| 2017-18 | 1,111,283,222 | 1,167,340,281 | (56,057,059) | 34,537 | 21,471 | 1,770 |

Source: Agency records.

To establish each client's individual budget (iBudget), State law[4] requires the Agency to use an allocation methodology based on an algorithm that uses variables with a statistically validated relationship to the client's need for services provided through iBudget Florida and, as applicable, incorporate any funding authorized by the Agency for extraordinary or significant client needs.[5] The methodology and algorithm may consider individual client characteristics, including, but not limited to, a client's age and living situation, information from a formal assessment instrument the Agency determines valid and reliable, and information from other appropriate assessment processes.[6]

Pursuant to State law,[7] the Agency adopted rules specifying the allocation methodology and algorithm; criteria and processes for clients to access funds reserved for extraordinary needs, temporarily or

[4] Sections 393.0662(1)(a) and 393.063(3) and (4), Florida Statutes.

[5] Section 393.0662(1)(b), Florida Statutes, authorizes the Agency to provide additional funding to a client when the client has 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 funds are approved. Additionally, the Agency is authorized to provide additional funding when a client has a significant need for one-time or temporary support or services, for increased services after the beginning of the service plan year, or for transportation services that, if not provided, would place the health and safety of the client, the client's caregiver, or the public, as applicable, in serious jeopardy.

[6] Section 393.0661(3), Florida Statutes.

[7] Section 393.0662(7), Florida Statutes.

permanently changed needs, and one-time needs; and processes and requirements for the selection and review of services, development of support and cost plans, and management of iBudget Florida. Effective July 7, 2016, the Agency revised the algorithm for individuals enrolled in iBudget Florida.[8] According to Agency management, as of April 3, 2019, approximately 19,000 of the 34,600 iBudget Florida clients had been transitioned to the new algorithm and all clients were expected to transition to the new algorithm by July 2020. Additionally, Agency management indicated that the Agency was implementing a new information technology system to manage iBudget Florida, with a planned completion date of Fall 2020.

As part of iBudget Florida, the Agency annually authorizes a cost plan for each client outlining the client's approved services and costs for the fiscal year. To implement the algorithm, clients and their families meet with Waiver Support Coordinators (WSCs)[9] who are responsible for preparing an Amount Implementation Meeting (AIM) Worksheet that communicates a client's algorithm amount, identifies proposed services based on the algorithm amount, and documents significant additional needs (SANs), if any, that cannot be met by the algorithm amount.[10] The Agency conducts individual reviews to determine whether the services requested meet health and safety needs and waiver coverage limitations. The Agency is to approve an amount greater than the algorithm amount if additional funding is required to meet a client's SANs. Within 30 days of receiving an AIM worksheet, the Agency is to advise the client or their representative of the Agency's decision and approved cost plan amount.

## *FINDINGS AND RECOMMENDATIONS*

### Finding 1: iBudget Florida Allocation Methodology and Algorithm

To improve the financial management of the HCBS waiver program, avoid deficits that impede the provision of services to individuals on the waiting list for enrollment in the program, and provide clients and their families greater flexibility to choose the services that best allow them to live in their community within the limits of an established budget, the Agency established an allocation methodology and algorithm that served as the basis for each client's iBudget. As part of our audit, we evaluated the effectiveness of the Agency's allocation methodology and algorithm in achieving the legislative intent of iBudget Florida. Our evaluation found that, while the Agency's algorithm was statistically valid, statutory allowances for additional client funding and differences in client circumstances and needs inhibit the achievement of iBudget Florida financial management goals and reduction of the number of individuals on the waiting list, as reflected in Table 1 in the ***BACKGROUND*** section of this report. Specifically:

[8] Agency Rules 65G-4.0213 through 4.0218, Florida Administrative Code.

[9] WSCs are individuals selected by the client to assist the client and their family in identifying their capacities, needs, and resources; finding and gaining access to necessary supports and services; coordinating the delivery of supports and services; advocating on behalf of the client 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 client, family, and others who participated in the development of the support plan.

[10] SANs represent needs for additional funding that if not provided would place the health and safety of the client, their caregiver, or public in serious jeopardy that are authorized by Section 393.0662(1)(b), Florida Statutes.

- While, in addition to a client's iBudget amount as determined by the algorithm, State law[11] authorizes the Agency to allot additional funding for extraordinary or significant client needs, the vast majority of clients' approved cost plan amounts far exceeded their algorithm amounts.

  - Our examination of the calculation of the algorithm amounts for 60 clients who received services during the period July 2017 through January 2018 found that 51 of the clients' approved cost plan amounts exceeded their algorithm amounts. For example, one client's approved cost plan totaled $60,257, including $37,528 for SANs services not covered by the algorithm. For another client, the client's approved cost plan totaled $173,196, including $108,259 for SANs services not covered by the algorithm.

  - To assess the potential impact of fully implementing the July 2016 algorithm and determine the extent to which additional funding requirements beyond client algorithm amounts impact the achievement of iBudget Florida financial management goals and reduction of the number of individuals on the waiting list, we recalculated the algorithm amounts for all clients as of April 30, 2018, using the July 2016 algorithm. We then compared each client's recalculated algorithm amount to their cost plan amount and noted that over 61 percent of client cost plan amounts would exceed 125 percent of their algorithm amounts and, in some cases, 1,000 percent of the algorithm amounts. In total, based on the approved client cost plan amounts at the time of our audit and using the July 2016 algorithm for all clients, the Agency would have to provide additional funds to 86 percent of its clients. The results of our comparison of recalculated client algorithm amounts to cost plan amounts are presented in Table 2.

**Table 2**
**Comparison of Recalculated Client Algorithm Amounts to Cost Plan Amounts**

| Percentage Difference Between Cost Plan Amount and Algorithm Amount | Number of Cost Plans | Percent of Total Cost Plans | Total Algorithm Amounts | Total Cost Plan Amounts | Percent of Total Cost Plan Amounts |
|---|---|---|---|---|---|
| Cost Plan 200% or More than Algorithm | 7,562 | 22.04% | $146,841,020 | $ 434,787,497 | 29.77% |
| Cost Plan 150% to 199% of Algorithm | 6,853 | 19.98% | 177,029,156 | 301,257,930 | 20.63% |
| Cost Plan 125% to 149% of Algorithm | 6,713 | 19.57% | 220,733,027 | 300,889,728 | 20.60% |
| Cost Plan 101% to 124% of Algorithm | 8,485 | 24.73% | 287,393,519 | 321,806,419 | 22.03% |
| Cost Plan 100% or Less than Algorithm | 4,691 | 13.67% | 124,462,907 | 101,833,661 | 6.97% |
| **Totals** | **34,304** | | **$956,459,629** | **$1,460,575,235** | |

Source: Agency records and auditor calculations.

- As shown in Table 1 in the ***BACKGROUND*** section of this report, since the July 2013 implementation of iBudget Florida, the HCBS waiver program has experienced frequent deficits, most recently for the 2017-18 fiscal year. Additionally, while the Agency has moved over 12,000 individuals off the waiting list since the 2013-14 fiscal year, the overall number of individuals on the waiting list has remained relatively unchanged.

[11] Section 393.0662(1)(b), Florida Statutes.

We inquired of Agency management regarding how the Agency monitored and controlled iBudget Florida expenditures to ensure that expenditures were limited to the amount appropriated for the HCBS waiver program. While Agency management indicated that methods, including expenditure forecasting, had been developed to monitor and control iBudget Florida expenditures, the methods were not effective in ensuring that iBudget Florida expenditures did not exceed appropriated amounts.

Absent an effective methodology to allocate and control iBudget Florida expenditures, the Agency's ability to improve the financial management of the HCBS wavier program and avoid deficits that impede the provision of services to individuals on the program's waiting list is limited.

**Recommendation: We recommend that Agency management consult with the Legislature regarding whether potential statutory revisions are necessary to achieve iBudget Florida financial management and waiting list goals.**

## PRIOR AUDIT FOLLOW-UP

Except as discussed in the preceding paragraphs, the Agency had taken corrective actions for the applicable findings included in our report No. 2014-056.

## OBJECTIVES, SCOPE, AND METHODOLOGY

The Auditor General conducts operational audits of governmental entities to provide the Legislature, Florida's citizens, public entity management, and other stakeholders unbiased, timely, and relevant information for use in promoting government accountability and stewardship and improving government operations.

We conducted this operational audit from February 2018 through February 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

This operational audit of the Agency for Persons with Disabilities (Agency) focused on the administration of iBudget Florida. The overall objectives of the audit were:

- To evaluate management's performance in establishing and maintaining internal controls, including controls designed to prevent and detect fraud, waste, and abuse, and in administering assigned responsibilities in accordance with applicable laws, administrative rules, contracts, grant agreements, and other guidelines.
- To examine internal controls designed and placed in operation to promote and encourage the achievement of management's control objectives in the categories of compliance, economic and efficient operations, the reliability of records and reports, and the safeguarding of assets, and identify weaknesses in those internal controls.
- To determine whether management had corrected, or was in the process of correcting, all applicable deficiencies disclosed in our report No. 2014-056 (finding Nos. 1 through 3).
- To identify statutory and fiscal changes that may be recommended to the Legislature pursuant to Section 11.45(7)(h), Florida Statutes.

This audit was designed to identify, for those programs, activities, or functions included within the scope of the audit, deficiencies in management's internal controls, instances of noncompliance with applicable governing laws, rules, or contracts, and instances of inefficient or ineffective operational policies, procedures, or practices. The focus of this audit was to identify problems so that they may be corrected in such a way as to improve government accountability and efficiency and the stewardship of management. Professional judgment has been used in determining significance and audit risk and in selecting the particular transactions, legal compliance matters, records, and controls considered.

As described in more detail below, for those programs, activities, and functions included within the scope of our audit, our audit work included, but was not limited to, communicating to management and those charged with governance the scope, objectives, timing, overall methodology, and reporting of our audit; obtaining an understanding of the program, activity, or function; exercising professional judgment in considering significance and audit risk in the design and execution of the research, interviews, tests, analyses, and other procedures included in the audit methodology; obtaining reasonable assurance of the overall sufficiency and appropriateness of the evidence gathered in support of our audit's findings and conclusions; and reporting on the results of the audit as required by governing laws and auditing standards.

Our audit included the selection and examination of transactions and records. Unless otherwise indicated in this report, these transactions and records were not selected with the intent of statistically projecting the results, although we have presented for perspective, where practicable, information concerning relevant population value or size and quantifications relative to the items selected for examination.

An audit by its nature, does not include a review of all records and actions of agency management, staff, and vendors, and as a consequence, cannot be relied upon to identify all instances of noncompliance, fraud, abuse, or inefficiency.

In conducting our audit, we:

- Reviewed applicable laws, rules, policies and procedures, Agency handbooks, and other guidelines, and interviewed and observed Department personnel to obtain an understanding of iBudget Florida.
- For the 34,304 iBudget Florida clients who received services during the period July 2017 through January 2018, recalculated the clients' iBudget algorithm amounts as of April 30, 2018, using the July 2016 algorithm and compared the recalculated algorithm amounts to authorized client cost plan amounts to determine whether the algorithm was effective at estimating client service costs.
- For the 2016-17 fiscal year, compared total iBudget Florida expenditures to the Agency's Medicaid Home and Community-Based Services waiver program authorized budget to determine whether expenditures exceeded the authorized amount.
- Analyzed Agency iBudget Florida waiting lists for the 2014-15 through 2016-17 fiscal years to determine whether legislative appropriations had been appropriately utilized to remove clients from the waiting lists.
- Reviewed the client data provided to the actuary and statistician for the February 2018 actuarial report on the iBudget Florida reserve and the June 2015 statistical report on the iBudget algorithm, respectively, to determine whether the data was accurate and complete. We also reviewed Agency records to determine whether the Agency reviewed the actuary's and statistician's methodology and conclusions for appropriateness.

- Analyzed the Agency's application and use of the iBudget Florida reserve to determine whether the Agency complied with applicable laws governing the reserve.
- From the population of 10,193 clients who were transitioned to the July 2016 iBudget Florida algorithm during the period July 2016 through April 12, 2018, examined Agency records for 60 selected clients to determine whether the algorithm and allocation methodology were in accordance with applicable laws and Agency rules. Additionally, we examined the documentation for the data items utilized in the algorithm to determine if the items were accurate and properly supported and, if the client's funding amount was decreased from the previous algorithm, if appropriate procedures were followed to document the decrease and communication of the change to the client.
- From the population of 10,193 clients who were transitioned to the July 2016 iBudget Florida algorithm during the period July 2016 through April 12, 2018, examined Agency records for 60 selected clients to determine whether the Agency appropriately established and approved client cost plans for the 2017-18 fiscal year. Additionally, we selected and examined Agency payment records for 10 of the 60 clients to determine whether payments on behalf of clients did not exceed the amounts authorized in client cost plans as of April 30, 2018.
- From the population of 10,735,727 payments, totaling $1,632,868,910, made on behalf of clients during the period July 2016 through January 2018, examined Agency records for 97 selected payments, totaling $122,751, made on behalf of 60 clients to determine whether the payments were properly authorized, calculated, and coded, and paid at the appropriate rate.
- Observed, documented, and evaluated the effectiveness of selected Agency processes and procedures for:
    - Budgetary, revenue and cash receipt, and purchasing activities.
    - The assignment and use of motor vehicles. As of January 3, 2018, the Agency was responsible for 172 motor vehicles with related acquisition costs totaling $2,833,511.
    - The assignment and use of mobile devices with related costs totaling $224,022 during the period July 2016 through February 2018.
    - The acquisition and management of real property leases in accordance with State law, Department of Management Services rules, and other applicable guidelines. As of January 31, 2018, the Agency was responsible for 15 real property leases.
- Communicated on an interim basis with applicable officials to ensure the timely resolution of issues involving controls and noncompliance.
- Performed various other auditing procedures, including analytical procedures, as necessary, to accomplish the objectives of the audit.
- Prepared and submitted for management response the findings and recommendations that are included in this report and which describe the matters requiring corrective actions. Management's response is included in this report under the heading ***MANAGEMENT'S RESPONSE***.

## AUTHORITY

Section 11.45, Florida Statutes, requires that the Auditor General conduct an operational audit of each State agency on a periodic basis. Pursuant to the provisions of Section 11.45, Florida Statutes, I have directed that this report be prepared to present the results of our operational audit.

Sherrill F. Norman, CPA
Auditor General

# MANAGEMENT'S RESPONSE

agency for persons with disabilities
State of Florida

Ron DeSantis
Governor

Barbara Palmer
Director

State Office
4030 Esplanade Way
Suite 380
Tallahassee
Florida
32399-0950

(850) 488-4257
Fax:
(850) 922-6456

Toll Free:
(866) APD-CARES
(866-273-2273)

August 9, 2019

Sherrill F. Norman, CPA
Auditor General
State of Florida
G74 Claude Pepper Building
111 West Madison Street
Tallahassee, FL 32399-1450

Re: Preliminary and Tentative Audit Findings – Agency for Persons with Disabilities, iBudget Florida

Dear Ms. Norman:

I appreciate this opportunity to respond to the preliminary and tentative audit findings and recommendations concerning your operational audit of the *Agency for Persons with Disabilities, iBudget Florida*. Our response is enclosed as required by section 11.45(4)(d), Florida Statutes.

I appreciate the effort of you and your staff in assisting to improve our operations. If you have any questions or need additional information, please contact Shawn McCormick, Director of Audit at (850) 414-8774.

Sincerely,

Barbara Palmer

Barbara Palmer
Director

BP/sm
Enclosure

http://apdcares.org

## AGENCY FOR PERSONS WITH DISABILITIES, IBUDGET FLORIDA

### Finding No. 1: iBudget Florida Allocation Methodology and Algorithm

**Finding:** Statutory allowances for additional client funding and differences in client circumstances and needs inhibit the achievement of iBudget Florida financial management goals and the reduction of the number of individuals on the waiting list.

**Recommendation:** We recommend that Agency management consult with the Legislature regarding whether potential statutory revisions are necessary to achieve iBudget Florida financial management and waiting list goals.

**Agency Response:** The Agency for Persons with Disabilities (Agency) concurs with the Auditor General's recommendation.

The 2019 implementing bill requires the Agency for Persons with Disabilities, in conjunction with the Agency for Health Care Administration, to develop and submit a plan to redesign the iBudget Waiver Program to the President of the Senate and the Speaker of the House of Representatives for consideration and ultimate Legislative approval.

THE FLORIDA SENATE

Duplicate

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/15/20
*Meeting Date*

SB82
*Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic Individuals with Disabilities

Name Laura Mohesky

Job Title Waiver Support Coordinator

Address 205 Sutton Street
*Street*

Phone 321-794-3328

Rockledge
*City*

FL
*State*

32955
*Zip*

Email lmohesky@cfl.rr.com

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing Support Coordination Association of Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/14/14)

THE FLORIDA SENATE

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

January 15, 2020
*Meeting Date*

SB82
*Bill Number (if applicable)*

Topic Agency for Persons with Disabilities Waiver Redesign

*Amendment Barcode (if applicable)*

Name Dina Justice

Job Title mom to Emily, member Family Care Council Florida

Address 9029 Woodrun Road
*Street*

Phone 850-485-2155

Pensacola FL 32514
*City* *State* *Zip*

Email dinamjustice@gmail.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing Emily and other developmental disabilities individuals

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

SR

Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic DD waitlist

Name Allison Tant

Job Title Mom

Address 6035 Boynton Homestead (Street)

Phone 850-251-6040

TLH FL 32312 (City / State / Zip)

Email allisontant@gmail.com

Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing Children like my son

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

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**THE FLORIDA SENATE**

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/15/2020
*Meeting Date*

SB 82
*Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic HCBS Waiver

Name BARBARA BRAUN

Job Title WSE Waiver Support Coord.

Address 2943 Maiden Lane
*Street*
Sarasota FL 34231
*City* *State* *Zip*

Phone 941-302-3189

Email bbraun@ateamapproachinc.com

Speaking: ☐ For ☒ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11/15/20
*Meeting Date*

SB 82
*Bill Number (if applicable)*

Topic APD Amendments - Chapter 393

*Amendment Barcode (if applicable)*

Name Suzanne Sewell

Job Title President & CEO

Address 2475 Apalachee Parkway
*Street*

Tallahassee, FL
*City* *State* *Zip*

Phone 850-942-3580

Email ssewell@floridaarf.org

Speaking: ☑ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing FL. Association of Rehabilitation Facilities

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-15-2026
*Meeting Date*

SB 82
*Bill Number (if applicable)*

Topic 393 Amendments - Agency for Persons w/ Disabilities
*Amendment Barcode (if applicable)*

Name Valerie Breen

Job Title Executive Director

Address 124 Marriott Drive #203
*Street*

Tallahassee FL 32301
*City* *State* *Zip*

Phone 850-488-4180

Email ValerieB@FDDC.org

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing Florida Developmental Disabilities Council

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-15-2020
*Meeting Date*

CS2
*Bill Number (if applicable)*

Topic _____

*Amendment Barcode (if applicable)*

Name Amanda Baker

Job Title Advocate

Address 3373 Apalachee Parkway Apt 2010
*Street*

Tallahassee FL 32311
*City* *State* *Zip*

Phone 850-691-8572

Email amandajoebaker@gmail.com

Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing _____

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/15/2020
*Meeting Date*

SB 82
*Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic iBudget

Name Olivia Babis

Job Title Public Policy Analyst

Address 2473 Care Dr. Suite 200
*Street*

Phone 850-617-9718

Tallahassee FL 32308
*City* *State* *Zip*

Email oliviab@disabilityrightsflorida.org

Speaking: ☐ For ☒ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing Disability Rights Florida

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

01/15/2020
*Meeting Date*

SB 82
*Bill Number (if applicable)*

Topic Individuals with Disabilities

*Amendment Barcode (if applicable)*

Name Kirk Hall

Job Title CEO

Address 2898 Mahan Drive, Suite 1
*Street*

Phone (850) 921-0460

Tallahassee FL 32308
*City* *State* *Zip*

Email kirk@arcflorida.org

Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing The Arc of Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

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S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/15/20
*Meeting Date*

SB 82
*Bill Number (if applicable)*

Topic Indiv. w/ Disabilities

*Amendment Barcode (if applicable)*

Name Ryan Chandler

Job Title Support Coordinator

Address 2136 Herschel St
*Street*

Jacksonville FL 32204
*City* *State* *Zip*

Phone 904-477-4750

Email chandlersupportservices@gmail.com

Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing Assoc. of Supp. Coord. Agencies

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

JAN 14, 2020
*Meeting Date*

Mr. Otto B

SB 82
*Bill Number (if applicable)*

Topic _____

*Amendment Barcode (if applicable)*

Name Sex Buds Clay County FL Hotels

Job Title Owner

Address 2904 - 2910 Hwy 21
*Street*

Phone 904-415-3221

Middle Burg FL. 32068
*City* *State* *Zip*

Email SEXBUD1@Gmail.com

Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing SEX TOYS of Clay County FL.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/14/14)

**The Florida Senate**

# BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

| | |
|---|---|
| BILL: | SB 994 |
| INTRODUCER: | Senator Passidomo |
| SUBJECT: | Guardianship |
| DATE: | January 14, 2020 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Delia | Hendon | CF | **Favorable** |
| 2. | | | JU | |
| 3. | | | RC | |

## I. Summary:

SB 994 makes a number of changes to chapter 744 of the Florida Statutes to improve guardianship laws in the state. The bill adds additional factors for a court to consider when appointing a guardian and provides that a guardian may only consent to or authorize a do-not-resuscitate order with court approval. The bill provides additional requirements for a petition for the appointment of a guardian and also defines the term "alternatives to guardianship." The bill creates an additional requirement for an initial guardianship plan and provides additional requirements for annual guardianship reports, as well as additional requirements for an annual guardianship plan. Finally the bill revises provisions relating to conflicts of interest for professional guardians.

The bill could have an indeterminate fiscal impact on the state court system and has an effective date of July 1, 2020.

## II. Present Situation:

### Guardianship

Guardianship is a concept whereby a "guardian" acts for another, called a "ward," whom the law regards as incapable of managing his or her own affairs due to age or incapacity. Guardianships are generally disfavored due to the loss of individual civil rights, and a guardian may be appointed only if the court finds there is no sufficient alternative to guardianship.

There are two main forms of guardianship: guardianship over the person or guardianship over the property, which may be limited or plenary.[1] For adults, a guardianship may be established when a person has demonstrated that he or she is unable to manage his or her own affairs. If the adult

[1] *See generally*, s. 744.102(9), F.S.

is competent, this can be accomplished voluntarily. However, when an individual's mental competence is in question, an involuntary guardianship may be established through the adjudication of incompetence which is determined by a court appointed examination committee.[2]

Florida courts have long recognized the relationship between a guardian and his or her ward as a classic fiduciary relationship.[3] A fiduciary relationship exists between two persons when one of them is under a duty to act or to give advice for the benefit of another upon matters within the scope of that relationship.[4] The most basic duty of a fiduciary is the duty of loyalty: a fiduciary must refrain from self-dealing, must not take unfair advantage of the ward, must act in the best interest of the ward, and must disclose material facts.[5] In addition to the duty of loyalty, a fiduciary also owes a duty of care to carry out his or her responsibilities in an informed and considered manner.

Section 744.361, F.S., imposes specific duties upon a guardian consistent with the basic duties of a fiduciary including protecting and preserving the property of the ward and his or her overall physical and social health. A guardian must file with the court an initial guardianship report,[6] an annual guardianship report,[7] and an annual accounting of the ward's property.[8] The reports provide evidence of the guardian's faithful execution of his or her fiduciary duties.[9]

At the heart of a court's interpretation of a fiduciary relationship is a concern that persons who assume trustee-like positions with discretionary power over the interests of others might breach their duties and abuse their position. Section 744.446, F.S., states that the "fiduciary relationship which exists between the guardian and the ward may not be used for the private gain of the guardian other than the remuneration for fees and expenses provided by law." In the event of a breach by the guardian of the guardian's fiduciary duty, the court must take the necessary actions to protect the ward and the ward's assets.[10]

**Professional Guardians**

In Florida, a "professional guardian" means any guardian who has, at any time, rendered services to three or more wards as their guardian.[11] A professional guardian must register annually with the Statewide Public Guardianship Office.[12] Professional guardians must receive a minimum of 40 hours of instruction and training and a minimum of 16 hours of continuing education every 2 years after the initial educational requirement is met. The instruction and education must be completed through a course approved or offered by the Statewide Public Guardianship Office.[13]

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[2] *See generally*, s. 744.102(12), F.S.
[3] *In re Guardianship of Lawrence v. Norris,* 563 So. 2d 195, 197 (Fla. 1st DCA 1990).
[4] *Doe v. Evans,* 814 So. 2d 370, 374 (Fla. 2002).
[5] *Capital Bank v. MVP, Inc.* 644 So. 2d 515, 520 (Fla. 3d DCA 1994).
[6] Section 744.362, F.S.
[7] Section 744.367, F.S.
[8] Section 744.3678, F.S.
[9] Section 744.368, F.S.
[10] Section 744.446(4), F.S.
[11] Section 744.102(17), F.S.
[12] Section 744.2002(1)F.S.
[13] Section 744.2003(3), F.S.

A professional guardian is subject to a level 2 background check,[14] an investigation of the guardian's credit history,[15] and is required to demonstrate competency to act as a professional guardian by taking an examination approved by the DOEA.[16] These requirements do not apply to a professional guardian or the employees of that professional guardian when that guardian is a:

- Trust company;
- State banking corporation;
- State savings association authorized and qualified to exercise fiduciary powers in this state; or
- National banking association or federal savings and loan association authorized and qualified to exercise fiduciary duties in this state.[17]

**Determining Incapacity**

The process to determine incapacity and the appointment of a guardian begins with a petition filed in the appropriate circuit court. A petition may be executed by an adult and must be served on and read to the alleged incapacitated person. The notice and copies of the petition must be provided to the attorney for the alleged incapacitated person and served on all next of kin identified in the petition.[18]

In the hearing on the petition alleging incapacity, the partial or total incapacity of the person must be established by clear and convincing evidence.[19] The court must enter a written order determining incapacity after finding that a person is incapacitated with respect to the exercise of a particular right or all rights. A person is determined to be incapacitated only with respect to those rights specified in the court's order.[20] When an order determines that a person is incapable of exercising delegable rights, the court must consider whether there is an alternative to guardianship which will sufficiently address the problems of the incapacitated person. If an alternative to guardianship will not sufficiently address the problems of the incapacitated person, a guardian will be appointed.[21]

**Court Proceedings**

The court retains jurisdiction over all guardianships and shall review the appropriateness and extent of a guardianship annually.[22] At any time, any interested person, including the ward, may petition the court for review alleging that the guardian is not complying with the guardianship plan or is exceeding his or her authority under the guardianship plan and is not acting in the best interest of the ward. If the petition for review is found to be without merit the court may assess costs and attorney fees against the petitioner.[23]

[14] Section 744.2003(5), F.S.
[15] Section 744.2003(4), F.S.
[16] Section 744.2003(6), F.S.
[17] Section 744.2003(10), F.S.
[18] Section 744.331(1), F.S.
[19] Section 744.331(5)(c), F.S.
[20] Section 744.331(6), F.S.
[21] Section 744.331(6)(b), F.S.
[22] Section 744.372, F.S.
[23] Section 744.3715, F.S.

A guardian, or an attorney who has rendered services to the ward or to the guardian on the ward's behalf, is entitled to a reasonable fee.[24] Fees and costs incurred are generally awardable from the guardianship estate, unless the court finds the requested compensation substantially unreasonable.[25]

A ward has the right to be restored to capacity at the earliest possible time.[26] The ward, or any interested person filing a suggestion of capacity, has the burden of proving the ward is capable of exercising some or all of the rights which were removed. Immediately upon the filing of the suggestion of capacity, the court must appoint a physician to examine the ward. The physician must examine the ward and file a report with the court within 20 days.[27] All objections to the suggestion of capacity must be filed within 20 days after formal notice is served on the ward, guardian, attorney for the ward, if any, and any other interested persons designated by the court.[28] If an objection is timely filed, or if the medical examination suggests that full restoration is not appropriate, the court must set the matter for hearing.[29]

**Guardian Compensation**

The guardian, or an attorney who has rendered services to the ward or to the guardian on the ward's behalf, is entitled to a reasonable fee for services rendered and reimbursement for costs incurred on behalf of the assets of the guardianship estate unless the court finds the requested compensation to be substantially unreasonable.[30] Before the fees may be paid, a petition for fees or expenses must be filed with the court and accompanied by an itemized description of the services performed for the fees and expenses sought to be recovered.[31] When fees for a guardian or an attorney are submitted to the court for determination, the court shall consider:

- The time and labor required;
- The novelty and difficulty of the questions involved and the skill required to perform the services properly;
- The likelihood that the acceptance of the particular employment will preclude other employment of the person;
- The fee customarily charged in the locality for similar services;
- The nature and value of the incapacitated person's property, the amount of income earned by the estate, and the responsibilities and potential liabilities assumed by the person;
- The results obtained;
- The time limits imposed by the circumstances;
- The nature and length of the relationship with the incapacitated person; and
- The experience, reputation, diligence, and ability of the person performing the service.[32]

[24] Section 744.108(1), F.S.
[25] Section 744.108(8), F.S.
[26] Section 744.3215(1)(c), F.S.
[27] Section 744.464(2)(b), F.S.
[28] Section 744.464(2)(d), F.S.
[29] Section 744.464(2)(e), F.S.
[30] s. 744.108(1), (8), F.S.
[31] s. 744.108(5), (7), F.S.
[32] s. 744.108(2), F.S.

**Conflict of Interest**

Unless the court gives prior approval, or such relationship existed prior to the appointment of the guardian and is disclosed to the court in the petition for appointment of a guardian, a guardian may not:

- Have any interest, financial or otherwise, direct or indirect, in any business transaction or activity with the guardianship;
- Acquire an ownership, possessory, security, or other monetary interest adverse to the ward;
- Be designated as a beneficiary on any life insurance policy, pension, or benefit plan of the ward unless such designation was made by the ward prior to adjudication of incapacity; and
- Directly or indirectly purchase, rent, lease, or sell any property or services from or to any business entity that the guardian, or the guardian's spouse or family, is an officer, partner, director, shareholder, or proprietor, or has any financial interest.[33]

A guardian with such a conflict of interest may be removed from the guardianship by the court.[34]

**End of Life Decision-Making**

Florida law defines an advance directive as any witnessed, oral statements or written instructions that express a person's desires about any aspect of his or her future health care, including the designation of a health care surrogate, a living will, or an anatomical gift.[35] Designation of each of these can serve different purposes and have their own unique requirements and specifications under the law.

One type of advance directive, a "do not resuscitate order" (DNRO) results in the withholding of cardiopulmonary resuscitation (CPR) from an individual if a DNRO is presented to the health care professional treating the patient. For the DNRO to be valid, it must be on the form adopted by the Department of Health, signed by the patient's physician and by the patient, or if the patient is incapacitated, the patient's health care surrogate or proxy, court-appointed guardian, or attorney in fact under a durable power of attorney.[36] Florida's DNRO form is printed on yellow paper.[37] It is the responsibility of the Emergency Medical Services provider to ensure that the DNRO form or the patient identification device, which is a miniature version of the form, accompanies the patient.[38] A DNRO may be revoked by the patient at any time, if signed by the patient, or the patient's health care surrogate, proxy, court-appointed guardian or a person acting under a durable power of attorney.[39]

Media Reports

[33] s. 744.446, F.S.
[34] *Id.*
[35] s. 765.101, F.S.
[36] s. 401.45(3), F.S.
[37] Rule 64J-2.018, F.A.C.
[38] *Id.*
[39] *Id.*

In July 2019, Steven Stryker, a ward appointed to professional guardian Rebecca Fierle,[40] died in a Tampa hospital after choking on food.[41] Hospital staff could not perform lifesaving procedures on him due to a DNRO executed by Fierle.[42]

It was also reported that Fierle had billed AdventHealth, an Orlando area hospital, approximately $4 million for services rendered to wards[43] (all of whom were also AdentHealth patients) and developed conflicts of interest with members of appointed examining committees used to determine incapacity of a person.[44]

The Clerk of the Circuit Court and Comptroller of Okaloosa County (Clerk)[45] investigated complaints filed against Fierle with the OPPG. The Clerk found Fierle had executed a DNRO against Stryker's wishes, violating the standards of practice established by the OPPG.[46] The Clerk reported that Fierle kept a DNRO in place after a psychiatrist examined Stryker while he was admitted to St. Joseph's hospital and determined Stryker had the ability to decide that he wanted to live and stated that Stryker wanted to be resuscitated.

The Orange County Comptroller also investigated Fierle's guardianships.[47] The Comptroller found Fierle had submitted over 6,000 invoices and charges of at least $3.9M to AdventHealth for payments between January 2009 and June 2019.[48] The payments were made on behalf of 682 patients. The Comptroller also found that in some cases Fierle had billed both AdventHealth and the wards for identical fees and services. Additionally, the Comptroller identified conflicts of interest, including several situations in which Fierle had previous relationships with wards to whom she was appointed guardian and did not disclose these relationships in the petitions for appointment of a guardian.

An Orange County judge removed Fierle from nearly 100 cases to which she had been appointed.[49] Fierle has appealed the judge's decision.[50] In a letter to the OPPG, Fierle resigned from all appointed guardianship cases (approximately 450 in 13 counties) in July, 2019.[51] As of

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[40] The Orlando Sentinel, *Florida's Troubled Guardian Program,* https://www.orlandosentinel.com/news/florida/guardians/ (last visited Jan. 7, 2020).
[41] Adrianna Iwasinski, *Orange commissioners approve new position to help monitor guardianship cases,* Click Orlando (Oct. 22, 2019), https://www.clickorlando.com/news/2019/10/23/orange-commissioners-approve-new-position-to-help-monitor-guardianship-cases/ (last visited Jan. 7, 2020).
[42] *Id.*
[43] *Supra* note 56.
[44] Monivette Cordeiro, *Florida's troubled guardianship system riddled with conflicts of interest, critics claim | Special Report,* Orlando Sentinel (Aug. 14, 2019), https://www.orlandosentinel.com/news/florida/guardians/os-ne-guardianship-examining-committee-conflicts-20190814-osbekpwlnfezneolyxttvzmrhy-story.html (last visited Jan. 7, 2020).
[45] J.D. Peacock II, Clerk of the Circuit Court and Comptroller Okaloosa County, Florida, *OPPG Investigation Case Number 19-064* (July 9, 2019), https://www.scribd.com/document/417992870/Fierle-State-Report (last visited Jan. 7, 2020).
[46] *Id.*
[47] Orange County Comptroller, *Report No. 479 – Investigation of Payments Made to Professional Guardian – Rebecca Fierle by AdventHealth*, https://occompt.com/wpfb-file/rpt479-pdf/ (last visited Jan. 7, 2020).
[48] *Id.*
[49] *Supra* note 56.
[50] *Id.*
[51] Greg Angel, *Embattled Guardian Resigns From Cases Statewide; Criminal Investigation Continues,* Spectrum News 13 (July 29, 2019), https://www.mynews13.com/fl/orlando/crime/2019/07/29/embattled-guardian-resigns-from-cases-statewide (last visited Jan. 7, 2020).

November 2019, Fierle is under criminal investigation by the Florida Department of Law Enforcement.[52]

## III. Effect of Proposed Changes:

**Section 1** amends s. 744.312, F.S., to specifically require the court to consider a guardian's potential disqualification under s. 744.309, F.S., or potential conflicts of interest under s. 744.446, F.S., before appointing them as a guardian.

**Section 2** amends 744.3215, F.S., to specifically address do-not-resuscitate (DNR) orders by requiring that a guardian may not consent to or authorize a do-not-resuscitate order without court approval.

**Section 3** amends s. 744.334, F.S., requiring that a petition for the appointment of a guardian state the reasons why an individual should be appointed guardian and whether he or she is a professional guardian. The bill also adds the word "alleged" before "incapacitated person or minor," and provides that the petition must explain any other type of guardianship under part III of Chapter 744 or "alternatives to guardianship," which it defines as an advance directive, a durable power of attorney, a representative payee, or a trust instrument. The bill requires the petition to state why a guardian advocate or other alternatives to guardianship are insufficient to meet the needs of the alleged incapacitated person or minor. The bill further provides that if the petitioner is a professional guardian, he or she may not petition for his or her own appointment unless the petitioner is a relative of the alleged incapacitated person or minor.

**Section 4** amends s. 744.363, F.S., to require specific information relating to preexisting do-not-resuscitate orders or preexisting advance directives to be included in an initial guardianship plan in addition to the contents that are presently required.

**Section 5** amends s. 744.367, F.S., to require that guardians make disclosures to the court of all remuneration received by the guardian from any source for services rendered to or on behalf of the ward as part of their annual guardianship report. This applies to both guardians of the person and guardians of the property. The bill also defines remuneration as any payment or other benefit made directly or indirectly, overtly or covertly, or in cash or in kind to the guardian.

**Section 6** amends s. 744.3675, F.S., to require specific information relating to preexisting do-not-resuscitate orders or preexisting advance directives to be included in the annual guardianship plan in addition to the contents that are presently and statutorily required to be included.

**Section 7** amends s. 744.446, F.S., relating to conflicts of interest. The bill renumbers subsections (2), (3), and (4), and adds a new subsection (2), to more specifically prohibit guardians from offering, paying, soliciting, or receiving a commission, benefit, bonus, rebate, or kickback, directly or indirectly, overtly or covertly, or in cash or in kind, or engage in a split-fee arrangements in return for referring, soliciting, or engaging in a transaction for goods or services

[52] Greg Angel, *Watchdog: Judge Dismisses Embattled Guardian's Appeal to Reverse Court Order,* Spectrum News 13 (Nov. 19, 2019) https://www.mynews13.com/fl/orlando/news/2019/11/19/watchdog-fierle-appeal-to-reverse-court-order-dismissed (last visited Jan. 7, 2020).

on behalf of an alleged incapacitated person or minor, or a ward, for past or future goods or services. Additionally, the bill specifies who the guardian may not have any conflict of interest with as it relates to the guardianship, such as the ward, the judge presiding over the case, any member of the appointed examining committee, any court employee involved in the guardianship process, or the attorney for the ward.

**Section 8** provides an effective date of July 1, 2020.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The State Courts Administrator predicts an increase in workload and judicial time as a result of modifying screening and monitoring requirements of guardians and guardianship plans. The impact is unquantifiable at this time but any judicial workload increases resulting from the bill will be reflected in the Supreme Court of Florida's annual opinion, In re: Certification of Need for Additional Judges.

The Florida Court Clerks and Comptrollers (Clerks) estimates that there will be an increase in the number of items the Clerk's staff will need to review, but the impact is indeterminate. The Clerks also estimate there will be an increase in auditing if additional complaints are received relating to DNROs, assuming the number of court hearings do not increase. If the number of court hearings do increase, there will be an impact due to court docketing and related duties.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends sections 744.312, 744.3215, 744.334, 744.363, 744.367, 744.3675, and 744.446 of the Florida Statutes.

## IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

**By** Senator Passidomo

28-01346-20 2020994__

A bill to be entitled

An act relating to guardianship; amending s. 744.312, F.S.; expanding factors for a court to consider when appointing a guardian; amending s. 744.3215, F.S.; prohibiting a guardian from consenting to or signing on behalf of a ward an order not to resuscitate without court approval; amending s. 744.334, F.S.; revising requirements for a petition for the appointment of a guardian; defining the term "alternatives to guardianship"; prohibiting professional guardians from petitioning for their own appointment except under certain circumstances; defining the term "relative"; amending s. 744.363, F.S.; expanding requirements for initial guardianship plans; amending s. 744.367, F.S.; expanding requirements for annual guardianship reports; defining the term "remuneration"; amending s. 744.3675, F.S.; expanding requirements for annual guardianship plans; amending s. 744.446, F.S.; prohibiting guardians from taking certain actions on behalf of an alleged incapacitated person or minor; revising provisions relating to conflicts of interest; providing an effective date.

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

Section 1. Paragraph (e) is added to subsection (3) of section 744.312, Florida Statutes, and subsection (1) of that section is republished, to read:

744.312 Considerations in appointment of guardian.—

(1) If the person designated is qualified to serve pursuant to s. 744.309, the court shall appoint any standby guardian or preneed guardian, unless the court determines that appointing such person is contrary to the best interests of the ward.

(3) The court shall also:

(e) Inquire into and consider potential disqualifications under s. 744.309 and potential conflicts of interest under s. 744.446.

Section 2. Paragraph (f) is added to subsection (4) of section 744.3215, Florida Statutes, and paragraph (e) of subsection (1) of that section is republished, to read:

744.3215 Rights of persons determined incapacitated.—

(1) A person who has been determined to be incapacitated retains the right:

(e) To have a qualified guardian.

(4) Without first obtaining specific authority from the court, as described in s. 744.3725, a guardian may not:

(f) Consent to or sign on behalf of the ward an order not to resuscitate executed under s. 401.45(3).

Section 3. Section 744.334, Florida Statutes, is amended to read:

744.334 Petition for appointment of guardian or professional guardian; contents.—

(1) Every petition for the appointment of a guardian shall be verified by the petitioner and shall contain statements, to the best of petitioner’s knowledge and belief, showing the name, age, residence, and post office address of the alleged incapacitated person or minor; the nature of her or his

incapacity, if any; the extent of guardianship desired, either plenary or limited; the residence and post office address of the petitioner; the names and addresses of the next of kin of the alleged incapacitated person or minor, if known to the petitioner; the name of the proposed guardian and the reasons why she or he should be appointed guardian; whether the proposed guardian is a professional guardian; the relationship and previous relationship of the proposed guardian to the alleged incapacitated person or minor ~~ward~~; any other type of guardianship under part III of this chapter or alternatives to guardianship that the alleged incapacitated person or minor has designated or is in currently or has been in previously; the reasons why a guardian advocate under s. 744.3085 or other alternatives to guardianship are insufficient to meet the needs of the alleged incapacitated person or minor; and the nature and value of property subject to the guardianship~~; and the reasons why this person should be appointed guardian~~. The petition must state whether ~~If~~ a willing and qualified guardian cannot be located~~, the petition must so state~~. As used in this subsection, the term "alternatives to guardianship" means an advance directive as defined in s. 765.101, a durable power of attorney as provided in chapter 709, a representative payee under 42 U.S.C. s. 1007, or a trust instrument as defined in s. 736.0103.

(2) If the petitioner is a professional guardian, she or he may not petition for her or his own appointment unless the petitioner is a relative of the alleged incapacitated person or minor. For purposes of this subsection, the term "relative" means an individual who would qualify to serve as a nonresident guardian under s. 744.309(2) ~~The petition for appointment of a~~

~~professional guardian must comply with the provisions of subsection (1), and must state that the petitioner is a professional guardian~~.

Section 4. Subsection (1) of section 744.363, Florida Statutes, is amended to read:

744.363 Initial guardianship plan.—

(1) The initial guardianship plan shall include all of the following:

(a) The provision of medical, mental, or personal care services for the welfare of the ward.~~;~~

(b) The provision of social and personal services for the welfare of the ward.~~;~~

(c) The place and kind of residential setting best suited for the needs of the ward.~~;~~

(d) The application of health and accident insurance and any other private or governmental benefits to which the ward may be entitled to meet any part of the costs of medical, mental health, or related services provided to the ward.~~; and~~

(e) Any physical and mental examinations necessary to determine the ward's medical and mental health treatment needs.

(f) A list of any preexisting orders not to resuscitate executed under s. 401.45(3) or preexisting advance directives, as defined in s. 765.101, the date an order or directive was signed, whether such order or directive has been suspended by the court, and a description of the steps taken to identify and locate the preexisting order not to resuscitate or advance directive.

Section 5. Subsection (3) of section 744.367, Florida Statutes, is amended to read:

744.367 Duty to file annual guardianship report.—

(3)(a) The annual guardianship report of a guardian of the property must consist of an annual accounting, and the annual guardianship report of a guardian of the person must consist of an annual guardianship plan. The annual guardianship report of a guardian of the property and the annual guardianship report of a guardian of the person must both include a declaration of all remuneration received by the guardian from any source for services rendered to or on behalf of the ward. As used in this paragraph, the term "remuneration" means any payment or other benefit made directly or indirectly, overtly or covertly, or in cash or in kind to the guardian.

(b) The annual guardianship report must ~~shall~~ be served on the ward, unless the ward is a minor or is totally incapacitated, and on the attorney for the ward, if any. The guardian shall provide a copy to any other person as the court may direct.

Section 6. Paragraph (d) is added to subsection (1) of section 744.3675, Florida Statutes, to read:

744.3675 Annual guardianship plan.—Each guardian of the person must file with the court an annual guardianship plan which updates information about the condition of the ward. The annual plan must specify the current needs of the ward and how those needs are proposed to be met in the coming year.

(1) Each plan for an adult ward must, if applicable, include:

(d) A list of any preexisting orders not to resuscitate executed under s. 401.45(3) or preexisting advance directives, as defined in s. 765.101, the date an order or directive was

signed, whether such order or directive has been suspended by the court, and a description of the steps taken to identify and locate the preexisting order not to resuscitate or advance directive.

Section 7. Present subsections (2), (3), and (4) of section 744.446, Florida Statutes, are redesignated as subsections (3), (4), and (5), respectively, a new subsection (2) is added to that section, and present subsection (2) of that section is amended, to read:

744.446 Conflicts of interest; prohibited activities; court approval; breach of fiduciary duty.—

(2) A guardian may not offer, pay, solicit, or receive a commission, benefit, bonus, rebate, or kickback, directly or indirectly, overtly or covertly, in cash or in kind, or engage in a split-fee arrangement in return for referring, soliciting, or engaging in a transaction for goods or services on behalf of an alleged incapacitated person or minor, or a ward, for past or future goods or services.

(3)~~(2)~~ Unless prior approval is obtained by court order, or unless such relationship existed before ~~prior to~~ appointment of the guardian and is disclosed to the court in the petition for appointment of guardian, a guardian may not:

(a) Have any interest, financial or otherwise, direct or indirect, in any business transaction or activity with the ward, the judge presiding over the case, any member of the appointed examining committee, any court employee involved in the guardianship process, or the attorney for the ward;

(b) Acquire an ownership, possessory, security, or other pecuniary interest adverse to the ward;

(c) Be designated as a beneficiary on any life insurance policy, pension, or benefit plan of the ward unless such designation was validly made by the ward before ~~prior to~~ adjudication of incapacity of the ward; and

(d) Directly or indirectly purchase, rent, lease, or sell any property or services from or to any business entity of which the guardian or the guardian's spouse or any of the guardian's lineal descendants, or collateral kindred, is an officer, partner, director, shareholder, or proprietor, or has any financial interest.

Section 8. This act shall take effect July 1, 2020.

**The Florida Senate**

# COMMITTEE VOTE RECORD

**COMMITTEE:** Children, Families, and Elder Affairs
**ITEM:** SB 994
**FINAL ACTION:** Favorable
**MEETING DATE:** Wednesday, January 15, 2020
**TIME:** 10:30 a.m.—12:30 p.m.
**PLACE:** 301 Senate Building

| FINAL VOTE | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Yea** | **Nay** | **SENATORS** | **Yea** | **Nay** | **Yea** | **Nay** | **Yea** | **Nay** |
| X | | Bean | | | | | | |
| X | | Harrell | | | | | | |
| X | | Rader | | | | | | |
| X | | Torres | | | | | | |
| X | | Wright | | | | | | |
| X | | Mayfield, VICE CHAIR | | | | | | |
| X | | Book, CHAIR | | | | | | |
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| 7 | 0 | **TOTALS** | | | | | | |
| **Yea** | **Nay** | | **Yea** | **Nay** | **Yea** | **Nay** | **Yea** | **Nay** |

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

**THE FLORIDA SENATE**

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/15/20
*Meeting Date*

994
*Bill Number (if applicable)*

Topic GUARDIANSHIP

*Amendment Barcode (if applicable)*

Name JACK McCRAY

Job Title

Address 215 S. MONROE ST. #603
*Street*

Phone 850-228-7295

TLH FL 32301
*City* *State* *Zip*

Email jmcray@aarp.org

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing AARP

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/15/2020
*Meeting Date*

SB 994
*Bill Number (if applicable)*

Topic Guardianship / Supported Decision Making

*Amendment Barcode (if applicable)*

Name Olivia Babis

Job Title Public Policy Analyst

Address 2473 Care Dr suite 200
*Street*

Tallahassee FL 32308
*City* *State* *Zip*

Phone 850-617-9718

Email oliviab@disabilityrightsflorida.org

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing Disability Rights Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/15/20
*Meeting Date*

994
*Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic SB 994

Name Bryan Cherry

Job Title Consultant

Address 150 S. Monroe St, STE 303
*Street*

Phone (850) 544-5673

Tallahassee FL 32301
*City* *State* *Zip*

Email bryan@pinpointresults

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing FL. Public Guardian Coalition

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

994
Bill Number (if applicable)

Topic Guardianship

Amendment Barcode (if applicable)

Name Ken Kniepmann (Keh-neep-man)

Job Title Associate -

Address 201 W Park
Street

Tallahassee
City State Zip

Phone

Email

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing Florida Conference Catholic Bishops

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

Duplicate

**THE FLORIDA SENATE**

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/15/2020
*Meeting Date*

994
*Bill Number (if applicable)*

Topic Guardianship

*Amendment Barcode (if applicable)*

Name JD Peacock II

Job Title Okaloosa County Clerk of the Circuit Court and Comptroller

Address 101 E. James Lee Blvd. Suite 108
*Street*

Phone 850-689-5000

Crestview FL 32536
*City* *State* *Zip*

Email JDPeacock@OkaloosaClerk.cor

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing Florida Court Clerks & Comptrollers

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/14/14)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-15-20
*Meeting Date*

994
*Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic Guardianship

Name Doug Franks

Job Title Advocate for the ABUSED

Address 1034 Justice Ln
*Street*

Acworth GA 30102
*City* *State* *Zip*

Phone 678 570 3010

Email douglasFranks360@gmail.com

Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☒ Against
*(The Chair will read this information into the record.)*

Representing Ernestine Franks AAAPCS.Net Cear.org

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/14/14)

JAN 14 2020
SB 994

**THE FLORIDA SENATE**

# APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

SB 994
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Gaming / Lotto.

Name Sex & Buds Clay County FL Hotels

Job Title owner

Address 2904-2910 Hwy 21
Street

Phone 904 415 3224

Email Sex Buds FL@gmail.com

City State Zip

Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
*(The Chair will read this information into the record.)*

Representing Sex Tots of Clay County

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/14/14)

**The Florida Senate**

# BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

| | |
|---|---|
| BILL: | CS/ SB 1324 |
| INTRODUCER: | Children, Families, and Elder Affairs and Senator Simpson |
| SUBJECT: | Child Welfare |
| DATE: | January 17, 2020 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Preston | Hendon | CF | **Fav/CS** |
| 2. | | | AHS | |
| 3. | | | AP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/SB 1324 makes a number of changes to the laws relating to child welfare designed to increase the accountability of parents with children in out-of-home care, encourage better communication between caregivers and birth parents, and shorten the length of time children spend in out-of-home care. Specifically, the bill:

- Requires circuit and county court dependency judges to receive education relating to the value of secure attachments, stable placements and the impact of trauma on children in out-of-home care.
- Codifies the creation and establishment of Early Childhood Court (ECC) programs that serve cases involving children typically under the age of three by using specialized dockets, multidisciplinary teams, evidence-based treatment and a nonadversarial approach.
- Requires that background screenings for prospective foster parents be completed within 14 business days after criminal history results are received by the department, unless additional information regarding the criminal history is required to complete processing.
- Requires the department to notify the court of any report to the central abuse hotline that involves a child under court jurisdiction.
- Allows the department to file a shelter or dependency petition without the need for a new child protective investigation or the concurrence of the child protective investigator if the department determines that the safety plan is no longer sufficient to keep the child safe or that the parent or caregiver has not sufficiently increased his or her level of protective capacities to ensure the child's safety.

- Provides factors for the court to consider when determining whether a change of legal custody or placement is in the child's best interest.
- Provides circumstances under which a court may remove a child and place he or she in out-of-home care if a child was placed in the child's own home with an in-home safety plan or was reunited with a parent with an in home safety plan.
- Provides legislative findings and intent and codifies provisions and responsibilities for working partnerships between foster parents and birth parents in order to ensure that children in out-of-home care achieve permanency as soon as possible, reduce the likelihood they will re-enter care and to ensure that families are prepared to resume care of their children.
- Provides a process for a community-based care lead agency (CBC) to demonstrate the need to directly provide more than 35 percent of all child welfare services in the lead agency's service area.
- Specifies timelines and steps in the process necessary for both foster parent licensing and approval of adoptive parents.

The bill will have a fiscal impact on the state and has an effective date of July 1, 2020.

## II. Present Situation:

### Judicial Education

The Florida Court Education Council was established in 1978 and charged with providing oversight of the development and maintenance of a comprehensive educational program for Florida judges and certain court support personnel. The Council's responsibilities include making budgetary, programmatic, and policy recommendations to the Supreme Court regarding continuing education for Florida judges and certain court professionals.

All judges new to the bench are required to complete the Florida Judicial College program during their first year of judicial service following selection to the bench. Taught by faculty chosen from among the state's most experienced trial and appellate court judges, the College's curriculum includes:

- A comprehensive orientation program in January, including an in-depth trial skills workshop, a mock trial experience and other classes.
- Intensive substantive law courses in March, incorporating education for both new trial judges and those who are switching divisions.
- A separate program designed especially for new appellate judges.
- A mentor program providing new trial court judges regular one-to-one guidance from experienced judges.[1]

All Florida county, circuit, and appellate judges and Florida supreme court justices are required to comply with the following judicial education requirements:

- Each judge and justice shall complete a minimum of 30 credit hours of approved judicial education programs every 3 years.

[1] The Florida Courts, *Information for New Judges*, *available at*: https://www.flcourts.org/Resources-Services/Judiciary-Education/Information-for-New-Judges (Last visited December 26, 2019).

- Each judge or justice must complete 4 hours of training in the area of judicial ethics. Approved courses in fairness and diversity also can be used to fulfill the judicial ethics requirement.
- In addition to the 30-hour requirement, every judge new to a level of trial court must complete the Florida Judicial College program in that judge's first year of judicial service following selection to that level of court.
- Every new appellate court judge or justice must, within 2 years following selection to that level of court, complete an approved appellate-judge program. Every new appellate judge who has never been a trial judge or who has never attended Phase I of the Florida Judicial College as a magistrate must also attend Phase I of the Florida Judicial College in that judge's first year of judicial service following the judge's appointment.[2]

To help judges satisfy this educational requirement, Florida Judiciary Education currently presents a variety of educational programs for new judges, experienced judges, and some court staff. About 900 hours of instruction are offered each year through live presentations and distance learning formats. This education helps judges and staff to enhance their legal knowledge, administrative skills and ethical standards.

In addition, extensive information is available to judges handling dependency cases in the Dependency Benchbook. The benchbook is a compilation of promising and science-informed practices as well as a legal resource guide. It is a comprehensive tool for judges, providing information regarding legal and non-legal considerations in dependency cases. Topics covered include the importance of a secure attachment with a primary caregiver, the advantages of stable placements and the effects of trauma on child development.[3]

**Early Childhood Courts**

***Problem-Solving Courts***

In 1989, Florida started problem-solving court initiatives by creating the first drug court in the United States in Miami-Dade County. Other types of problem-solving court dockets subsequently followed using the drug court model and were implemented to assist individuals with a range of problems such as drug addiction, mental illness, domestic violence, and child abuse and neglect.[4]

Florida's problem-solving courts address the root causes of an individual's involvement with the justice system through specialized dockets, multidisciplinary teams, and a nonadversarial approach. Offering evidence-based treatment, judicial supervision, and accountability, problem-

[2] Fla. R. Jud. Admin. 2.320 As amended through August 29, 2019, *available at*: https://casetext.com/rule/florida-court-rules/florida-rules-of-judicial-administration/part-iii-judicial-officers/rule-2320-continuing-judicial-education (Last visited December 26, 2019).
[3] The Florida Courts, *Dependency Benchbook*, *available at* https://www.flcourts.org/Resources-Services/Court-Improvement/Family-Courts/Dependency/Dependency-Benchbook (Last visited December 27, 2019).
[4] The most common problem-solving courts in Florida are drug courts, mental health courts, veterans courts and early childhood courts. Florida Courts, Office of Court Improvement, Problem-Solving Courts, *available at*: https://www.flcourts.org/Resources-Services/Court-Improvement/Problem-Solving-Courts (last visited October 2, 2019).

solving courts provide individualized interventions for participants, to reduce recidivism and promote confidence and satisfaction with the justice system process.[5]

***Early Childhood Courts in Florida***

Early Childhood Courts address child welfare cases involving children typically under the age of three. ECC is considered a "problem-solving court" that is coordinated by the Office of the State Courts Administrator with a goal of improving child safety and well-being, healing trauma and repairing the parent-child relationship, expediting permanency, preventing recurrence of maltreatment, and stopping the intergenerational cycle of abuse/neglect/violence.[6]

Using the Miami Child Well-Being Court model and the National ZERO TO THREE organization's Safe Babies Court Teams approach, Florida's Early Childhood Court program began a little more than 4 years ago.[7] Currently, there are 24 ECC programs in Florida.

The Legislature appropriated $11.3 million in current year for problem-solving courts, including early childhood courts. The Trial Court Budget Commission determines the allocation of those funds to the circuits.[8]

***The Miami Child Well-Being Court***

The development of the Miami Child Well-Being Court (CWBC) model began in the early 1990s out of an atypical collaboration that included a judge, a psychologist, and an early interventionist/education expert. The Miami CWBC model evolved over the course of more than a decade and is now widely recognized as one of the country's leading court improvement efforts, with ties to the National Council for Juvenile and Family Court Judges and Office of Juvenile Justice and Delinquency Prevention Model Courts Project.[9]

The Miami CWBC was unique due to the leadership of a judge who insisted that the court process should be informed by the science of early childhood development and who required the court to engage in intensive efforts to heal the child and—if possible—the parent-child relationship. As with the problem-solving approach of drug and mental health courts, such leadership represented a paradigm shift away from the traditional adversarial culture of the court for one in which judges utilize a systems-integration approach to promote healing and recovery from trauma in maltreated young children and to break the intergenerational nature of child abuse and neglect.[10,11]

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[5] *Id*.
[6] Center for Prevention & Early Intervention Policy, Florida State University, Florida's Early Childhood Court Manual, April 2017, *available at*: http://cpeip.fsu.edu/babyCourt/resources/Early%20Childhood%20Court%20Manual%204172015.pdf. (last visited October 2, 2019).
[7] *Id*.
[8] Chapter 2019-115, L.O.F. Specific Appropriation 3247.
[9] The Miami Child Well-Being Court Model, Essential Elements and Implementation Guidance, *available at*: http://www.floridaschildrenfirst.org/wp-content/uploads/2013/02/MiamiChild.pdf. (last visited October 3, 2019).
[10] Harvard Law School, Child Advocacy Program, The Miami Child Well Being Court Model, *available at*: http://cap.law.harvard.edu/wp-content/uploads/2015/07/22_miami-child-well-being-court-model.pdf (last visited October 3, 2019).
[11] In 1994, Dr. Joy Osofsky began developing a similar court in New Orleans, working through an "infant team" of judges, lawyers, therapists and others to provide interventions for abused and neglected babies. They had two goals: to achieve

The Miami CWBC galvanized the long-term commitment and shared vision of decision-makers across the judiciary, child welfare, child mental health, and other child- and family-serving systems in Miami-Dade to create meaningful, lasting change for court involved children and their families. The Miami CWBC model is anchored by three essential principles:

- The needs of vulnerable children involved in dependency court will be best served through a problem-solving court approach led by a science informed judge. This approach is realized through a court team that is committed to collaboration in the interest of the child's safety and emotional well-being. In addition to the judge, the court team includes the attorney representing the parent, the attorney for the state, the guardian ad litem (GAL) or court-appointed special advocate, child's attorney, or both; and the child welfare caseworker.
- Young children exposed to maltreatment and other harmful experiences need evidence-based clinical intervention to restore their sense of safety and trust and ameliorate early emotional and behavioral problems. Such intervention must address the child-caregiver relationship and has the potential to catalyze the parent's insight to address the risks to the child's safety and well-being. The intervention employed in the Miami CWBC is Child-Parent Psychotherapy applied to the context of court-ordered treatment.
- The judicial decision-making process is improved when the treating clinician provides ongoing assessment of the child-parent relationship, the parent's ability to protect and care for the child, and the child's wellbeing. This is best accomplished by involving the
- clinician on the court team to collaborate with the other parties usually involved in court proceedings. This unusual role for the clinician in the court process is actively supported by the judge.[12]

***Safe Babies Court Teams***

ZERO TO THREE was founded in 1977 as the National Center for Clinical Infant Programs by internationally recognized professionals in the fields of medicine, mental health, social science research, child development and community leadership interested in advancing the healthy development of infants, toddlers, and families. ZERO TO THREE has a history of turning the science of early development into helpful resources, practical tools and responsive policies for millions of parents, professionals, and policymakers. The organization houses a number of programs including Safe Babies Court Teams.[13]

In 2003, in partnership with the National Council of Juvenile and Family Court Judges, Court Teams for Maltreated Infants and Toddlers were conceptualized and in 2005, the first court teams were established in Fort Bend, Texas; Hattiesburg, Mississippi; and Des Moines, Iowa. Currently, the initiative operates in multiple sites around the country.[14]

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permanency more quickly, although not necessarily reunification, and to prevent further abuse and neglect.

[12] The Miami Child Well-Being Court Model, Essential Elements and Implementation Guidance, *available at*: http://www.floridaschildrenfirst.org/wp-content/uploads/2013/02/MiamiChild.pdf. (last visited October 3, 2019).

[13] ZERO TO THREE, Our History, *available at*: https://www.zerotothree.org/about/our-history (last visited September 30, 2019).

[14] ZERO TO THREE, The Safe Babies Court Team Approach: Championing Children, Encouraging Parents, Engaging Communities, *available at*: https://www.zerotothree.org/resources/528-the-safe-babies-court-team-approach-championingchildren-encouraging-parents-engaging-communities. (last visited September 30, 2019).

Based on the Miami Child Well-Being Court and the New Orleans models,[15,16] the Safe Babies Court Teams Project is based on developmental science and aims to:

- Increase awareness among those who work with maltreated infants and toddlers about the negative impact of abuse and neglect on very young children; and,
- Change local systems to improve outcomes and prevent future court involvement in the lives of very young children.[17]

This approach is recognized by the California Evidence-Based Clearinghouse for Child Welfare offsite link as being highly relevant to the child welfare system and demonstrating promising research evidence.[18]

The following numbers are based on data extracted from the Florida Dependency Court Information System (FDCIS) on December 2018, for children who were removed from their parents' care due to allegations of abandonment, abuse, or neglect. These measures compare groups of children ages 0-3 at the time of removal who were in the Early Childhood Court (ECC) program to children ages 0-3 who were not in the ECC program.[19]

| Measure | # For Children not in ECC | # For Children in ECC |
|---|---|---|
| Median number of days from removal to reunification closure | 736.2 | 477.1 |
| Median number of days from removal to adoption closure | 699.0 | 687.3 |
| Median number of days from removal to permanent guardianship | 683.3 | 453.1 |
| Average time to overall permanency in days | 695.0 | 552.9 |
| Children in ECC had a 40% reduction in recurrence of maltreatment compared to non-ECC children | | |

Shortening the time children spend in out-of-home care should serve as a potential cost savings for the state due to the reduction in out-of-home care cost.

**Differences Between Early Childhood Courts and Regular Dependency Courts**

| Services | Early Childhood Court | "Regular" Dependency Court |
|---|---|---|
| Court hearings | Monthly hearings assess progress and solve problems quickly | Only a 6-month judicial review |

[15] ACES Too High, In Safe Babies Courts, 99% of kids don't suffer more abuse — but less than 1% of U.S. family courts are Safe Babies Courts. February 23, 2015, *available at*: https://acestoohigh.com/2015/02/23/in-safe-babies-courts-99-of-kids-dont-suffer-more-abuse-but-less-than-1-of-u-s-family-courts-are-safe-babies-courts/ (last visited October 1, 2019).
[16] *Id*. Safe Babies Courts differ from the other models by providing community coordinators who work with court personnel to keep the process on track.
[17] ZERO TO THREE, Safe Babies Court Teams, *available a*t: https://www.zerotothree.org/our-work/safe-babies-court-team (last visited October 1, 2019).
[18] The California Evidence-Based Clearinghouse for Child Welfare, *available at*: http://www.cebc4cw.org/program/safe-babies-court-teams-project/ (last visited September 30, 2019).
[19] Florida Courts, Office of Court Improvement, Early Childhood Courts, *available at*: https://www.flcourts.org/Resources-Services/Court-Improvement/Problem-Solving-Courts/Early-Childhood-Courts (last visited October 1, 2019).

| | | |
|---|---|---|
| Community Coordinator | Coordinates monthly parent team meetings to prioritize family services, integrate fast track services to expedite permanency for the child. | No coordinator. Case plans may not address real family needs. Reviewed every 6 months; not fluid to changing family needs that impact permanency. Needed services often delayed or wait listed. |
| Integrated Multidisciplinary Team approach | Families encouraged and supported by multidisciplinary team including court staff, community-based care case managers, attorneys, GAL staff & volunteers, and clinicians specializing in Child Parent Therapy. | No teams. Piecemeal services. Not integrated. Families struggle to get needed services timely and to complete case plan. |
| Visitation | Daily contact encouraged (3x week minimum) to strengthen parent child attachment & promote reunification | Only monthly visitation required in statute. |
| Evidence based Clinical services | Child Parent Therapy offered to all families in ECC to heal trauma, improve parenting & optimize child/parent relationship. Clinician reports to court to inform decisions toward stable placement. | Therapies and evidence based interventions not usually offered to children younger than 5 and families. |
| Time to permanency | Spent 112 days less in the system than non-ECC children to reach a permanent stable family (reunification or placed with relative or non-relative) in 2016. | Stayed in out-of-home care 112 days longer than ECC children in 2016 |
| Re-entry into child welfare | Only two ECC children re-entered the system in 2016 (3.39% compared to 3.86% for non ECC). | Statewide recurrence is 9.69% |

**Postdisposition Change of Custody**

Currently, the court may change the temporary legal custody or the conditions of protective supervision at a postdisposition hearing, without the necessity of another adjudicatory hearing. The standard for changing custody of the child shall be the best interest of the child. When applying this standard, the court shall consider the continuity of the child's placement in the same out-of-home residence as a factor when determining the best interests of the child. If the child is not placed in foster care, then the new placement for the child must meet the home study criteria and court approval pursuant to this chapter.[20]

- In cases where the issue before the court is whether a child should be reunited with a parent, the court shall review the conditions for return and determine whether the circumstances that caused the out-of-home placement and issues subsequently identified have been remedied to the extent that the return of the child to the home with an in-home safety plan prepared or

[20] Section 39.522, F.S.

approved by the department will not be detrimental to the child's safety, well-being, and physical, mental, and emotional health.[21]

- In cases where the issue before the court is whether a child who is placed in the custody of a parent should be reunited with the other parent upon a finding that the circumstances that caused the out-of-home placement and issues subsequently identified have been remedied to the extent that the return of the child to the home of the other parent with an in-home safety plan prepared or approved by the department will not be detrimental to the child, the standard shall be that the safety, well-being, and physical, mental, and emotional health of the child would not be endangered by reunification and that reunification would be in the best interest of the child.[22]

**Adoption Home Study and Screening**

- The adoption of a child from Florida's foster care system is a process that the department estimates can usually be completed within nine months. The process typically includes an orientation session, an in-depth training program to help prospective parents determine if adoption is right for the family, a home study and a background check. Once the process has been completed, prospective parents are ready to be matched with a child available for adoption.[23]
- The prospective adoptive parents' initial inquiry to the department or to the CBC lead agency or subcontractor staff, whether written or verbal, shall receive a written response or a telephone call within seven (7) business days. Prospective adoptive parents who indicate an interest in adopting children must be referred to a department approved adoptive parent training program, as prescribed in rule 65C-13.024, F.A.C.
- An application to adopt must be made on the "Adoptive Home Application."
- An ***adoptive home study which includes*** observation, screening and evaluation of the child and adoptive applicants shall be completed by a staff person with the CBC, subcontractor agency, or other licensed child-placing agency prior to the adoptive placement of the child. The aim of this evaluation is to select families who will be able to meet the physical, emotional, social, educational and financial needs of a child, while safeguarding the child from further loss and separation from siblings and significant adults. The adoptive home study is valid for 12 months from the approval date. An adoptive parent application file shall consist of the following documentation including, but not limited to:
    - The child's choice, if the child is developmentally able to participate in the decision. The child's consent to the adoption is required if the child is age 12 or older unless excused by the court;
    - The ability and willingness of the adoptive family to adopt some or all of a sibling group, although no individual child shall be impeded or disadvantaged in receiving an adoptive family due to the inability of the adoptive family to adopt all siblings. The needs of each individual child must be considered, as well as the family's demonstrated efforts to maintain the sibling connection;

[21] *Id*.
[22] *Id*.
[23] Florida Department of Children and Families, The Road to Adoption, *available at*: http://www.adoptflorida.org/roadtoadoption.shtml (last visited December 30, 2019).

- The commitment of the applicant to value, respect, appreciate, and educate the child regarding his or her racial and ethnic heritage and to permit the child the opportunity to know and appreciate that ethnic and racial heritage;
- The family's child rearing experience;
- Marital status;
- Residence;
- Income;
- Housing;
- Health;
- Other children and household members;
- ***Background Screening. All adoptive applicants must complete the requirements for background screening as outlined in rule 65C-16.007, F.A.C. which includes abuse and neglect history checks on all adoptive applicants and other household members 12 years of age and older, pursuant to sections 39.0138 and 39.521, F.S.***; and
- References.

The department approved adoptive parent training must be provided to and successfully completed by all prospective adoptive parents except licensed foster parents and relative and non-relative caregivers who previously attended the training within the last five (5) years, as prescribed in rule 65C-13.024, F.A.C., or have the child currently placed in their home for six (6) months or longer and been determined to understand the challenges and parenting skills needed to successfully parent the children available for adoption from foster care.

There are a number of factors that can affect the time necessary for the typical adoption home study process to be completed.

**Foster Care Licensing Home Study and Background Screening**

Current law provides for the establishment of licensing requirements for family foster homes, residential child-caring agencies, and child-placing agencies in order to protect the health, safety, and well-being of all children in the state who are cared for by these homes and agencies and provides procedures to determine adherence to these requirements.[24]

- Each applicant wishing to become a licensed out-of-home caregiver shall complete the "Application for License to Provide Out-of-Home Care for Dependent Children." Persons living together in a caretaking role must both sign the application.
- The child-placing agency completing the ***Unified Home Study*** shall, at a minimum, conduct two visits to the applicant's home, inspect the entire indoor and outdoor premises, document the conditions, and conduct face-to-face interviews with all household members. The dates, names of persons interviewed and summary of these interviews shall be documented in the Unified Home Study.
- A staff person, certified pursuant to section 402.40, F.S., from the supervising agency shall perform a thorough assessment of each prospective licensed out-of-home caregiver and document this assessment in the Unified Home Study section of Florida Safe Families

[24] Section 409.175, F.S.

Network (FSFN). The assessment must include an extensive and comprehensive list of information.

- The Unified Home Study shall be reviewed and signed by the applicant, licensing counselor and his or her supervisor. A copy of the Unified Home Study shall be provided to the applicant. The complete application file shall be submitted in accordance with the traditional or attestation model for licensure. A request for additional information shall be submitted by the Regional Licensing Authority within 10 business days of receipt of the file. A traditional licensing application file shall consist of the following documentation including, but not limited to:
    - Application for License to Provide Out-of-Home Care for Dependent Children;
    - ***Licensing Unified Home Study;***
    - Proof of Income;
    - A "Partnership Plan for Children in Out-of-Home Care;"
    - Parent Preparation Pre-service Training certificate;
    - ***Verification of criminal history screening for applicant and all household members*** as specified in subsection 65C-13.023(2), F.A.C.;
    - Required references; and
    - Family Documents.

A licensing specialist who has been trained by the department or other state entity, such as the local health department, in the areas of water supply, food holding temperature, plumbing, pest control, sewage, and garbage disposal, shall complete the Foster Home Inspection Checklist, incorporated by reference in rule 65C-13.025, F.A.C.

If the application file is approved, a license shall be issued to the applicant(s). The license shall include the name and address of the caregiver(s), the name of the supervising agency, the licensed capacity, and the dates for which the license is valid. The DCF Regional Managing Director or designee within upper level management shall sign the license. Any limitations shall be displayed on the license. The CBC lead agency or supervising agency is responsible for ensuring the license is sent to the foster parent.

If the department determines that the application shall be denied, the department shall within 10 business days notify the applicant and supervising agency by certified mail, identifying the reasons for the denial of the license, the statutory authority for the denial of the license, and the applicant's right of appeal pursuant to chapter 120, F.S.[25]

[25] 65C-13.025, F.A.C.

**Parenting Partnerships**

***Quality Parenting Initiative (QPI)***

The Quality Parenting Initiative, a strategy of the Youth Law Center in California, is an approach to strengthening foster care, refocusing on excellent parenting for all children in the child welfare system. It was launched in 2008 in Florida, and as of 2018, over 75 jurisdictions in 10 states (California, Florida, Illinois, Louisiana, Minnesota, Nevada, Ohio, Pennsylvania, Texas and Wisconsin) have adopted the QPI approach.[26]

In order to thrive, all children need excellent parenting. When parents cannot care for their children, the foster parent or other caregiver must be able to provide the loving, committed, skilled care that the child needs, in partnership with the system, to ensure that children thrive. Both the caregiver's parenting skills and the system's policies and practices should be based on child development research, information and tools. QPI is based on five core principles:

- Excellent parenting is the most important service we can provide to children in out-of-home care. Children need families, not beds;
- Child development and trauma research indicates that children need constant, consistent, effective parenting to grow and reach their full potential;
- Each community must define excellent parenting for itself;
- Policy and practice must be changed to align with that definition; and
- Participants in the system are in the best position to recommend and implement that change.[27]

QPI is an approach, a philosophy and a network of sites that share information and ideas about how to improve parenting as well as recruit and retain excellent families. It is an effort to rebrand foster care, not simply by changing a logo or an advertisement, but by changing the expectations of and support for caregivers. The child welfare system commits to fully supporting excellent parenting by putting the needs of the child first. QPI was developed to ensure that every child removed from the home because of abandonment, abuse or neglect is cared for by a foster family who provides skilled, nurturing parenting while helping the child maintain connections with his or her family.

When QPI is successful, caregivers have a voice. They work as a team with agency staff, case workers, birth parents, courts, attorneys and others to protect the child's best interests agency staff to support children. Caregivers receive the support and training they need to work with children and families, understand what is expected of them, and know what to expect from the system. Systems are then able to select and retain enough excellent caregivers to meet the needs of each child for a home and family. When these changes are accomplished, outcomes for children and their families will improve.

In 2013, the legislature enacted some of the basic principles of quality parenting including, but not limited to roles and responsibilities for caregivers, the department, community-based lead

[26] QPI Florida, Quality Parenting Initiative, Just in Time Training, available at: http://www.qpiflorida.org/about.html (Last visited December 26, 2019).
[27] *Id*.

agency and other agency staff, transitions for children changing placements and information sharing.[28]

## III. Effect of Proposed Changes:

**Section 1** amends s. 25.385, F.S., relating to standards for instruction of circuit and county court judges, to require circuit and county court dependency judges to receive education relating to the value of secure attachments, stable placements and the impact of trauma on children in out-of-home care.

**Section 2** creates s. 39.01304, F.S., relating to early childhood courts, to codify the creation and establishment of early childhood court programs that serve cases involving children typically under the age of three by using specialized dockets, multidisciplinary teams, evidence-based treatment and a nonadversarial approach.

**Section 3** amends s. 39.0138, F.S., relating to criminal history and other records checks, to require that background screenings for prospective foster parents be completed within 14 business days after criminal history results are received by the department, unless additional information regarding the criminal history is required to complete processing.

**Section 4** amends s. 39.301, F.S., relating to protective investigations, to require the department to notify the court of any report to the central abuse hotline that involves a child under court jurisdiction. Also allows the department to file a shelter or dependency petition without the need for a new child protective investigation or the concurrence of the child protective investigator if the department determines that the safety plan is no longer sufficient to keep the child safe or that the parent or caregiver has not sufficiently increased his or her level of protective capacities to ensure the child's safety.

**Section 5** amends s. 39.522, F.S., relating to postdisposition change of custody, to provide factors for the court to consider when determining whether a change of legal custody or placement is in the child's best interest. Those factors include:

- The child's age.
- The developmental and therapeutic benefits to the child of remaining in his or her current placement or moving to the proposed placement.
- The stability and longevity of the child's current placement.
- The established bonded relationship between the child and the current or proposed caregiver.
- The reasonable preference of the child, if the court has found that the child is of sufficient intelligence, understanding, and experience to express a preference.
- The recommendation of the child's current caregiver.
- The recommendation of the child's guardian ad litem, if one has been appointed.
- The quality of the child's relationship with a sibling, if the change of legal custody or placement will separate or reunite siblings.
- The likelihood of the child attaining permanency in the current or proposed placement.
- Any other relevant factors.

[28] Section 409.145, F.S.

It also provides circumstances under which a court may remove a child and place he or she in out-of-home care if a child was placed in the child's own home with an in-home safety plan or was reunited with a parent with an in home safety plan. Those circumstances include:

- The child is abused, neglected, or abandoned by the parent or caregiver, or is suffering from or is in imminent danger of illness or injury as a result of abuse, neglect, or abandonment.
- The parent or caregiver has materially violated a condition of placement imposed by the court, including, but not limited to, not complying with the in-home safety plan or case plan.
- The parent or caregiver is unlikely, within a reasonable amount of time, to achieve the full protective capacities needed to keep the child safe without an in-home safety plan.

If a child meets the above criteria for removal and placement in out-of-home care, the court must consider all of the following in making its determination to remove the child and place the child in out-of-home care:

- The circumstances that caused the child's dependency and other identified issues.
- The length of time the child has been placed in the home with an in-home safety plan.
- The parent's or caregiver's current level of protective capacities.
- The level of increase, if any, in the parent's or caregiver's protective capacities since the child's placement in the home, based on the length of time the child has been placed in the home.

**Section 6** amends s. 39.6011, F.S., relating to case plan development, to include in provisions required in a case plan the responsibility of the parents and caregivers to work together to successfully implement the case plan. The case plan must specify how the case manager will assist the parents and caregivers in developing a productive relationship, including meaningful communication and mutual support.

**Section 7** amends s. 39.701, F.S., relating to judicial reviews, to require the court to retain jurisdiction over a child placed in a home with a parent or caregiver with an in-home safety plan and update language related to service providers. It also requires the case plan assessment made before every judicial review to include a statement related to the working relationship between the parents of a child and the caregivers.

**Section 8** amends s. 63.092, F.S., relating to preliminary home studies, to require that preliminary home studies for identified prospective adoptive minors that are in the custody of the department be completed within 30 days of initiation.

**Section 9** creates s. 63.093, F.S., relating to the adoption of a child from the child welfare system to specify the requirements in the process.

**Section 10** creates s. 409.1415, F.S., relating to parenting partnerships, to provide legislative findings and intent and codify provisions and responsibilities for working partnerships between foster parents and birth parents in order to ensure that children in out-of-home care achieve permanency as soon as possible, reduce the likelihood they will re-enter care and to ensure that families are prepared to resume care of their children.

**Section 11** amends s. 409.145, F.S., relating to care of children and quality parenting, to remove similar provisions being relocated to newly created s. 409.1415, F.S.

**Section 12** amends s. 409.175, F.S., relating to licensure of family foster homes, residential child-caring agencies, and child-placing agencies, to require that a licensing study of a family foster home must be completed by the department or an authorized licensed child-placing agency within 30 days of initiation. It also sets timelines and requirements for the entire licensure process.

**Section 13** amends s. 409.988, F.S., relating to duties of community-based care lead agencies, to provide a process for a lead agency to demonstrate the need to provide more than 35 percent of all child welfare services in the lead agency's service area. Currently, a lead agency is prohibited from directly providing more than 35 percent of all child welfare services.

**Section 14** amends s. 39.302, F.S., relating to protective investigations of institutional child abuse, to conform to changes made by the act.

**Section 15** amends s. 39.6225, F.S., relating to the Guardianship Assistance Program, to conform to changes made by the act.

**Section 16** amends s. 393.065, F.S., relating to application and eligibility determination for developmental disability services, to conform to changes made by the act.

**Section 17** amends s. 409.1451, F.S., relating to independent living services, to conform to changes made by the act.

**Section 18** provides an effective date of July 1, 2020.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

**State Courts**

***Judicial Time and Workload***

The total fiscal impact of the bill cannot be accurately determined due to the unavailability of data needed to quantifiably establish the increase in judicial time and workload resulting from increased time or quantify of ECC hearings as well as the actual number of staff required to meet the requirements of the bill.[29]

Trial court judicial workload is measured using a case weighting system that calculates the amount of time that it takes for a judge to dispose of a case. Passage of this bill may impact the case weighting system. The number of case filings using the case weighting system is used to determine the needs for additional judicial resources each year. Any judicial workload increases in the future as a result of this bill will be reflected in the Supreme Court's annual opinion In re: Certification of Need for Additional Judges.[30]

The additional judicial workload may be offset to the extent the programs reduce recidivism. Shortening the time children spend in out-of-home care would reduce costs to the state due to the reduction in out-of-home care cost and court time and resources.

***Additional Positions and Training***

The bill will also have a fiscal impact on the state by requiring specialized staff and support services. Each circuit with an early childhood court would need a community coordinator. In addition, the bill would require training for judges, magistrates and staff. The Office of State Courts Administrator estimates the additional costs of the bill as follows:

| Position | FTE | Annual Cost |
|---|---|---|

[29] Office of the State Courts Administrator, 2020 Judicial Impact Statement, SB 236, October 7, 2019.
[30] *Id*.

| | | |
|---|---|---|
| Statewide training specialist | 1 | $101,442 |
| Court community coordinators and oversight positions | 20 | $1.912,128 |
| Training requirements | | $100,000 |
| | | |
| Total | 21 | **$2,113,570** |

A cost savings from the use of ECC may also be realized upon the implementation of the Families First Prevention Services Act in 2021. The ECC and its use of some model of parent-child therapy may be eligible for a federal funding match for prevention services.

**Department of Children and Families**

The bill requires the department to contract with one or more university based centers with an expertise in infant mental health to hire a statewide clinical consultant which is anticipated to result in a cost to the agency of $136,120.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 25.385, 39.0138, 39.301, 39.302, 39.522, 39.6011, 39.701, 63.092, 409.145, 409.175, 409.988, 39.6225, 393.065, and 409.1451.

This bill creates the following sections of the Florida Statutes: 39.01304, 63.090 and 409.1415.

## IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

**CS by Children, Families, and Elder Affairs on January 15, 2020:**

- Makes changes to provisions relating to the timeframes relating to the completion of background screenings and home or licensing studies to reflect the steps in the approval of adoptive parents and the licensure of foster homes.

B. Amendments:

None.

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LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: FAV | . | |
| 01/15/2020 | . | |
| | . | |
| | . | |
| | . | |

The Committee on Children, Families, and Elder Affairs (Simpson) recommended the following:

**Senate Amendment (with title amendment)**

Delete everything after the enacting clause
and insert:

Section 1 Section 25.385, Florida Statutes, is amended to read:

25.385 Standards for instruction of circuit and county court judges ~~in handling domestic violence cases~~.—

(1) The Florida Court Educational Council shall establish standards for instruction of circuit and county court judges who

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have responsibility for domestic violence cases, and the council shall provide such instruction on a periodic and timely basis.

~~(2)~~ As used in this subsection, ~~section:~~

~~(a)~~ the term "domestic violence" has the meaning set forth in s. 741.28.

~~(b) "Family or household member" has the meaning set forth in s. 741.28.~~

(2) The Florida Court Educational Council shall establish standards for instruction of circuit and county court judges who have responsibility for dependency cases regarding the benefits of a secure attachment with a primary caregiver, the importance of a stable placement, and the impact of trauma on child development. The council shall provide such instruction to the circuit and county court judges handling dependency cases on a periodic and timely basis.

Section 1. Section 39.01304, Florida Statutes, is created to read:

39.01304 Early childhood court programs.—

(1) It is the intent of the Legislature to encourage the department, the Department of Health, the Association of Early Learning Coalitions, and other such agencies; local governments; interested public or private entities; and individuals to support the creation and establishment of early childhood court programs. The purpose of an early childhood court program is to address the root cause of court involvement through specialized dockets, multidisciplinary teams, evidence-based treatment, and the use of a nonadversarial approach. Such programs depend on the leadership of a judge or magistrate who is educated about the science of early childhood development and who requires

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rigorous efforts to heal children physically and emotionally in the context of a broad collaboration among professionals from different systems working directly in the court as a team, recognizing that the parent-child relationship is the foundation of child well-being.

(2) A circuit court may create an early childhood court program to serve the needs of infants and toddlers in dependency court. An early childhood court program must have all of the following components:

(a) Therapeutic jurisprudence, which must drive every aspect of judicial practice. The judge or magistrate must support the therapeutic needs of the parent and child in a nonadversarial manner. As used in this paragraph, the term "therapeutic jurisprudence" means the study of how the law may be used as a therapeutic agent and focuses on how laws impact emotional and psychological well-being.

(b) A procedure for coordinating services and resources for families who have a case on the court docket. To meet this requirement, the court may create and fill at least one community coordinator position pursuant to paragraph (3)(a).

(c) A multidisciplinary team made up of key community stakeholders who commit to work with the judge or magistrate to restructure the way the community responds to the needs of maltreated children. The team may include, but is not limited to, early intervention specialists; mental health and infant mental health professionals; attorneys representing children, parents, and the child welfare system; children's advocates; early learning coalitions and child care providers; substance abuse program providers; primary health care providers; domestic

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violence advocates; and guardians ad litem. The multidisciplinary team must address the need for children in an early childhood court program to receive medical care in a medical home, a screening for developmental delays conducted by the local agency responsible for complying with part C of the federal Individuals with Disabilities Education Act, and quality child care.

(d) A continuum of mental health services which includes a focus on the parent-child relationship and is appropriate for each child and family served.

(3) Contingent upon an annual appropriation by the Legislature, and subject to available resources:

(a) The Office of the State Courts Administrator shall coordinate with each participating circuit court to create and fill at least one community coordinator position for the circuit's early childhood court program. Each community coordinator shall provide direct support to the program by providing coordination between the multidisciplinary team and the judiciary, coordinating the responsibilities of the participating agencies and service providers, and managing the collection of data for program evaluation and accountability. The Office of State Courts Administrator may hire a statewide training specialist to provide training to the participating court teams.

(b) The department shall contract with one or more university-based centers that have expertise in infant mental health, and such university-based centers shall hire a clinical director charged with ensuring the quality, accountability, and fidelity of the program's evidence-based treatment, including,

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but not limited to, training and technical assistance related to clinical services, clinical consultation and guidance for difficult cases, and ongoing clinical training for court teams.

Section 2. Subsection (1) of section 39.0138, Florida Statutes, is amended to read

39.0138 Criminal history and other records checks; limit on placement of a child.—

(1) The department shall conduct a records check through the State Automated Child Welfare Information System (SACWIS) and a local and statewide criminal history records check on all persons, including parents, being considered by the department for placement of a child under this chapter, including all nonrelative placement decisions, and all members of the household, 12 years of age and older, of the person being considered. For purposes of this section, a criminal history records check may include, but is not limited to, submission of fingerprints to the Department of Law Enforcement for processing and forwarding to the Federal Bureau of Investigation for state and national criminal history information, and local criminal records checks through local law enforcement agencies of all household members 18 years of age and older and other visitors to the home. Background screenings must be completed within 14 business days after criminal history results are received by the department, unless additional information regarding the criminal history is required to complete processing. An out-of-state criminal history records check must be initiated for any person 18 years of age or older who resided in another state if that state allows the release of such records. The department shall establish by rule standards for evaluating any information

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contained in the automated system relating to a person who must be screened for purposes of making a placement decision.

Section 3. Subsection (1) and paragraph (a) of subsection (9) of section 39.301, Florida Statutes, are amended to read:

39.301 Initiation of protective investigations.—

(1)(a) Upon receiving a report of known or suspected child abuse, abandonment, or neglect, or that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care, the central abuse hotline shall determine if the report requires an immediate onsite protective investigation. For reports requiring an immediate onsite protective investigation, the central abuse hotline shall immediately notify the department's designated district staff responsible for protective investigations to ensure that an onsite investigation is promptly initiated. For reports not requiring an immediate onsite protective investigation, the central abuse hotline shall notify the department's designated district staff responsible for protective investigations in sufficient time to allow for an investigation. At the time of notification, the central abuse hotline shall also provide information to district staff on any previous report concerning a subject of the present report or any pertinent information relative to the present report or any noted earlier reports.

(b) The department shall promptly notify the court of any report to the central abuse hotline that is accepted for a protective investigation and involves a child over whom the court has jurisdiction.

(9)(a) For each report received from the central abuse

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hotline and accepted for investigation, the department or the sheriff providing child protective investigative services under s. 39.3065, shall perform the following child protective investigation activities to determine child safety:

1. Conduct a review of all relevant, available information specific to the child and family and alleged maltreatment; family child welfare history; local, state, and federal criminal records checks; and requests for law enforcement assistance provided by the abuse hotline. Based on a review of available information, including the allegations in the current report, a determination shall be made as to whether immediate consultation should occur with law enforcement, the Child Protection Team, a domestic violence shelter or advocate, or a substance abuse or mental health professional. Such consultations should include discussion as to whether a joint response is necessary and feasible. A determination shall be made as to whether the person making the report should be contacted before the face-to-face interviews with the child and family members.

2. Conduct face-to-face interviews with the child; other siblings, if any; and the parents, legal custodians, or caregivers.

3. Assess the child's residence, including a determination of the composition of the family and household, including the name, address, date of birth, social security number, sex, and race of each child named in the report; any siblings or other children in the same household or in the care of the same adults; the parents, legal custodians, or caregivers; and any other adults in the same household.

4. Determine whether there is any indication that any child


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in the family or household has been abused, abandoned, or neglected; the nature and extent of present or prior injuries, abuse, or neglect, and any evidence thereof; and a determination as to the person or persons apparently responsible for the abuse, abandonment, or neglect, including the name, address, date of birth, social security number, sex, and race of each such person.

5. Complete assessment of immediate child safety for each child based on available records, interviews, and observations with all persons named in subparagraph 2. and appropriate collateral contacts, which may include other professionals. The department’s child protection investigators are hereby designated a criminal justice agency for the purpose of accessing criminal justice information to be used for enforcing this state’s laws concerning the crimes of child abuse, abandonment, and neglect. This information shall be used solely for purposes supporting the detection, apprehension, prosecution, pretrial release, posttrial release, or rehabilitation of criminal offenders or persons accused of the crimes of child abuse, abandonment, or neglect and may not be further disseminated or used for any other purpose.

6. Document the present and impending dangers to each child based on the identification of inadequate protective capacity through utilization of a standardized safety assessment instrument. If present or impending danger is identified, the child protective investigator must implement a safety plan or take the child into custody. If present danger is identified and the child is not removed, the child protective investigator shall create and implement a safety plan before leaving the home

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or the location where there is present danger. If impending danger is identified, the child protective investigator shall create and implement a safety plan as soon as necessary to protect the safety of the child. The child protective investigator may modify the safety plan if he or she identifies additional impending danger.

a. If the child protective investigator implements a safety plan, the plan must be specific, sufficient, feasible, and sustainable in response to the realities of the present or impending danger. A safety plan may be an in-home plan or an out-of-home plan, or a combination of both. A safety plan may include tasks or responsibilities for a parent, caregiver, or legal custodian. However, a safety plan may not rely on promissory commitments by the parent, caregiver, or legal custodian who is currently not able to protect the child or on services that are not available or will not result in the safety of the child. A safety plan may not be implemented if for any reason the parents, guardian, or legal custodian lacks the capacity or ability to comply with the plan. If the department is not able to develop a plan that is specific, sufficient, feasible, and sustainable, the department shall file a shelter petition. A child protective investigator shall implement separate safety plans for the perpetrator of domestic violence, if the investigator, using reasonable efforts, can locate the perpetrator to implement a safety plan, and for the parent who is a victim of domestic violence as defined in s. 741.28. Reasonable efforts to locate a perpetrator include, but are not limited to, a diligent search pursuant to the same requirements as in s. 39.503. If the perpetrator of domestic violence is not

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the parent, guardian, or legal custodian of any child in the home and if the department does not intend to file a shelter petition or dependency petition that will assert allegations against the perpetrator as a parent of a child in the home, the child protective investigator shall seek issuance of an injunction authorized by s. 39.504 to implement a safety plan for the perpetrator and impose any other conditions to protect the child. The safety plan for the parent who is a victim of domestic violence may not be shared with the perpetrator. If any party to a safety plan fails to comply with the safety plan resulting in the child being unsafe, the department shall file a shelter petition.

b. The child protective investigator shall collaborate with the community-based care lead agency in the development of the safety plan as necessary to ensure that the safety plan is specific, sufficient, feasible, and sustainable. The child protective investigator shall identify services necessary for the successful implementation of the safety plan. The child protective investigator and the community-based care lead agency shall mobilize service resources to assist all parties in complying with the safety plan. The community-based care lead agency shall prioritize safety plan services to families who have multiple risk factors, including, but not limited to, two or more of the following:

(I) The parent or legal custodian is of young age;

(II) The parent or legal custodian, or an adult currently living in or frequently visiting the home, has a history of substance abuse, mental illness, or domestic violence;

(III) The parent or legal custodian, or an adult currently

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living in or frequently visiting the home, has been previously found to have physically or sexually abused a child;

(IV) The parent or legal custodian or an adult currently living in or frequently visiting the home has been the subject of multiple allegations by reputable reports of abuse or neglect;

(V) The child is physically or developmentally disabled; or

(VI) The child is 3 years of age or younger.

c. The child protective investigator shall monitor the implementation of the plan to ensure the child's safety until the case is transferred to the lead agency at which time the lead agency shall monitor the implementation.

d. The department may file a petition for shelter or dependency without a new child protective investigation or the concurrence of the child protective investigator if the child is unsafe but for the use of a safety plan and the parent or caregiver has not sufficiently increased protective capacities within 90 days after the transfer of the safety plan to the lead agency.

Section 4. Subsection (1) of section 39.522, Florida Statutes, is amended, and subsection (4) is added to that section, to read:

39.522 Postdisposition change of custody.—The court may change the temporary legal custody or the conditions of protective supervision at a postdisposition hearing, without the necessity of another adjudicatory hearing.

(1)(a) At any time before a child is residing in the permanent placement approved at the permanency hearing, a child who has been placed in the child's own home under the protective

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supervision of an authorized agent of the department, in the home of a relative, in the home of a legal custodian, or in some other place may be brought before the court by the department or by any other interested person, upon the filing of a motion alleging a need for a change in the conditions of protective supervision or the placement. If the parents or other legal custodians deny the need for a change, the court shall hear all parties in person or by counsel, or both. Upon the admission of a need for a change or after such hearing, the court shall enter an order changing the placement, modifying the conditions of protective supervision, or continuing the conditions of protective supervision as ordered. The standard for changing custody of the child shall be the best interests ~~interest~~ of the child. When determining whether a change of legal custody or placement is in ~~applying this standard, the court shall consider the continuity of the child's placement in the same out-of-home residence as a factor when determining~~ the best interests of the child, the court shall consider:

1. The child's age.

2. The physical, mental, and emotional health benefits to the child by remaining in his or her current placement or moving to the proposed placement.

3. The stability and longevity of the child's current placement.

4. The established bonded relationship between the child and the current or proposed caregiver.

5. The reasonable preference of the child, if the court has found that the child is of sufficient intelligence, understanding, and experience to express a preference.


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6. The recommendation of the child's current caregiver.

7. The recommendation of the child's guardian ad litem, if one has been appointed.

8. The child's previous and current relationship with a sibling, if the change of legal custody or placement will separate or reunite siblings.

9. The likelihood of the child attaining permanency in the current or proposed placement.

10. Any other relevant factors.

(b) If the child is not placed in foster care, ~~then~~ the new placement for the child must meet the home study criteria and court approval under ~~pursuant to~~ this chapter.

(4)(a) The court or any party to the case may file a petition to place a child in out-of-home care after the child was placed in the child's own home with an in-home safety plan or the child was reunified with a parent or caregiver with an in-home safety plan if:

1. The child has again been abused, neglected, or abandoned by the parent or caregiver, or is suffering from or is in imminent danger of illness or injury as a result of abuse, neglect, or abandonment that has reoccurred; or

2. The parent or caregiver has materially violated a condition of placement imposed by the court, including, but not limited to, not complying with the in-home safety plan or case plan.

(b) If a child meets the criteria in paragraph (a) to be removed and placed in out-of-home care, the court must consider, at a minimum, the following in making its determination to remove the child and place the child in out-of-home care:

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1. The circumstances that caused the child's dependency and other subsequently identified issues.

2. The length of time the child has been placed in the home with an in-home safety plan.

3. The parent's or caregiver's current level of protective capacities.

4. The level of increase, if any, in the parent's or caregiver's protective capacities since the child's placement in the home based on the length of time the child has been placed in the home.

(c) The court shall evaluate the child's permanency goal and change the permanency goal as needed if doing so would be in the best interests of the child.

Section 5. Subsection (5) of section 39.6011, Florida Statutes, is amended to read:

39.6011 Case plan development.—

(5) The case plan must describe all of the following:

(a) The role of the foster parents or caregivers ~~legal custodians~~ when developing the services that are to be provided to the child, foster parents, or caregivers. ~~legal custodians;~~

(b) The responsibility of the parents and caregivers to work together to successfully implement the case plan, how the case manager will assist the parents and caregivers in developing a productive relationship that includes meaningful communication and mutual support, and the ability of the parents or caregivers to notify the court or the case manager if ineffective communication takes place that negatively impacts the child.

(c) ~~(b)~~ The responsibility of the case manager to forward a


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relative's request to receive notification of all proceedings and hearings submitted under ~~pursuant to~~ s. 39.301(14)(b) to the attorney for the department.~~;~~

(d)~~(c)~~ The minimum number of face-to-face meetings to be held each month between the parents and the department's family services counselors to review the progress of the plan, to eliminate barriers to progress, and to resolve conflicts or disagreements between parents and caregivers, service providers, or any other professional assisting the parents in the completion of the case plan.~~; and~~

(e)~~(d)~~ The parent's responsibility for financial support of the child, including, but not limited to, health insurance and child support. The case plan must list the costs associated with any services or treatment that the parent and child are expected to receive which are the financial responsibility of the parent. The determination of child support and other financial support shall be made independently of any determination of indigency under s. 39.013.

Section 6. Paragraph (b) of subsection (1) and paragraphs (a) and (c) of subsection (2) of section 39.701, Florida Statutes, are amended to read:

39.701 Judicial review.—

(1) GENERAL PROVISIONS.—

(b)1. The court shall retain jurisdiction over a child returned to his or her parents for a minimum period of 6 months following the reunification, but, at that time, based on a report of the social service agency and the guardian ad litem, if one has been appointed, and any other relevant factors, the court shall make a determination as to whether supervision by


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the department and the court's jurisdiction shall continue or be terminated.

2. Notwithstanding subparagraph 1., the court must retain jurisdiction over a child if the child is placed in the home with a parent or caregiver with an in-home safety plan and such safety plan remains necessary for the child to reside safely in the home.

(2) REVIEW HEARINGS FOR CHILDREN YOUNGER THAN 18 YEARS OF AGE.—

(a) Social study report for judicial review.—Before every judicial review hearing or citizen review panel hearing, the social service agency shall make an investigation and social study concerning all pertinent details relating to the child and shall furnish to the court or citizen review panel a written report that includes, but is not limited to:

1. A description of the type of placement the child is in at the time of the hearing, including the safety of the child and the continuing necessity for and appropriateness of the placement.

2. Documentation of the diligent efforts made by all parties to the case plan to comply with each applicable provision of the plan.

3. The amount of fees assessed and collected during the period of time being reported.

4. The services provided to the foster family or caregiver ~~legal custodian~~ in an effort to address the needs of the child as indicated in the case plan.

5. A statement that either:

a. The parent, though able to do so, did not comply

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substantially with the case plan, and the agency recommendations;

b. The parent did substantially comply with the case plan; or

c. The parent has partially complied with the case plan, with a summary of additional progress needed and the agency recommendations.

6. A statement from the foster parent or caregiver ~~legal custodian~~ providing any material evidence concerning the well-being of the child, the impact of any services provided to the child, the working relationship between the parents and caregivers, and the return of the child to the ~~parent or~~ parents.

7. A statement concerning the frequency, duration, and results of the parent-child visitation, if any, and the agency and caregiver recommendations for an expansion or restriction of future visitation.

8. The number of times a child has been removed from his or her home and placed elsewhere, the number and types of placements that have occurred, and the reason for the changes in placement.

9. The number of times a child's educational placement has been changed, the number and types of educational placements which have occurred, and the reason for any change in placement.

10. If the child has reached 13 years of age but is not yet 18 years of age, a statement from the caregiver on the progress the child has made in acquiring independent living skills.

11. Copies of all medical, psychological, and educational records that support the terms of the case plan and that have

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been produced concerning the parents or any caregiver since the last judicial review hearing.

12. Copies of the child's current health, mental health, and education records as identified in s. 39.6012.

(c) *Review determinations.*—The court and any citizen review panel shall take into consideration the information contained in the social services study and investigation and all medical, psychological, and educational records that support the terms of the case plan; testimony by the social services agency, the parent, the foster parent or caregiver ~~legal custodian~~, the guardian ad litem or surrogate parent for educational decisionmaking if one has been appointed for the child, and any other person deemed appropriate; and any relevant and material evidence submitted to the court, including written and oral reports to the extent of their probative value. These reports and evidence may be received by the court in its effort to determine the action to be taken with regard to the child and may be relied upon to the extent of their probative value, even though not competent in an adjudicatory hearing. In its deliberations, the court and any citizen review panel shall seek to determine:

1. If the parent was advised of the right to receive assistance from any person or social service agency in the preparation of the case plan.

2. If the parent has been advised of the right to have counsel present at the judicial review or citizen review hearings. If not so advised, the court or citizen review panel shall advise the parent of such right.

3. If a guardian ad litem needs to be appointed for the

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child in a case in which a guardian ad litem has not previously been appointed or if there is a need to continue a guardian ad litem in a case in which a guardian ad litem has been appointed.

4. Who holds the rights to make educational decisions for the child. If appropriate, the court may refer the child to the district school superintendent for appointment of a surrogate parent or may itself appoint a surrogate parent under the Individuals with Disabilities Education Act and s. 39.0016.

5. The compliance or lack of compliance of all parties with applicable items of the case plan, including the parents' compliance with child support orders.

6. The compliance or lack of compliance with a visitation contract between the parent and the social service agency for contact with the child, including the frequency, duration, and results of the parent-child visitation and the reason for any noncompliance.

7. The frequency, kind, and duration of contacts among siblings who have been separated during placement, as well as any efforts undertaken to reunite separated siblings if doing so is in the best <u>interests</u> ~~interest~~ of the child.

8. The compliance or lack of compliance of the parent in meeting specified financial obligations pertaining to the care of the child, including the reason for failure to comply, if applicable.

9. Whether the child is receiving safe and proper care according to s. 39.6012, including, but not limited to, the appropriateness of the child's current placement, including whether the child is in a setting that is as family-like and as close to the parent's home as possible, consistent with the

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child's best interests and special needs, and including maintaining stability in the child's educational placement, as documented by assurances from the community-based care lead agency ~~provider~~ that:

a. The placement of the child takes into account the appropriateness of the current educational setting and the proximity to the school in which the child is enrolled at the time of placement.

b. The community-based care lead agency has coordinated with appropriate local educational agencies to ensure that the child remains in the school in which the child is enrolled at the time of placement.

10. A projected date likely for the child's return home or other permanent placement.

11. When appropriate, the basis for the unwillingness or inability of the parent to become a party to a case plan. The court and the citizen review panel shall determine if the efforts of the social service agency to secure party participation in a case plan were sufficient.

12. For a child who has reached 13 years of age but is not yet 18 years of age, the adequacy of the child's preparation for adulthood and independent living. For a child who is 15 years of age or older, the court shall determine if appropriate steps are being taken for the child to obtain a driver license or learner's driver license.

13. If amendments to the case plan are required. Amendments to the case plan must be made under s. 39.6013.

14. If the parents and caregivers have developed a productive relationship that includes meaningful communication

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and mutual support.

Section 7. Section 63.090, F.S., is created to read:

63.090 Adoption of a child from the child welfare system.—The adoption of a child from Florida's foster care system is a process that typically includes an orientation session, an in-depth training program to help prospective parents determine if adoption is right for the family, a home study and a background check. Once the process has been completed, prospective parents are ready to be matched with a child available for adoption.

(1) The prospective adoptive parents' initial inquiry to the department or to the community-based care lead agency or subcontractor staff, whether written or verbal, shall receive a written response or a telephone call within 7 business days. Prospective adoptive parents who indicate an interest in adopting children in the custody of the department must be referred to a department approved adoptive parent training program as prescribed in rule.

(2) An application to adopt must be made on the "Adoptive Home Application."

(3) An adoptive home study which includes observation, screening and evaluation of the child and adoptive applicants shall be completed by a staff person with the community-based care lead agency, subcontractor agency, or other licensed child-placing agency prior to the adoptive placement of the child. The aim of this evaluation is to select families who will be able to meet the physical, emotional, social, educational and financial needs of a child, while safeguarding the child from further loss and separation from siblings and significant adults. The adoptive home study is valid for 12 months from the approval

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date.

(4) In addition to other required documentation, an adoptive parent application file shall include the adoptive home study and verification that all background screening requirements have been met.

(5) The department approved adoptive parent training must be provided to and successfully completed by all prospective adoptive parents except licensed foster parents and relative and non-relative caregivers who previously attended the training within the last 5 years, as prescribed in rule or have the child currently placed in their home for 6 months or longer and been determined to understand the challenges and parenting skills needed to successfully parent the children available for adoption from foster care.

(6) At the conclusion of the preparation and study process, the counselor and supervisor will make a decision about the family's appropriateness to adopt. The decision to approve or not to approve will be reflected in the final recommendation included in the home study. If the recommendation is for approval, the adoptive parent application file will be submitted to the community-based lead agency or subcontractor agency for approval which must be made within 14 business days.

Section 8. Subsection (3) of section 63.092, Florida Statutes, is amended to read:

63.092 Report to the court of intended placement by an adoption entity; at-risk placement; preliminary study.—

(3) PRELIMINARY HOME STUDY.—Before placing the minor in the intended adoptive home, a preliminary home study must be performed by a licensed child-placing agency, a child-caring


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agency registered under s. 409.176, a licensed professional, or an agency described in s. 61.20(2), unless the adoptee is an adult or the petitioner is a stepparent or a relative. If the adoptee is an adult or the petitioner is a stepparent or a relative, a preliminary home study may be required by the court for good cause shown. The department is required to perform the preliminary home study only if there is no licensed child-placing agency, child-caring agency registered under s. 409.176, licensed professional, or agency described in s. 61.20(2), in the county where the prospective adoptive parents reside. The preliminary home study must be made to determine the suitability of the intended adoptive parents and may be completed prior to identification of a prospective adoptive minor. Preliminary home studies initiated for identified prospective adoptive minors that are in the custody of the department must be completed within 30 days of initiation. A favorable preliminary home study is valid for 1 year after the date of its completion. Upon its completion, a signed copy of the home study must be provided to the intended adoptive parents who were the subject of the home study. A minor may not be placed in an intended adoptive home before a favorable preliminary home study is completed unless the adoptive home is also a licensed foster home under s. 409.175. The preliminary home study must include, at a minimum:

(a) An interview with the intended adoptive parents;

(b) Records checks of the department's central abuse registry, which the department shall provide to the entity conducting the preliminary home study, and criminal records correspondence checks under s. 39.0138 through the Department of Law Enforcement on the intended adoptive parents;

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(c) An assessment of the physical environment of the home;

(d) A determination of the financial security of the intended adoptive parents;

(e) Documentation of counseling and education of the intended adoptive parents on adoptive parenting, as determined by the entity conducting the preliminary home study. The training specified in s. 409.175(14) shall only be required for persons who adopt children from the department;

(f) Documentation that information on adoption and the adoption process has been provided to the intended adoptive parents;

(g) Documentation that information on support services available in the community has been provided to the intended adoptive parents; and

(h) A copy of each signed acknowledgment of receipt of disclosure required by s. 63.085.

If the preliminary home study is favorable, a minor may be placed in the home pending entry of the judgment of adoption. A minor may not be placed in the home if the preliminary home study is unfavorable. If the preliminary home study is unfavorable, the adoption entity may, within 20 days after receipt of a copy of the written recommendation, petition the court to determine the suitability of the intended adoptive home. A determination as to suitability under this subsection does not act as a presumption of suitability at the final hearing. In determining the suitability of the intended adoptive home, the court must consider the totality of the circumstances in the home. A minor may not be placed in a home in which there

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resides any person determined by the court to be a sexual predator as defined in s. 775.21 or to have been convicted of an offense listed in s. 63.089(4)(b)2.

Section 9. Section 409.1415, Florida Statutes, is created to read:

409.1415 Parenting partnerships for children in out-of-home care.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that reunification is the most common outcome for children in out-of-home care and that foster parents are one of the most important resources to help children reunify with their families.

(b) The Legislature further finds that the most successful foster parents understand that their role goes beyond supporting the children in their care to supporting the children's families, as a whole, and that children and their families benefit when foster and birth parents are supported by an agency culture that encourages a meaningful partnership between them and provides quality support.

(c) Therefore, in keeping with national trends, it is the intent of the Legislature to bring birth parents and foster parents together in order to build strong relationships that lead to more successful reunifications and more stability for children being fostered in out-of-home care.

(2) PARENTING PARTNERSHIPS.—

(a) *General provisions.*—In order to ensure that children in out-of-home care achieve legal permanency as soon as possible, to reduce the likelihood that they will re-enter care or that other children in the family are abused or neglected or enter

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out-of-home care, and to ensure that families are fully prepared to resume custody of their children, the department and community-based care lead agencies shall develop and support relationships between foster families and the legal parents of children in out-of-home care to the extent that it is safe and in the child's best interest, by:

1. Facilitating telephone communication between the foster parent and the birth or legal parent as soon as possible after the child is placed in the home.

2. Facilitating and attending an in-person meeting between the foster parent and the birth or legal parent within 2 weeks after placement.

3. Developing and supporting a plan for birth or legal parents to participate in medical appointments, educational and extra-curricular activities, and other events involving the child.

4. Facilitating participation by the foster parent in visitation between the birth parent and child.

5. Involving the foster parent in planning meetings with the birth parent.

6. Developing and implementing effective transition plans for the child's return home or placement in any other living environment.

7. Supporting continued contact between the foster family and the child after the child returns home or moves to another permanent living arrangement.

8. Supporting continued connection with the birth parent after adoption.

(b) *Responsibilities.*—To ensure that a child in out-of-home

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care receives support for healthy development which gives him or her the best possible opportunity for success, foster parents, birth parents, the department, community-based care lead agency staff, and other agency staff, as applicable, shall work cooperatively in a respectful partnership by adhering to the following requirements:

1. All members of the partnership must interact and communicate professionally with one another, must share all relevant information promptly, and must respect the confidentiality of all information related to a child and his or her family.

2. Caregivers, the family, the department, community-based care lead agency staff, and other agency staff must participate in developing a case plan for the child and family, and all members of the team must work together to implement the plan. Caregivers must participate in all team meetings or court hearings related to the child's care and future plans. The department, community-based care lead agency staff, and other agency staff must support and facilitate caregiver participation through timely notification of such meetings and hearings and an inclusive process, and by providing alternative methods for participation for caregivers who cannot be physically present at a meeting or hearing.

3. Excellent parenting is a reasonable expectation of caregivers. Caregivers must provide, and the department, community-based care lead agency staff, and other agency staff must support, excellent parenting. "Excellent parenting" means a loving commitment to the child and the child's safety and well-being; appropriate supervision and positive methods of

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discipline; encouragement of the child's strengths; respect for the child's individuality and likes and dislikes; providing opportunities to develop the child's interests and skills; being aware of the impact of trauma on behavior; facilitating equal participation of the child in family life; involving the child within his or her community; and a commitment to enable the child to lead a normal life.

4. Children in out-of-home care may be placed only with a caregiver who has the ability to care for the child, is willing to accept responsibility for providing care, and is willing and able to learn about and be respectful of the child's culture, religion, and ethnicity; special physical or psychological needs; any circumstances unique to the child; and family relationships. The department, the community-based care lead agency, and other agencies must provide a caregiver with all available information necessary to assist the caregiver in determining whether he or she is able to appropriately care for a particular child.

5. A caregiver must have access to and take advantage of all training that he or she needs to improve his or her skills in parenting a child who has experienced trauma due to neglect, abuse, or separation from home; to meet the child's special needs; and to work effectively with child welfare agencies, the courts, the schools, and other community and governmental agencies.

6. The department, community-based care lead agency staff, and other agency staff must provide caregivers with the services and support they need to enable them to provide quality care for the child.

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7. Once a family accepts the responsibility of caring for a child, the child may be removed from that family only if the family is clearly unable to care for him or her safely or legally, when the child and his or her biological family are reunified, when the child is being placed in a legally permanent home in accordance with a case plan or court order, or when the removal is demonstrably in the best interests of the child.

8. If a child must leave the caregiver's home for one of the reasons stated in subparagraph 7., and in the absence of an unforeseeable emergency, the transition must be accomplished according to a plan that involves cooperation and sharing of information among all persons involved, respects the child's developmental stage and psychological needs, ensures the child has all of his or her belongings, allows for a gradual transition from the caregiver's home, and, if possible, allows for continued contact with the caregiver after the child leaves.

9. When the plan for a child includes reunification, caregivers and agency staff must work together to assist the biological parents in improving their ability to care for and protect their children and to provide continuity for the child.

10. A caregiver must respect and support the child's ties to his or her biological family including parents, siblings, and extended family members and must assist the child in visitation and other forms of communication. The department, community-based care lead agency staff, and other agency staff must provide caregivers with the information, guidance, training, and support necessary for fulfilling this responsibility.

11. A caregiver must work in partnership with the department, community-based care lead agency staff, and other

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agency staff to obtain and maintain records that are important to the child's well-being including, but not limited to, child resource records, medical records, school records, photographs, and records of special events and achievements.

12. A caregiver must effectively advocate for a child in his or her care with the child welfare system, the court, and community agencies, including schools, child care providers, health and mental health providers, and employers. The department, community-based care lead agency staff, and other agency staff must support a caregiver in effectively advocating for a child and may not retaliate against the caregiver as a result of this advocacy.

13. A caregiver must be as fully involved in the child's medical, psychological, and dental care as he or she would be for his or her biological child. Agency staff must support and facilitate such participation. Caregivers, the department, community-based care lead agency staff, and other agency staff must share information with each other about the child's health and well-being.

14. A caregiver must support a child's school success, including, when possible, maintaining school stability by participating in school activities and meetings, including individual education plan meetings; assisting with school assignments; supporting tutoring programs; meeting with teachers and working with an educational surrogate, if one has been appointed; and encouraging the child's participation in extracurricular activities. Agency staff must facilitate this participation and must be kept informed of the child's progress and needs.

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15. Caseworkers and caseworker supervisors must mediate disagreements that occur between foster parents and birth parents.

(c) *Residential group homes.*—All caregivers employed by residential group homes must meet the same education, training, and background and other screening requirements as foster parents and must adhere to the requirements in paragraph (b).

(3) RULEMAKING.—The department shall adopt by rule procedures to administer this section.

Section 10. Section 409.145, Florida Statutes, is amended to read:

409.145 Care of children; ~~quality parenting;~~ "reasonable and prudent parent" standard.—The child welfare system of the department shall operate as a coordinated community-based system of care which empowers all caregivers for children in foster care to provide quality parenting, including approving or disapproving a child's participation in activities based on the caregiver's assessment using the "reasonable and prudent parent" standard.

(1) SYSTEM OF CARE.—The department shall develop, implement, and administer a coordinated community-based system of care for children who are found to be dependent and their families. This system of care must be directed toward the following goals:

(a) Prevention of separation of children from their families.

(b) Intervention to allow children to remain safely in their own homes.

(c) Reunification of families who have had children removed

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from their care.

(d) Safety for children who are separated from their families by providing alternative emergency or longer-term parenting arrangements.

(e) Focus on the well-being of children through emphasis on maintaining educational stability and providing timely health care.

(f) Permanency for children for whom reunification with their families is not possible or is not in the best interest of the child.

(g) The transition to independence and self-sufficiency for older children who remain in foster care through adolescence.

~~(2) QUALITY PARENTING.—A child in foster care shall be placed only with a caregiver who has the ability to care for the child, is willing to accept responsibility for providing care, and is willing and able to learn about and be respectful of the child's culture, religion and ethnicity, special physical or psychological needs, any circumstances unique to the child, and family relationships. The department, the community-based care lead agency, and other agencies shall provide such caregiver with all available information necessary to assist the caregiver in determining whether he or she is able to appropriately care for a particular child.~~

~~(a) *Roles and responsibilities of caregivers.*—A caregiver shall:~~

~~1. Participate in developing the case plan for the child and his or her family and work with others involved in his or her care to implement this plan. This participation includes the caregiver's involvement in all team meetings or court hearings~~


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~~related to the child's care.~~

~~2. Complete all training needed to improve skills in parenting a child who has experienced trauma due to neglect, abuse, or separation from home, to meet the child's special needs, and to work effectively with child welfare agencies, the court, the schools, and other community and governmental agencies.~~

~~3. Respect and support the child's ties to members of his or her biological family and assist the child in maintaining allowable visitation and other forms of communication.~~

~~4. Effectively advocate for the child in the caregiver's care with the child welfare system, the court, and community agencies, including the school, child care, health and mental health providers, and employers.~~

~~5. Participate fully in the child's medical, psychological, and dental care as the caregiver would for his or her biological child.~~

~~6. Support the child's educational success by participating in activities and meetings associated with the child's school or other educational setting, including Individual Education Plan meetings and meetings with an educational surrogate if one has been appointed, assisting with assignments, supporting tutoring programs, and encouraging the child's participation in extracurricular activities.~~

~~a. Maintaining educational stability for a child while in out-of-home care by allowing the child to remain in the school or educational setting that he or she attended before entry into out-of-home care is the first priority, unless not in the best interest of the child.~~


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~~b. If it is not in the best interest of the child to remain in his or her school or educational setting upon entry into out-of-home care, the caregiver must work with the case manager, guardian ad litem, teachers and guidance counselors, and educational surrogate if one has been appointed to determine the best educational setting for the child. Such setting may include a public school that is not the school of origin, a private school pursuant to s. 1002.42, a virtual instruction program pursuant to s. 1002.45, or a home education program pursuant to s. 1002.41.~~

~~7. Work in partnership with other stakeholders to obtain and maintain records that are important to the child's well-being, including child resource records, medical records, school records, photographs, and records of special events and achievements.~~

~~8. Ensure that the child in the caregiver's care who is between 13 and 17 years of age learns and masters independent living skills.~~

~~9. Ensure that the child in the caregiver's care is aware of the requirements and benefits of the Road-to-Independence Program.~~

~~10. Work to enable the child in the caregiver's care to establish and maintain naturally occurring mentoring relationships.~~

~~(b) *Roles and responsibilities of the department, the community-based care lead agency, and other agency staff.*~~ ~~The department, the community-based care lead agency, and other agency staff shall:~~

~~1. Include a caregiver in the development and~~


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~~implementation of the case plan for the child and his or her family. The caregiver shall be authorized to participate in all team meetings or court hearings related to the child's care and future plans. The caregiver's participation shall be facilitated through timely notification, an inclusive process, and alternative methods for participation for a caregiver who cannot be physically present.~~

~~2. Develop and make available to the caregiver the information, services, training, and support that the caregiver needs to improve his or her skills in parenting children who have experienced trauma due to neglect, abuse, or separation from home, to meet these children's special needs, and to advocate effectively with child welfare agencies, the courts, schools, and other community and governmental agencies.~~

~~3. Provide the caregiver with all information related to services and other benefits that are available to the child.~~

~~4. Show no prejudice against a caregiver who desires to educate at home a child placed in his or her home through the child welfare system.~~

~~(c) *Transitions.*—~~

~~1. Once a caregiver accepts the responsibility of caring for a child, the child will be removed from the home of that caregiver only if:~~

~~a. The caregiver is clearly unable to safely or legally care for the child;~~

~~b. The child and his or her biological family are reunified;~~

~~c. The child is being placed in a legally permanent home pursuant to the case plan or a court order; or~~

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~~d. The removal is demonstrably in the child's best interest.~~

~~2. In the absence of an emergency, if a child leaves the caregiver's home for a reason provided under subparagraph 1., the transition must be accomplished according to a plan that involves cooperation and sharing of information among all persons involved, respects the child's developmental stage and psychological needs, ensures the child has all of his or her belongings, allows for a gradual transition from the caregiver's home and, if possible, for continued contact with the caregiver after the child leaves.~~

~~(d) *Information sharing.*—Whenever a foster home or residential group home assumes responsibility for the care of a child, the department and any additional providers shall make available to the caregiver as soon as is practicable all relevant information concerning the child. Records and information that are required to be shared with caregivers include, but are not limited to:~~

~~1. Medical, dental, psychological, psychiatric, and behavioral history, as well as ongoing evaluation or treatment needs;~~

~~2. School records;~~

~~3. Copies of his or her birth certificate and, if appropriate, immigration status documents;~~

~~4. Consents signed by parents;~~

~~5. Comprehensive behavioral assessments and other social assessments;~~

~~6. Court orders;~~

~~7. Visitation and case plans;~~

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~~8. Guardian ad litem reports;~~

~~9. Staffing forms; and~~

~~10. Judicial or citizen review panel reports and attachments filed with the court, except confidential medical, psychiatric, and psychological information regarding any party or participant other than the child.~~

~~(c) *Caregivers employed by residential group homes.*—All caregivers in residential group homes shall meet the same education, training, and background and other screening requirements as foster parents.~~

(2)~~(3)~~ REASONABLE AND PRUDENT PARENT STANDARD.—

(a) *Definitions.*—As used in this subsection, the term:

1. "Age-appropriate" means an activity or item that is generally accepted as suitable for a child of the same chronological age or level of maturity. Age appropriateness is based on the development of cognitive, emotional, physical, and behavioral capacity which is typical for an age or age group.

2. "Caregiver" means a person with whom the child is placed in out-of-home care, or a designated official for a group care facility licensed by the department under s. 409.175.

3. "Reasonable and prudent parent" standard means the standard of care used by a caregiver in determining whether to allow a child in his or her care to participate in extracurricular, enrichment, and social activities. This standard is characterized by careful and thoughtful parental decisionmaking that is intended to maintain a child's health, safety, and best interest while encouraging the child's emotional and developmental growth.

(b) *Application of standard of care.*—

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1. Every child who comes into out-of-home care pursuant to this chapter is entitled to participate in age-appropriate extracurricular, enrichment, and social activities.

2. Each caregiver shall use the reasonable and prudent parent standard in determining whether to give permission for a child living in out-of-home care to participate in extracurricular, enrichment, or social activities. When using the reasonable and prudent parent standard, the caregiver must consider:

a. The child's age, maturity, and developmental level to maintain the overall health and safety of the child.

b. The potential risk factors and the appropriateness of the extracurricular, enrichment, or social activity.

c. The best interest of the child, based on information known by the caregiver.

d. The importance of encouraging the child's emotional and developmental growth.

e. The importance of providing the child with the most family-like living experience possible.

f. The behavioral history of the child and the child's ability to safely participate in the proposed activity.

(c) *Verification of services delivered.*—The department and each community-based care lead agency shall verify that private agencies providing out-of-home care services to dependent children have policies in place which are consistent with this section and that these agencies promote and protect the ability of dependent children to participate in age-appropriate extracurricular, enrichment, and social activities.

(d) *Limitation of liability.*—A caregiver is not liable for

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harm caused to a child who participates in an activity approved by the caregiver, provided that the caregiver has acted in accordance with the reasonable and prudent parent standard. This paragraph may not be interpreted as removing or limiting any existing liability protection afforded by law.

(3) ~~(4)~~ FOSTER CARE ROOM AND BOARD RATES.—

(a) Effective July 1, 2018, room and board rates shall be paid to foster parents as follows:

Monthly Foster Care Rate

| 0-5 Years Age | 6-12 Years Age | 13-21 Years Age |
|---|---|---|
| $457.95 | $469.68 | $549.74 |

Section 1 Section 25.385, Florida Statutes, is amended to read:

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Section 1 Section 25.385, Florida Statutes, is amended to read:

Section 1 Section 25.385, Florida Statutes, is amended to read:

(b) Each January, foster parents shall receive an annual cost of living increase. The department shall calculate the new room and board rate increase equal to the percentage change in the Consumer Price Index for All Urban Consumers, U.S. City Average, All Items, not seasonally adjusted, or successor

reports, for the preceding December compared to the prior December as initially reported by the United States Department of Labor, Bureau of Labor Statistics. The department shall make available the adjusted room and board rates annually.

(c) Effective July 1, 2019, foster parents of level I family foster homes, as defined in s. 409.175(5)(a) shall receive a room and board rate of $333.

(d) Effective July 1, 2019, the foster care room and board rate for level II family foster homes as defined in s. 409.175(5)(a) shall be the same as the new rate established for family foster homes as of January 1, 2019.

(e) Effective January 1, 2020, paragraph (b) shall only apply to level II through level V family foster homes, as defined in s. 409.175(5)(a).

(f) The amount of the monthly foster care room and board rate may be increased upon agreement among the department, the community-based care lead agency, and the foster parent.

(g) From July 1, 2018, through June 30, 2019, community-based care lead agencies providing care under contract with the department shall pay a supplemental room and board payment to foster care parents of all family foster homes, on a per-child basis, for providing independent life skills and normalcy supports to children who are 13 through 17 years of age placed in their care. The supplemental payment shall be paid monthly to the foster care parents in addition to the current monthly room and board rate payment. The supplemental monthly payment shall be based on 10 percent of the monthly room and board rate for children 13 through 21 years of age as provided under this section and adjusted annually. Effective July 1, 2019, such

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supplemental payments shall only be paid to foster parents of level II through level V family foster homes.

(4)~~(5)~~ RULEMAKING.—The department shall adopt by rule procedures to administer this section.

Section 11. Paragraph (b)of subsection(6)of section 409.175, Florida Statutes, is amended and new paragraph(d)is added, to read:

409.175 Licensure of family foster homes, residential child-caring agencies, and child-placing agencies; public records exemption.—

(6)

(b) Upon application for licensure, the department shall conduct a licensing study based on its licensing rules; shall inspect the home or the agency and the records, including financial records, of the applicant or agency; and shall interview the applicant. The department may authorize a licensed child-placing agency to conduct the licensing study of a family foster home to be used exclusively by that agency and to verify to the department that the home meets the licensing requirements established by the department. A licensing study of a family foster home must be completed by the department or an authorized licensed child-placing agency within 30 days of initiation. The department shall post on its website a list of the agencies authorized to conduct such studies.

1. The complete application file shall be submitted in accordance with the traditional or attestation model for licensure as prescribed in rule. In addition to other required documentation a traditional licensing application file must include a completed licensing study and verification of

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background screening requirements.

2.The department regional licensing authority is responsible for ensuring that the licensing application file is complete and that all licensing requirements are met for the issuance of the license. If the child-placing agency is contracted with a community-based care lead agency, the licensing application file shall contain documentation of a review by the community-based care lead agency and the regional licensing authority and a recommendation for approval or denial by the community-based care lead agency. ~~Upon certification by a licensed child-placing agency that a family foster home meets the licensing requirements and upon receipt of a letter from a community-based care lead agency in the service area where the home will be licensed which indicates that the family foster home meets the criteria established by the lead agency, the department shall issue the license. A letter from the lead agency is not required if the lead agency where the proposed home is located is directly supervising foster homes in the same service area.~~

3. An application file must be approved or denied within 10 business days after receipt by the regional licensing authority. If the application file is approved, a license shall be issued to the applicant(s). The license shall include the name and address of the caregiver(s), the name of the supervising agency, the licensed capacity, and the dates for which the license is valid. The department regional managing director or designee within upper level management shall sign the license. Any limitations shall be displayed on the license.

4. A copy of the license shall be provided by the regional


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licensing authority to the community-based care lead agency or supervising agency. The community-based care lead agency or supervising agency is responsible for ensuring the license is sent to the foster parent.

(d) The department must issue a determination regarding an application for a family foster home license within 100 days of completion of orientation as provided in s. 409.175(14)(b)1, Florida Statutes. Licenses that require additional certifications pursuant to 409.175(5)(a), may be given additional time to issue a determination.

Section 12. Paragraph (j) of subsection (1) of section 409.988, Florida Statutes, is amended to read:

409.988 Lead agency duties; general provisions.—

(1) DUTIES.—A lead agency:

(j) May subcontract for the provision of services required by the contract with the lead agency and the department; however, the subcontracts must specify how the provider will contribute to the lead agency meeting the performance standards established pursuant to the child welfare results-oriented accountability system required by s. 409.997. The lead agency shall directly provide no more than 35 percent of all child welfare services provided unless it can demonstrate a need, within the lead agency's geographic service area, to exceed this threshold. The local community alliance in the geographic service area in which the lead agency is seeking to exceed the threshold shall review the lead agency's justification for need and recommend to the department whether the department should approve or deny the lead agency's request for an exemption from the services threshold. If there is not a community alliance

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operating in the geographic service area in which the lead agency is seeking to exceed the threshold, such review and recommendation shall be made by representatives of local stakeholders, including at least one representative from each of the following:

1. The department.

2. The county government.

3. The school district.

4. The county United Way.

5. The county sheriff's office.

6. The circuit court corresponding to the county.

7. The county children's board, if one exists.

Section 13. Paragraph (b) of subsection (7) of section 39.302, Florida Statutes, is amended to read:

39.302 Protective investigations of institutional child abuse, abandonment, or neglect.—

(7) When an investigation of institutional abuse, neglect, or abandonment is closed and a person is not identified as a caregiver responsible for the abuse, neglect, or abandonment alleged in the report, the fact that the person is named in some capacity in the report may not be used in any way to adversely affect the interests of that person. This prohibition applies to any use of the information in employment screening, licensing, child placement, adoption, or any other decisions by a private adoption agency or a state agency or its contracted providers.

(b) Likewise, if a person is employed as a caregiver in a residential group home licensed pursuant to s. 409.175 and is named in any capacity in three or more reports within a 5-year period, the department may review all reports for the purposes


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of the employment screening required pursuant to s. 409.1415(2)(c) ~~s. 409.145(2)(c)~~.

Section 14. Paragraph (d) of subsection (5) of section 39.6225, Florida Statutes, is amended to read:

39.6225 Guardianship Assistance Program.—

(5) A guardian with an application approved pursuant to subsection (2) who is caring for a child placed with the guardian by the court pursuant to this part may receive guardianship assistance payments based on the following criteria:

(d) The department shall provide guardianship assistance payments in the amount of $4,000 annually, paid on a monthly basis, or in an amount other than $4,000 annually as determined by the guardian and the department and memorialized in a written agreement between the guardian and the department. The agreement shall take into consideration the circumstances of the guardian and the needs of the child. Changes may not be made without the concurrence of the guardian. However, in no case shall the amount of the monthly payment exceed the foster care maintenance payment that would have been paid during the same period if the child had been in licensed care at his or her designated level of care at the rate established in s. 409.145(3) ~~s. 409.145(4)~~.

Section 15. Paragraph (b) of subsection (5) of section 393.065, Florida Statutes, is amended to read:

393.065 Application and eligibility determination.—

(5) The agency shall assign and provide priority to clients waiting for waiver services in the following order:

(b) Category 2, which includes individuals on the waiting list who are:

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1. From the child welfare system with an open case in the Department of Children and Families' statewide automated child welfare information system and who are either:

a. Transitioning out of the child welfare system at the finalization of an adoption, a reunification with family members, a permanent placement with a relative, or a guardianship with a nonrelative; or

b. At least 18 years but not yet 22 years of age and who need both waiver services and extended foster care services; or

2. At least 18 years but not yet 22 years of age and who withdrew consent pursuant to s. 39.6251(5)(c) to remain in the extended foster care system.

For individuals who are at least 18 years but not yet 22 years of age and who are eligible under sub-subparagraph 1.b., the agency shall provide waiver services, including residential habilitation, and the community-based care lead agency shall fund room and board at the rate established in s. 409.145(3) ~~s. 409.145(4)~~ and provide case management and related services as defined in s. 409.986(3)(e). Individuals may receive both waiver services and services under s. 39.6251. Services may not duplicate services available through the Medicaid state plan.

Section 16. Paragraph (b) of subsection (2) of section 409.1451, Florida Statutes, is amended to read:

409.1451 The Road-to-Independence Program.—

(2) POSTSECONDARY EDUCATION SERVICES AND SUPPORT.—

(b) The amount of the financial assistance shall be as follows:

1. For a young adult who does not remain in foster care and

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is attending a postsecondary school as provided in s. 1009.533, the amount is $1,256 monthly.

2. For a young adult who remains in foster care, is attending a postsecondary school, as provided in s. 1009.533, and continues to reside in a licensed foster home, the amount is the established room and board rate for foster parents. This takes the place of the payment provided for in s. 409.145(3) ~~s. 409.145(4)~~.

3. For a young adult who remains in foster care, but temporarily resides away from a licensed foster home for purposes of attending a postsecondary school as provided in s. 1009.533, the amount is $1,256 monthly. This takes the place of the payment provided for in s. 409.145(3) ~~s. 409.145(4)~~.

4. For a young adult who remains in foster care, is attending a postsecondary school as provided in s. 1009.533, and continues to reside in a licensed group home, the amount is negotiated between the community-based care lead agency and the licensed group home provider.

5. For a young adult who remains in foster care, but temporarily resides away from a licensed group home for purposes of attending a postsecondary school as provided in s. 1009.533, the amount is $1,256 monthly. This takes the place of a negotiated room and board rate.

6. A young adult is eligible to receive financial assistance during the months when he or she is enrolled in a postsecondary educational institution.

Section 17. This act shall take effect July 1, 2020.

================ T I T L E A M E N D M E N T ================

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And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to child welfare; amending s. 25.385, F.S.; requiring the Florida Court Educational Council to establish certain standards for instruction of circuit and county court judges for dependency cases; requiring the council to provide such instruction on a periodic and timely basis; creating s. 39.01304, F.S.; providing legislative intent; providing a purpose; authorizing circuit courts to create early childhood court programs; requiring that early childhood court programs have certain components; defining the term "therapeutic jurisprudence"; providing requirements and guidelines for the Office of the State Courts Administrator when hiring community coordinators and a statewide training specialist; requiring the Department of Children and Families to contract with certain university-based centers; requiring the university-based centers to hire a clinical director; amending s. 39.0138, F.S,; providing a limitation on the amount of time to complete background screenings; amending s. 39.301, F.S.; requiring the Department of Children and Families to notify the court of certain reports; authorizing the department to file specified petitions under certain circumstances; amending s. 39.522, F.S.; requiring the court to consider specified factors when making a certain determination;

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authorizing the court or any party to the case to file a petition to place a child in out-of-home care under certain circumstances; requiring the court to consider specified factors when determining whether the child should be placed in out-of-home care; amending s. 39.6011, F.S.; revising and providing requirements for case plan descriptions; amending s. 39.701, F.S.; requiring the court to retain jurisdiction over a child under certain circumstances; requiring specified parties to disclose certain information to the court; providing for certain caregiver recommendations to the court; requiring the court and citizen review panel to determine whether certain parties have developed a productive relationship; creating s. 63.090, F.S.; providing requirements for the adoption of children from the child welfare system; amending s. 63.092, F.S.; providing a deadline for completion of a preliminary home study; creating s. 409.1415, F.S.; providing legislative findings and intent; requiring the department and community-based care lead agencies to develop and support relationships between certain foster families and legal parents of children; providing responsibilities for foster parents, birth parents, the department, community-based care lead agency staff, and other agency staff; defining the term "excellent parenting"; requiring caregivers employed by residential group homes to meet specified requirements; requiring the department to adopt rules; amending s. 409.175, F.S.; providing specified


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requirements related to the licensure of foster parents; amending s. 409.145, F.S.; conforming provisions to changes made by the act; amending s. 409.988, F.S.; authorizing a lead agency to provide more than 35 percent of all child welfare services under certain conditions; requiring a specified local community alliance, or specified representatives in certain circumstances, to review and recommend approval or denial of the lead agency's request for a specified exemption; requiring the court to evaluate and change a child's permanency goal under certain circumstances; amending ss. 39.301, 39.6225, 393.065, 409.1451, F.S.; conforming cross-references; providing an effective date.

**By** Senator Simpson

10-01890A-20 20201324__

A bill to be entitled

An act relating to child welfare; amending s. 25.385, F.S.; deleting the definition of the term "family or household member"; requiring the Florida Court Educational Council to establish certain standards for instruction of circuit and county court judges for dependency cases; requiring the council to provide such instruction on a periodic and timely basis; creating s. 39.01304, F.S.; providing legislative intent; providing a purpose; authorizing circuit courts to create early childhood court programs; requiring that early childhood court programs have certain components; defining the term "therapeutic jurisprudence"; providing requirements and guidelines for the Office of the State Courts Administrator when hiring community coordinators and a statewide training specialist; requiring the Department of Children and Families to contract with certain university-based centers; requiring the university-based centers to hire a clinical director; amending s. 39.0138, F.S.; requiring that certain background screenings be completed within a specified timeframe; amending s. 39.301, F.S.; requiring the department to notify the court of certain reports; authorizing the department to file specified petitions under certain circumstances; amending s. 39.302, F.S.; conforming a provision to changes made by the act; amending s. 39.522, F.S.; requiring the court to consider specified factors when making a certain determination;

authorizing the court to place a child in out-of-home care under certain circumstances; requiring the court to consider specified factors when determining whether the child should be placed in out-of-home care; requiring the court to evaluate and change a child's permanency goal under certain conditions; amending s. 39.6011, F.S.; revising requirements for case plan development; amending s. 39.701, F.S.; requiring the court to retain jurisdiction over a child under certain circumstances; requiring community-based care lead agencies, rather than social service agencies, to make assessments before certain hearings; revising requirements for such assessments; conforming provisions to changes made by the act; revising determinations that courts and citizen review panels are required to make in certain deliberations; creating s. 409.1415, F.S.; providing legislative findings and intent; requiring the department and community-based care lead agencies to develop and support relationships between certain foster families and legal parents of children; providing responsibilities for foster parents, birth parents, the department, community-based care lead agency staff, and other agency staff; defining the term "excellent parenting"; requiring caregivers employed by residential group homes to meet specified requirements; requiring the department to adopt rules; amending s. 409.145, F.S.; conforming provisions to changes made by the act; amending s. 409.988, F.S.;

authorizing a lead agency to provide more than 35 percent of all child welfare services under certain conditions; requiring a specified local community alliance, or specified representatives in certain circumstances, to review and recommend approval or denial of the lead agency's request for a specified exemption; requiring lead agencies to conduct home studies of prospective parents; requiring such home studies to be completed within a specified timeframe; amending s. 409.996, F.S.; requiring the department to conduct background screenings of prospective adoptive parents; requiring such background screenings to be completed within a specified timeframe; amending ss. 39.6225, 393.065, 409.1451, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Section 25.385, Florida Statutes, is amended to read:

25.385 Standards for instruction of circuit and county court judges in handling domestic violence cases.—

(1) The Florida Court Educational Council shall establish standards for instruction of circuit and county court judges who have responsibility for domestic violence cases, and the council shall provide such instruction on a periodic and timely basis.

~~(2)~~ As used in this subsection, ~~section:~~

~~(a)~~ the term "domestic violence" has the meaning set forth in s. 741.28.

~~(b) "Family or household member" has the meaning set forth in s. 741.28.~~

(2) The Florida Court Educational Council shall establish standards for instruction of circuit and county court judges who have responsibility for dependency cases regarding the benefits of a secure attachment with a primary caregiver, the importance of a stable placement, and the impact of trauma on child development. The council shall provide such instruction to the circuit and county court judges handling dependency cases on a periodic and timely basis.

Section 2. Section 39.01304, Florida Statutes, is created to read:

39.01304 Early childhood court programs.—

(1) It is the intent of the Legislature to encourage the department, the Department of Health, the Association of Early Learning Coalitions, and other such agencies; local governments; interested public or private entities; and individuals to support the creation and establishment of early childhood court programs. The purpose of an early childhood court program is to address the root cause of court involvement through specialized dockets, multidisciplinary teams, evidence-based treatment, and the use of a nonadversarial approach. Such programs depend on the leadership of a judge or magistrate who is educated about the science of early childhood development and who requires rigorous efforts to heal children physically and emotionally in the context of a broad collaboration among professionals from different systems working directly in the court as a team, recognizing that the parent-child relationship is the foundation of child well-being.

(2) A circuit court may create an early childhood court program to serve the needs of infants and toddlers in dependency court. An early childhood court program must have all of the following components:

(a) Therapeutic jurisprudence, which must drive every aspect of judicial practice. The judge or magistrate must support the therapeutic needs of the parent and child in a nonadversarial manner. As used in this paragraph, the term "therapeutic jurisprudence" means the study of how the law may be used as a therapeutic agent and focuses on how laws impact emotional and psychological well-being.

(b) A procedure for coordinating services and resources for families who have a case on the court docket. To meet this requirement, the court may create and fill at least one community coordinator position pursuant to paragraph (3)(a).

(c) A multidisciplinary team made up of key community stakeholders who commit to work with the judge or magistrate to restructure the way the community responds to the needs of maltreated children. The team may include, but is not limited to, early intervention specialists; mental health and infant mental health professionals; attorneys representing children, parents, and the child welfare system; children's advocates; early learning coalitions and child care providers; substance abuse program providers; primary health care providers; domestic violence advocates; and guardians ad litem. The multidisciplinary team must address the need for children in an early childhood court program to receive medical care in a medical home, a screening for developmental delays conducted by the local agency responsible for complying with part C of the

federal Individuals with Disabilities Education Act, and quality child care.

(d) A continuum of mental health services which includes a focus on the parent-child relationship and is appropriate for each child and family served.

(3) Contingent upon an annual appropriation by the Legislature, and subject to available resources:

(a) The Office of the State Courts Administrator shall coordinate with each participating circuit court to create and fill at least one community coordinator position for the circuit's early childhood court program. Each community coordinator shall provide direct support to the program by providing coordination between the multidisciplinary team and the judiciary, coordinating the responsibilities of the participating agencies and service providers, and managing the collection of data for program evaluation and accountability. The Office of State Courts Administrator may hire a statewide training specialist to provide training to the participating court teams.

(b) The department shall contract with one or more university-based centers that have expertise in infant mental health, and such university-based centers shall hire a clinical director charged with ensuring the quality, accountability, and fidelity of the program's evidence-based treatment, including, but not limited to, training and technical assistance related to clinical services, clinical consultation and guidance for difficult cases, and ongoing clinical training for court teams.

Section 3. Subsection (1) of section 39.0138, Florida Statutes, is amended to read:

39.0138 Criminal history and other records checks; limit on placement of a child.—

(1) The department shall conduct a records check through the State Automated Child Welfare Information System (SACWIS) and a local and statewide criminal history records check on all persons, including parents, being considered by the department for placement of a child under this chapter, including all nonrelative placement decisions, and all members of the household, 12 years of age and older, of the person being considered. For purposes of this section, a criminal history records check may include, but is not limited to, submission of fingerprints to the Department of Law Enforcement for processing and forwarding to the Federal Bureau of Investigation for state and national criminal history information, and local criminal records checks through local law enforcement agencies of all household members 18 years of age and older and other visitors to the home. Level 1 and level 2 background screenings of prospective foster parents must be completed within 14 days after a completed application and finger prints are received by the department. An out-of-state criminal history records check must be initiated for any person 18 years of age or older who resided in another state if that state allows the release of such records. The department shall establish by rule standards for evaluating any information contained in the automated system relating to a person who must be screened for purposes of making a placement decision.

Section 4. Subsection (1) and paragraph (a) of subsection (9) of section 39.301, Florida Statutes, are amended to read:

39.301 Initiation of protective investigations.—

(1)(a) Upon receiving a report of known or suspected child abuse, abandonment, or neglect, or that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care, the central abuse hotline shall determine if the report requires an immediate onsite protective investigation. For reports requiring an immediate onsite protective investigation, the central abuse hotline shall immediately notify the department's designated district staff responsible for protective investigations to ensure that an onsite investigation is promptly initiated. For reports not requiring an immediate onsite protective investigation, the central abuse hotline shall notify the department's designated district staff responsible for protective investigations in sufficient time to allow for an investigation. At the time of notification, the central abuse hotline shall also provide information to district staff on any previous report concerning a subject of the present report or any pertinent information relative to the present report or any noted earlier reports.

(b) Upon notification by the central abuse hotline, the department shall promptly notify the court of any report that involves a child over whom the court has jurisdiction.

(9)(a) For each report received from the central abuse hotline and accepted for investigation, the department or the sheriff providing child protective investigative services under s. 39.3065, shall perform the following child protective investigation activities to determine child safety:

1. Conduct a review of all relevant, available information specific to the child and family and alleged maltreatment;

family child welfare history; local, state, and federal criminal records checks; and requests for law enforcement assistance provided by the abuse hotline. Based on a review of available information, including the allegations in the current report, a determination shall be made as to whether immediate consultation should occur with law enforcement, the Child Protection Team, a domestic violence shelter or advocate, or a substance abuse or mental health professional. Such consultations should include discussion as to whether a joint response is necessary and feasible. A determination shall be made as to whether the person making the report should be contacted before the face-to-face interviews with the child and family members.

2. Conduct face-to-face interviews with the child; other siblings, if any; and the parents, legal custodians, or caregivers.

3. Assess the child's residence, including a determination of the composition of the family and household, including the name, address, date of birth, social security number, sex, and race of each child named in the report; any siblings or other children in the same household or in the care of the same adults; the parents, legal custodians, or caregivers; and any other adults in the same household.

4. Determine whether there is any indication that any child in the family or household has been abused, abandoned, or neglected; the nature and extent of present or prior injuries, abuse, or neglect, and any evidence thereof; and a determination as to the person or persons apparently responsible for the abuse, abandonment, or neglect, including the name, address, date of birth, social security number, sex, and race of each

such person.

5. Complete assessment of immediate child safety for each child based on available records, interviews, and observations with all persons named in subparagraph 2. and appropriate collateral contacts, which may include other professionals. The department's child protection investigators are hereby designated a criminal justice agency for the purpose of accessing criminal justice information to be used for enforcing this state's laws concerning the crimes of child abuse, abandonment, and neglect. This information shall be used solely for purposes supporting the detection, apprehension, prosecution, pretrial release, posttrial release, or rehabilitation of criminal offenders or persons accused of the crimes of child abuse, abandonment, or neglect and may not be further disseminated or used for any other purpose.

6. Document the present and impending dangers to each child based on the identification of inadequate protective capacity through utilization of a standardized safety assessment instrument. If present or impending danger is identified, the child protective investigator must implement a safety plan or take the child into custody. If present danger is identified and the child is not removed, the child protective investigator shall create and implement a safety plan before leaving the home or the location where there is present danger. If impending danger is identified, the child protective investigator shall create and implement a safety plan as soon as necessary to protect the safety of the child. The child protective investigator may modify the safety plan if he or she identifies additional impending danger.

a. If the child protective investigator implements a safety plan, the plan must be specific, sufficient, feasible, and sustainable in response to the realities of the present or impending danger. A safety plan may be an in-home plan or an out-of-home plan, or a combination of both. A safety plan may include tasks or responsibilities for a parent, caregiver, or legal custodian. However, a safety plan may not rely on promissory commitments by the parent, caregiver, or legal custodian who is currently not able to protect the child or on services that are not available or will not result in the safety of the child. A safety plan may not be implemented if for any reason the parents, guardian, or legal custodian lacks the capacity or ability to comply with the plan. If the department is not able to develop a plan that is specific, sufficient, feasible, and sustainable, the department shall file a shelter petition. A child protective investigator shall implement separate safety plans for the perpetrator of domestic violence, if the investigator, using reasonable efforts, can locate the perpetrator to implement a safety plan, and for the parent who is a victim of domestic violence as defined in s. 741.28. Reasonable efforts to locate a perpetrator include, but are not limited to, a diligent search pursuant to the same requirements as in s. 39.503. If the perpetrator of domestic violence is not the parent, guardian, or legal custodian of any child in the home and if the department does not intend to file a shelter petition or dependency petition that will assert allegations against the perpetrator as a parent of a child in the home, the child protective investigator shall seek issuance of an injunction authorized by s. 39.504 to implement a safety plan

for the perpetrator and impose any other conditions to protect the child. The safety plan for the parent who is a victim of domestic violence may not be shared with the perpetrator. If any party to a safety plan fails to comply with the safety plan resulting in the child being unsafe, the department shall file a shelter petition.

b. The child protective investigator shall collaborate with the community-based care lead agency in the development of the safety plan as necessary to ensure that the safety plan is specific, sufficient, feasible, and sustainable. The child protective investigator shall identify services necessary for the successful implementation of the safety plan. The child protective investigator and the community-based care lead agency shall mobilize service resources to assist all parties in complying with the safety plan. The community-based care lead agency shall prioritize safety plan services to families who have multiple risk factors, including, but not limited to, two or more of the following:

(I) The parent or legal custodian is of young age;

(II) The parent or legal custodian, or an adult currently living in or frequently visiting the home, has a history of substance abuse, mental illness, or domestic violence;

(III) The parent or legal custodian, or an adult currently living in or frequently visiting the home, has been previously found to have physically or sexually abused a child;

(IV) The parent or legal custodian or an adult currently living in or frequently visiting the home has been the subject of multiple allegations by reputable reports of abuse or neglect;

(V) The child is physically or developmentally disabled; or

(VI) The child is 3 years of age or younger.

c. The child protective investigator shall monitor the implementation of the plan to ensure the child's safety until the case is transferred to the lead agency at which time the lead agency shall monitor the implementation.

d. The department may file, within 90 days after the transfer of the safety plan to the lead agency, a shelter or dependency petition without the need for a new child protective investigation or the concurrence of the child protective investigator if the department determines that the safety plan is no longer sufficient to keep the child safe or that the parent or caregiver has not sufficiently increased his or her level of protective capacities to ensure the child's safety.

Section 5. Paragraph (b) of subsection (7) of section 39.302, Florida Statutes, is amended to read:

39.302 Protective investigations of institutional child abuse, abandonment, or neglect.—

(7) When an investigation of institutional abuse, neglect, or abandonment is closed and a person is not identified as a caregiver responsible for the abuse, neglect, or abandonment alleged in the report, the fact that the person is named in some capacity in the report may not be used in any way to adversely affect the interests of that person. This prohibition applies to any use of the information in employment screening, licensing, child placement, adoption, or any other decisions by a private adoption agency or a state agency or its contracted providers.

(b) Likewise, if a person is employed as a caregiver in a residential group home licensed pursuant to s. 409.175 and is

named in any capacity in three or more reports within a 5-year period, the department may review all reports for the purposes of the employment screening required pursuant to s. 409.1415(2)(c) ~~s. 409.145(2)(c)~~.

Section 6. Subsection (1) of section 39.522, Florida Statutes, is amended, and subsection (4) is added to that section, to read:

39.522 Postdisposition change of custody.—The court may change the temporary legal custody or the conditions of protective supervision at a postdisposition hearing, without the necessity of another adjudicatory hearing.

(1)(a) At any time before a child is residing in the permanent placement approved at the permanency hearing, a child who has been placed in the child's own home under the protective supervision of an authorized agent of the department, in the home of a relative, in the home of a legal custodian, or in some other place may be brought before the court by the department or by any other interested person, upon the filing of a motion alleging a need for a change in the conditions of protective supervision or the placement. If the parents or other legal custodians deny the need for a change, the court shall hear all parties in person or by counsel, or both. Upon the admission of a need for a change or after such hearing, the court shall enter an order changing the placement, modifying the conditions of protective supervision, or continuing the conditions of protective supervision as ordered. The standard for changing custody of the child shall be the best interests ~~interest~~ of the child. When determining whether a change of legal custody or placement is in ~~applying this standard, the court shall consider~~

~~the continuity of the child's placement in the same out-of-home residence as a factor when determining~~ the best interests of the child, the court shall consider all of the following:

1. The child's age.

2. The developmental and therapeutic benefits to the child of remaining in his or her current placement or moving to the proposed placement.

3. The stability and longevity of the child's current placement.

4. The established bonded relationship between the child and the current or proposed caregiver.

5. The reasonable preference of the child, if the court has found that the child is of sufficient intelligence, understanding, and experience to express a preference.

6. The recommendation of the child's current caregiver.

7. The recommendation of the child's guardian ad litem, if one has been appointed.

8. The quality of the child's relationship with a sibling, if the change of legal custody or placement will separate or reunite siblings.

9. The likelihood of the child attaining permanency in the current or proposed placement.

10. Any other relevant factors.

(b) If the child is not placed in foster care, ~~then~~ the new placement for the child must meet the home study criteria and court approval under ~~pursuant to~~ this chapter.

(4)(a) If a child was placed in the child's own home with an in-home safety plan or was reunited with a parent with an in-home safety plan, the court may remove the child and place the

child in out-of-home care if:

1. The child is abused, neglected, or abandoned by the parent or caregiver, or is suffering from or is in imminent danger of illness or injury as a result of abuse, neglect, or abandonment;

2. The parent or caregiver has materially violated a condition of placement imposed by the court, including, but not limited to, not complying with the in-home safety plan or case plan; or

3. The parent or caregiver is unlikely, within a reasonable amount of time, to achieve the full protective capacities needed to keep the child safe without an in-home safety plan.

(b) If a child meets the criteria in paragraph (a) for removal and placement in out-of-home care, the court must consider all of the following in making its determination to remove the child and place the child in out-of-home care:

1. The circumstances that caused the child's dependency and other identified issues.

2. The length of time the child has been placed in the home with an in-home safety plan.

3. The parent's or caregiver's current level of protective capacities.

4. The level of increase, if any, in the parent's or caregiver's protective capacities since the child's placement in the home, based on the length of time the child has been placed in the home.

(c) The court shall evaluate the child's permanency goal and change the permanency goal as needed if doing so is in the best interests of the child.

Section 7. Subsection (5) of section 39.6011, Florida Statutes, is amended to read:

39.6011 Case plan development.—

(5) The case plan must describe:

(a) The role of the foster parents or legal custodians when developing the services that are to be provided to the child, foster parents, or legal custodians;

(b) The specific responsibilities of the parents and caregivers to work together to successfully implement the case plan. The case plan must specify how the case manager will assist the parents and caregivers in developing a productive relationship, including meaningful communication and mutual support;

(c) The responsibility of the case manager to forward a relative's request to receive notification of all proceedings and hearings submitted pursuant to s. 39.301(14)(b) to the attorney for the department;

(d) ~~(c)~~ The minimum number of face-to-face meetings to be held each month between the parents and the case manager ~~department's family services counselors~~ to review the progress of the plan, to eliminate barriers to progress, and to resolve conflicts or disagreements between the parents and the caregivers, service providers, or any professionals assisting the parents in the completion of the plan; and

(e) ~~(d)~~ The parent's responsibility for financial support of the child, including, but not limited to, health insurance and child support. The case plan must list the costs associated with any services or treatment that the parent and child are expected to receive which are the financial responsibility of the parent.

The determination of child support and other financial support shall be made independently of any determination of indigency under s. 39.013.

Section 8. Paragraph (b) of subsection (1) and subsection (2) of section 39.701, Florida Statutes, are amended to read:

39.701 Judicial review.—

(1) GENERAL PROVISIONS.—

(b)1. The court shall retain jurisdiction over a child returned to his or her parents for a minimum period of 6 months following the reunification, but, at that time, based on a report of the social service agency and the guardian ad litem, if one has been appointed, and any other relevant factors, the court shall make a determination as to whether supervision by the department and the court's jurisdiction shall continue or be terminated.

2. Notwithstanding subparagraph 1., the court shall retain jurisdiction over a child if the child is placed in a home with a parent or caregiver with an in-home safety plan.

(2) REVIEW HEARINGS FOR CHILDREN YOUNGER THAN 18 YEARS OF AGE.—

(a) *Case Plan Assessment* ~~*Social study report for judicial review.*~~—Before every judicial review hearing or citizen review panel hearing, the community-based care lead ~~social service~~ agency shall assess ~~make an investigation and social study concerning~~ all pertinent details relating to the child and shall furnish to the court or citizen review panel a written report that includes, but is not limited to:

1. A description of the type of placement the child is in at the time of the hearing, including the safety of the child

and the continuing necessity for and appropriateness of the placement.

2. Documentation of the diligent efforts made by all parties to the case plan to comply with each applicable provision of the plan.

3. The amount of fees assessed and collected during the period of time being reported.

4. The services provided to the foster family or legal custodian in an effort to address the needs of the child as indicated in the case plan.

5. A statement that either:

a. The parent, though able to do so, did not comply substantially with the case plan, and the agency recommendations;

b. The parent did substantially comply with the case plan; or

c. The parent has partially complied with the case plan, with a summary of additional progress needed and the agency recommendations.

6. A statement from the foster parent or legal custodian providing any material evidence concerning the well-being of the child, the impact of any services provided to the child, the working relationship between the caregiver and the parents, and the return of the child to the parent or parents.

7. A statement concerning the frequency, duration, and results of the parent-child visitation, if any, and the agency and caregiver recommendations for an expansion or restriction of future visitation.

8. The number of times a child has been removed from his or

her home and placed elsewhere, the number and types of placements that have occurred, and the reason for the changes in placement.

9. The number of times a child's educational placement has been changed, the number and types of educational placements which have occurred, and the reason for any change in placement.

10. If the child has reached 13 years of age but is not yet 18 years of age, a statement from the caregiver on the progress the child has made in acquiring independent living skills.

11. Copies of all medical, psychological, and educational records that support the terms of the case plan and that have been produced concerning the parents or any caregiver since the last judicial review hearing.

12. Copies of the child's current health, mental health, and education records as identified in s. 39.6012.

(b) *Submission and distribution of reports.*—

1. A copy of the case management ~~social service~~ agency's case plan assessment written report and the written report of the guardian ad litem must be served on all parties whose whereabouts are known; to the foster parents or legal custodians; and to the citizen review panel, at least 72 hours before the judicial review hearing or citizen review panel hearing. The requirement for providing parents with a copy of the written report does not apply to those parents who have voluntarily surrendered their child for adoption or who have had their parental rights to the child terminated.

2. In a case in which the child has been permanently placed with the community-based care lead ~~social service~~ agency, the agency shall furnish to the court a written report concerning

the progress being made to place the child for adoption. If the child cannot be placed for adoption, a report on the progress made by the child towards alternative permanency goals or placements, including, but not limited to, guardianship, long-term custody, long-term licensed custody, or independent living, must be submitted to the court. The report must be submitted to the court at least 72 hours before each scheduled judicial review.

3. In addition to or in lieu of any written statement provided to the court, the foster parent or legal custodian, or any preadoptive parent, shall be given the opportunity to address the court with any information relevant to the best interests of the child at any judicial review hearing.

(c) *Review determinations.*—The court and any citizen review panel shall take into consideration the information contained in the case plan assessment ~~social services study and investigation~~ and all medical, psychological, and educational records that support the terms of the case plan; testimony by the community-based care lead ~~social services~~ agency, the parent, the foster parent or legal custodian, the guardian ad litem or surrogate parent for educational decisionmaking if one has been appointed for the child, and any other person deemed appropriate; and any relevant and material evidence submitted to the court, including written and oral reports to the extent of their probative value. These reports and evidence may be received by the court in its effort to determine the action to be taken with regard to the child and may be relied upon to the extent of their probative value, even though not competent in an adjudicatory hearing. In its deliberations, the court and any citizen review panel shall

seek to determine:

1. If the parent was advised of the right to receive assistance from any person or community-based care lead ~~social service~~ agency in the preparation of the case plan.

2. If the parent has been advised of the right to have counsel present at the judicial review or citizen review hearings. If not so advised, the court or citizen review panel shall advise the parent of such right.

3. If a guardian ad litem needs to be appointed for the child in a case in which a guardian ad litem has not previously been appointed or if there is a need to continue a guardian ad litem in a case in which a guardian ad litem has been appointed.

4. Who holds the rights to make educational decisions for the child. If appropriate, the court may refer the child to the district school superintendent for appointment of a surrogate parent or may itself appoint a surrogate parent under the Individuals with Disabilities Education Act and s. 39.0016.

5. The compliance or lack of compliance of all parties with applicable items of the case plan, including the parents' compliance with child support orders.

6. The compliance or lack of compliance with a visitation contract between the parent and the community-based care lead ~~social service~~ agency for contact with the child, including the frequency, duration, and results of the parent-child visitation and the reason for any noncompliance.

7. If the parents and caregivers have developed a productive relationship with one another which is based on meaningful communication and mutual support.

8.~~7.~~ The frequency, kind, and duration of contacts among

siblings who have been separated during placement, as well as any efforts undertaken to reunite separated siblings if doing so is in the best interest of the child.

9.~~8.~~ The compliance or lack of compliance of the parent in meeting specified financial obligations pertaining to the care of the child, including the reason for failure to comply, if applicable.

10.~~9.~~ Whether the child is receiving safe and proper care according to s. 39.6012, including, but not limited to, the appropriateness of the child's current placement, including whether the child is in a setting that is as family-like and as close to the parent's home as possible, consistent with the child's best interests and special needs, and including maintaining stability in the child's educational placement, as documented by assurances from the community-based care provider that:

a. The placement of the child takes into account the appropriateness of the current educational setting and the proximity to the school in which the child is enrolled at the time of placement.

b. The community-based care agency has coordinated with appropriate local educational agencies to ensure that the child remains in the school in which the child is enrolled at the time of placement.

11.~~10.~~ A projected date likely for the child's return home or other permanent placement.

12.~~11.~~ When appropriate, the basis for the unwillingness or inability of the parent to become a party to a case plan. The court and the citizen review panel shall determine if the

efforts of the community-based care lead ~~social service~~ agency to secure party participation in a case plan were sufficient.

13.~~12.~~ For a child who has reached 13 years of age but is not yet 18 years of age, the adequacy of the child's preparation for adulthood and independent living. For a child who is 15 years of age or older, the court shall determine if appropriate steps are being taken for the child to obtain a driver license or learner's driver license.

14.~~13.~~ If amendments to the case plan are required. Amendments to the case plan must be made under s. 39.6013.

(d) *Orders.*—

1. Based upon the criteria set forth in paragraph (c) and the recommended order of the citizen review panel, if any, the court shall determine whether the social service agency shall initiate proceedings to have a child declared a dependent child, return the child to the parent, continue the child in out-of-home care for a specified period of time, or initiate termination of parental rights proceedings for subsequent placement in an adoptive home. Amendments to the case plan must be prepared as provided in s. 39.6013. If the court finds that the prevention or reunification efforts of the department will allow the child to remain safely at home or be safely returned to the home, the court shall allow the child to remain in or return to the home after making a specific finding of fact that the reasons for the creation of the case plan have been remedied to the extent that the child's safety, well-being, and physical, mental, and emotional health will not be endangered.

2. The court shall return the child to the custody of his or her parents at any time it determines that the circumstances

that caused the out-of-home placement, and any issues subsequently identified, have been remedied to the extent that returning the child to the home with an in-home safety plan prepared or approved by the department will not be detrimental to the child's safety, well-being, and physical, mental, and emotional health.

3. If, in the opinion of the court, the community-based care lead ~~social service~~ agency has not complied with its obligations as specified in the written case plan, the court may find the ~~social service~~ agency in contempt, shall order the ~~social service~~ agency to submit its plans for compliance with the agreement, and shall require the ~~social service~~ agency to show why the child could not safely be returned to the home of the parents.

4. If, at any judicial review, the court finds that the parents have failed to substantially comply with the case plan to the degree that further reunification efforts are without merit and not in the best interest of the child, on its own motion, the court may order the filing of a petition for termination of parental rights, regardless of whether the time period as contained in the case plan for substantial compliance has expired.

5. Within 6 months after the date that the child was placed in shelter care, the court shall conduct a judicial review hearing to review the child's permanency goal as identified in the case plan. At the hearing the court shall make findings regarding the likelihood of the child's reunification with the parent or legal custodian. In making such findings, the court shall consider the level of the parent or legal custodian's

compliance with the case plan and demonstrated change in protective capacities compared to that necessary to achieve timely reunification within 12 months after the removal of the child from the home. The court shall also consider the frequency, duration, manner, and level of engagement of the parent or legal custodian's visitation with the child in compliance with the case plan. If the court makes a written finding that it is not likely that the child will be reunified with the parent or legal custodian within 12 months after the child was removed from the home, the department must file with the court, and serve on all parties, a motion to amend the case plan under s. 39.6013 and declare that it will use concurrent planning for the case plan. The department must file the motion within 10 business days after receiving the written finding of the court. The department must attach the proposed amended case plan to the motion. If concurrent planning is already being used, the case plan must document the efforts the department is taking to complete the concurrent goal.

6. The court may issue a protective order in assistance, or as a condition, of any other order made under this part. In addition to the requirements included in the case plan, the protective order may set forth requirements relating to reasonable conditions of behavior to be observed for a specified period of time by a person or agency who is before the court; and the order may require any person or agency to make periodic reports to the court containing such information as the court in its discretion may prescribe.

7. If, at any judicial review, the court determines that the child shall remain in out-of-home care in a placement other

than with a parent, the court shall order that the department has placement and care responsibility for the child.

Section 9. Section 409.1415, Florida Statutes, is created to read:

409.1415 Parenting partnerships for children in out-of-home care.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that reunification is the most common outcome for children in out-of-home care and that foster parents are one of the most important resources to help children reunify with their families.

(b) The Legislature further finds that the most successful foster parents understand that their role goes beyond supporting the children in their care to supporting the children's families, as a whole, and that children and their families benefit when foster and birth parents are supported by an agency culture that encourages a meaningful partnership between them and provides quality support.

(c) Therefore, in keeping with national trends, it is the intent of the Legislature to bring birth parents and foster parents together in order to build strong relationships that lead to more successful reunifications and more stability for children being fostered in out-of-home care.

(2) PARENTING PARTNERSHIPS.—

(a) *General provisions.*—In order to ensure that children in out-of-home care achieve legal permanency as soon as possible, to reduce the likelihood that they will re-enter care or that other children in the family are abused or neglected or enter out-of-home care, and to ensure that families are fully prepared

to resume custody of their children, the department and community-based care lead agencies shall develop and support relationships between foster families and the legal parents of children in out-of-home care to the extent that it is safe and in the child's best interest, by:

1. Facilitating telephone communication between the foster parent and the birth or legal parent as soon as possible after the child is placed in the home.

2. Facilitating and attending an in-person meeting between the foster parent and the birth or legal parent within 2 weeks after placement.

3. Developing and supporting a plan for birth or legal parents to participate in medical appointments, educational and extra-curricular activities, and other events involving the child.

4. Facilitating participation by the foster parent in visitation between the birth parent and child.

5. Involving the foster parent in planning meetings with the birth parent.

6. Developing and implementing effective transition plans for the child's return home or placement in any other living environment.

7. Supporting continued contact between the foster family and the child after the child returns home or moves to another permanent living arrangement.

8. Supporting continued connection with the birth parent after adoption.

(b) *Responsibilities.*—To ensure that a child in out-of-home care receives support for healthy development which gives him or

her the best possible opportunity for success, foster parents, birth parents, the department, community-based care lead agency staff, and other agency staff, as applicable, shall work cooperatively in a respectful partnership by adhering to the following requirements:

1. All members of the partnership must interact and communicate professionally with one another, must share all relevant information promptly, and must respect the confidentiality of all information related to a child and his or her family.

2. Caregivers, the family, the department, community-based care lead agency staff, and other agency staff must participate in developing a case plan for the child and family, and all members of the team must work together to implement the plan. Caregivers must participate in all team meetings or court hearings related to the child's care and future plans. The department, community-based care lead agency staff, and other agency staff must support and facilitate caregiver participation through timely notification of such meetings and hearings and an inclusive process, and by providing alternative methods for participation for caregivers who cannot be physically present at a meeting or hearing.

3. Excellent parenting is a reasonable expectation of caregivers. Caregivers must provide, and the department, community-based care lead agency staff, and other agency staff must support, excellent parenting. "Excellent parenting" means a loving commitment to the child and the child's safety and well-being; appropriate supervision and positive methods of discipline; encouragement of the child's strengths; respect for

the child's individuality and likes and dislikes; providing opportunities to develop the child's interests and skills; being aware of the impact of trauma on behavior; facilitating equal participation of the child in family life; involving the child within his or her community; and a commitment to enable the child to lead a normal life.

4. Children in out-of-home care may be placed only with a caregiver who has the ability to care for the child, is willing to accept responsibility for providing care, and is willing and able to learn about and be respectful of the child's culture, religion, and ethnicity; special physical or psychological needs; any circumstances unique to the child; and family relationships. The department, the community-based care lead agency, and other agencies must provide a caregiver with all available information necessary to assist the caregiver in determining whether he or she is able to appropriately care for a particular child.

5. A caregiver must have access to and take advantage of all training that he or she needs to improve his or her skills in parenting a child who has experienced trauma due to neglect, abuse, or separation from home; to meet the child's special needs; and to work effectively with child welfare agencies, the courts, the schools, and other community and governmental agencies.

6. The department, community-based care lead agency staff, and other agency staff must provide caregivers with the services and support they need to enable them to provide quality care for the child.

7. Once a family accepts the responsibility of caring for a

child, the child may be removed from that family only if the family is clearly unable to care for him or her safely or legally, when the child and his or her biological family are reunified, when the child is being placed in a legally permanent home in accordance with a case plan or court order, or when the removal is demonstrably in the best interests of the child.

8. If a child must leave the caregiver's home for one of the reasons stated in subparagraph 7., and in the absence of an unforeseeable emergency, the transition must be accomplished according to a plan that involves cooperation and sharing of information among all persons involved, respects the child's developmental stage and psychological needs, ensures the child has all of his or her belongings, allows for a gradual transition from the caregiver's home, and, if possible, allows for continued contact with the caregiver after the child leaves.

9. When the plan for a child includes reunification, caregivers and agency staff must work together to assist the biological parents in improving their ability to care for and protect their children and to provide continuity for the child.

10. A caregiver must respect and support the child's ties to his or her biological family including parents, siblings, and extended family members and must assist the child in visitation and other forms of communication. The department, community-based care lead agency staff, and other agency staff must provide caregivers with the information, guidance, training, and support necessary for fulfilling this responsibility.

11. A caregiver must work in partnership with the department, community-based care lead agency staff, and other agency staff to obtain and maintain records that are important

to the child's well-being including, but not limited to, child resource records, medical records, school records, photographs, and records of special events and achievements.

12. A caregiver must effectively advocate for a child in his or her care with the child welfare system, the court, and community agencies, including schools, child care providers, health and mental health providers, and employers. The department, community-based care lead agency staff, and other agency staff must support a caregiver in effectively advocating for a child and may not retaliate against the caregiver as a result of this advocacy.

13. A caregiver must be as fully involved in the child's medical, psychological, and dental care as he or she would be for his or her biological child. Agency staff must support and facilitate such participation. Caregivers, the department, community-based care lead agency staff, and other agency staff must share information with each other about the child's health and well-being.

14. A caregiver must support a child's school success, including, when possible, maintaining school stability by participating in school activities and meetings, including individual education plan meetings; assisting with school assignments; supporting tutoring programs; meeting with teachers and working with an educational surrogate, if one has been appointed; and encouraging the child's participation in extracurricular activities. Agency staff must facilitate this participation and must be kept informed of the child's progress and needs.

15. Caseworkers and caseworker supervisors must mediate

disagreements that occur between foster parents and birth parents.

(c) *Residential group homes.*—All caregivers employed by residential group homes must meet the same education, training, and background and other screening requirements as foster parents and must adhere to the requirements in paragraph (b).

(3) RULEMAKING.—The department shall adopt by rule procedures to administer this section.

Section 10. Section 409.145, Florida Statutes, is amended to read:

409.145 Care of children; ~~quality parenting;~~ "reasonable and prudent parent" standard.—The child welfare system of the department shall operate as a coordinated community-based system of care which empowers all caregivers for children in foster care to provide quality parenting, including approving or disapproving a child's participation in activities based on the caregiver's assessment using the "reasonable and prudent parent" standard.

(1) SYSTEM OF CARE.—The department shall develop, implement, and administer a coordinated community-based system of care for children who are found to be dependent and their families. This system of care must be directed toward the following goals:

(a) Prevention of separation of children from their families.

(b) Intervention to allow children to remain safely in their own homes.

(c) Reunification of families who have had children removed from their care.

(d) Safety for children who are separated from their families by providing alternative emergency or longer-term parenting arrangements.

(e) Focus on the well-being of children through emphasis on maintaining educational stability and providing timely health care.

(f) Permanency for children for whom reunification with their families is not possible or is not in the best interest of the child.

(g) The transition to independence and self-sufficiency for older children who remain in foster care through adolescence.

~~(2) QUALITY PARENTING.—A child in foster care shall be placed only with a caregiver who has the ability to care for the child, is willing to accept responsibility for providing care, and is willing and able to learn about and be respectful of the child's culture, religion and ethnicity, special physical or psychological needs, any circumstances unique to the child, and family relationships. The department, the community-based care lead agency, and other agencies shall provide such caregiver with all available information necessary to assist the caregiver in determining whether he or she is able to appropriately care for a particular child.~~

~~(a) *Roles and responsibilities of caregivers.*—A caregiver shall:~~

~~1. Participate in developing the case plan for the child and his or her family and work with others involved in his or her care to implement this plan. This participation includes the caregiver's involvement in all team meetings or court hearings related to the child's care.~~

~~2. Complete all training needed to improve skills in parenting a child who has experienced trauma due to neglect, abuse, or separation from home, to meet the child's special needs, and to work effectively with child welfare agencies, the court, the schools, and other community and governmental agencies.~~

~~3. Respect and support the child's ties to members of his or her biological family and assist the child in maintaining allowable visitation and other forms of communication.~~

~~4. Effectively advocate for the child in the caregiver's care with the child welfare system, the court, and community agencies, including the school, child care, health and mental health providers, and employers.~~

~~5. Participate fully in the child's medical, psychological, and dental care as the caregiver would for his or her biological child.~~

~~6. Support the child's educational success by participating in activities and meetings associated with the child's school or other educational setting, including Individual Education Plan meetings and meetings with an educational surrogate if one has been appointed, assisting with assignments, supporting tutoring programs, and encouraging the child's participation in extracurricular activities.~~

~~a. Maintaining educational stability for a child while in out-of-home care by allowing the child to remain in the school or educational setting that he or she attended before entry into out-of-home care is the first priority, unless not in the best interest of the child.~~

~~b. If it is not in the best interest of the child to remain~~

~~in his or her school or educational setting upon entry into out-of-home care, the caregiver must work with the case manager, guardian ad litem, teachers and guidance counselors, and educational surrogate if one has been appointed to determine the best educational setting for the child. Such setting may include a public school that is not the school of origin, a private school pursuant to s. 1002.42, a virtual instruction program pursuant to s. 1002.45, or a home education program pursuant to s. 1002.41.~~

~~7. Work in partnership with other stakeholders to obtain and maintain records that are important to the child's well-being, including child resource records, medical records, school records, photographs, and records of special events and achievements.~~

~~8. Ensure that the child in the caregiver's care who is between 13 and 17 years of age learns and masters independent living skills.~~

~~9. Ensure that the child in the caregiver's care is aware of the requirements and benefits of the Road-to-Independence Program.~~

~~10. Work to enable the child in the caregiver's care to establish and maintain naturally occurring mentoring relationships.~~

~~(b) *Roles and responsibilities of the department, the community-based care lead agency, and other agency staff.* The department, the community-based care lead agency, and other agency staff shall:~~

~~1. Include a caregiver in the development and implementation of the case plan for the child and his or her~~

~~family. The caregiver shall be authorized to participate in all team meetings or court hearings related to the child's care and future plans. The caregiver's participation shall be facilitated through timely notification, an inclusive process, and alternative methods for participation for a caregiver who cannot be physically present.~~

~~2. Develop and make available to the caregiver the information, services, training, and support that the caregiver needs to improve his or her skills in parenting children who have experienced trauma due to neglect, abuse, or separation from home, to meet these children's special needs, and to advocate effectively with child welfare agencies, the courts, schools, and other community and governmental agencies.~~

~~3. Provide the caregiver with all information related to services and other benefits that are available to the child.~~

~~4. Show no prejudice against a caregiver who desires to educate at home a child placed in his or her home through the child welfare system.~~

~~(c) *Transitions.*—~~

~~1. Once a caregiver accepts the responsibility of caring for a child, the child will be removed from the home of that caregiver only if:~~

~~a. The caregiver is clearly unable to safely or legally care for the child;~~

~~b. The child and his or her biological family are reunified;~~

~~c. The child is being placed in a legally permanent home pursuant to the case plan or a court order; or~~

~~d. The removal is demonstrably in the child's best~~

~~interest.~~

~~2. In the absence of an emergency, if a child leaves the caregiver's home for a reason provided under subparagraph 1., the transition must be accomplished according to a plan that involves cooperation and sharing of information among all persons involved, respects the child's developmental stage and psychological needs, ensures the child has all of his or her belongings, allows for a gradual transition from the caregiver's home and, if possible, for continued contact with the caregiver after the child leaves.~~

~~(d) *Information sharing.* Whenever a foster home or residential group home assumes responsibility for the care of a child, the department and any additional providers shall make available to the caregiver as soon as is practicable all relevant information concerning the child. Records and information that are required to be shared with caregivers include, but are not limited to:~~

~~1. Medical, dental, psychological, psychiatric, and behavioral history, as well as ongoing evaluation or treatment needs;~~

~~2. School records;~~

~~3. Copies of his or her birth certificate and, if appropriate, immigration status documents;~~

~~4. Consents signed by parents;~~

~~5. Comprehensive behavioral assessments and other social assessments;~~

~~6. Court orders;~~

~~7. Visitation and case plans;~~

~~8. Guardian ad litem reports;~~

~~9. Staffing forms; and~~

~~10. Judicial or citizen review panel reports and attachments filed with the court, except confidential medical, psychiatric, and psychological information regarding any party or participant other than the child.~~

~~(c) *Caregivers employed by residential group homes.*—All caregivers in residential group homes shall meet the same education, training, and background and other screening requirements as foster parents.~~

(2)~~(3)~~ REASONABLE AND PRUDENT PARENT STANDARD.—

(a) *Definitions.*—As used in this subsection, the term:

1. "Age-appropriate" means an activity or item that is generally accepted as suitable for a child of the same chronological age or level of maturity. Age appropriateness is based on the development of cognitive, emotional, physical, and behavioral capacity which is typical for an age or age group.

2. "Caregiver" means a person with whom the child is placed in out-of-home care, or a designated official for a group care facility licensed by the department under s. 409.175.

3. "Reasonable and prudent parent" standard means the standard of care used by a caregiver in determining whether to allow a child in his or her care to participate in extracurricular, enrichment, and social activities. This standard is characterized by careful and thoughtful parental decisionmaking that is intended to maintain a child's health, safety, and best interest while encouraging the child's emotional and developmental growth.

(b) *Application of standard of care.*—

1. Every child who comes into out-of-home care pursuant to

this chapter is entitled to participate in age-appropriate extracurricular, enrichment, and social activities.

2. Each caregiver shall use the reasonable and prudent parent standard in determining whether to give permission for a child living in out-of-home care to participate in extracurricular, enrichment, or social activities. When using the reasonable and prudent parent standard, the caregiver must consider:

a. The child's age, maturity, and developmental level to maintain the overall health and safety of the child.

b. The potential risk factors and the appropriateness of the extracurricular, enrichment, or social activity.

c. The best interest of the child, based on information known by the caregiver.

d. The importance of encouraging the child's emotional and developmental growth.

e. The importance of providing the child with the most family-like living experience possible.

f. The behavioral history of the child and the child's ability to safely participate in the proposed activity.

(c) *Verification of services delivered.*—The department and each community-based care lead agency shall verify that private agencies providing out-of-home care services to dependent children have policies in place which are consistent with this section and that these agencies promote and protect the ability of dependent children to participate in age-appropriate extracurricular, enrichment, and social activities.

(d) *Limitation of liability.*—A caregiver is not liable for harm caused to a child who participates in an activity approved

by the caregiver, provided that the caregiver has acted in accordance with the reasonable and prudent parent standard. This paragraph may not be interpreted as removing or limiting any existing liability protection afforded by law.

(3)~~(4)~~ FOSTER CARE ROOM AND BOARD RATES.—

(a) Effective July 1, 2018, room and board rates shall be paid to foster parents as follows:

Monthly Foster Care Rate

| 0-5 Years Age | 6-12 Years Age | 13-21 Years Age |
|---|---|---|
| $457.95 | $469.68 | $549.74 |

(b) Each January, foster parents shall receive an annual cost of living increase. The department shall calculate the new room and board rate increase equal to the percentage change in the Consumer Price Index for All Urban Consumers, U.S. City Average, All Items, not seasonally adjusted, or successor reports, for the preceding December compared to the prior December as initially reported by the United States Department of Labor, Bureau of Labor Statistics. The department shall make available the adjusted room and board rates annually.

(c) Effective July 1, 2019, foster parents of level I family foster homes, as defined in s. 409.175(5)(a) shall receive a room and board rate of $333.

(d) Effective July 1, 2019, the foster care room and board

rate for level II family foster homes as defined in s. 409.175(5)(a) shall be the same as the new rate established for family foster homes as of January 1, 2019.

(e) Effective January 1, 2020, paragraph (b) shall only apply to level II through level V family foster homes, as defined in s. 409.175(5)(a).

(f) The amount of the monthly foster care room and board rate may be increased upon agreement among the department, the community-based care lead agency, and the foster parent.

(g) From July 1, 2018, through June 30, 2019, community-based care lead agencies providing care under contract with the department shall pay a supplemental room and board payment to foster care parents of all family foster homes, on a per-child basis, for providing independent life skills and normalcy supports to children who are 13 through 17 years of age placed in their care. The supplemental payment shall be paid monthly to the foster care parents in addition to the current monthly room and board rate payment. The supplemental monthly payment shall be based on 10 percent of the monthly room and board rate for children 13 through 21 years of age as provided under this section and adjusted annually. Effective July 1, 2019, such supplemental payments shall only be paid to foster parents of level II through level V family foster homes.

(4) ~~(5)~~ RULEMAKING.—The department shall adopt by rule procedures to administer this section.

Section 11. Paragraph (j) of subsection (1) of section 409.988, Florida Statutes, is amended, and paragraph (l) is added to that subsection, to read:

409.988 Lead agency duties; general provisions.—

(1) DUTIES.—A lead agency:

(j) May subcontract for the provision of services required by the contract with the lead agency and the department; however, the subcontracts must specify how the provider will contribute to the lead agency meeting the performance standards established pursuant to the child welfare results-oriented accountability system required by s. 409.997. The lead agency shall directly provide no more than 35 percent of all child welfare services provided unless it demonstrates a need, within the lead agency's geographic service area, to exceed this threshold. The local community alliance in the geographic service area in which the lead agency is seeking to exceed the threshold shall review the lead agency's justification for need and recommend to the department whether the department should approve or deny the lead agency's request for an exemption from the services threshold. If there is not a community alliance operating in a lead agency's geographic service area, such review and recommendation must be made by representatives of local stakeholders, including at least one representative from each of the following:

1. The department.

2. The county government.

3. The school district.

4. The county United Way.

5. The county sheriff's office.

6. The circuit court having jurisdiction in the county.

7. The county children's board, if one exists.

(l) Shall conduct home studies of prospective adoptive parents who wish to adopt a child after the state has terminated

parental rights. Home studies must assess the residence to ensure the safety of a newly adopted child and the financial and medical status of the prospective adoptive parents. Home studies must be completed within 2 weeks after the date on which the community-based care lead agency receives a completed application. The home study must be conducted concurrently with the required background screening of the prospective parents.

Section 12. Present subsections (11) through (23) of section 409.996, Florida Statutes, are redesignated as subsections (12) through (24), respectively, a new subsection (11) is added to that section, and paragraph (a) of subsection (1) of that section is amended, to read:

409.996 Duties of the Department of Children and Families.—The department shall contract for the delivery, administration, or management of care for children in the child protection and child welfare system. In doing so, the department retains responsibility for the quality of contracted services and programs and shall ensure that services are delivered in accordance with applicable federal and state statutes and regulations.

(1) The department shall enter into contracts with lead agencies for the performance of the duties by the lead agencies pursuant to s. 409.988. At a minimum, the contracts must:

(a) Provide for the services needed to accomplish the duties established in s. 409.988 and provide information to the department which is necessary to meet the requirements for a quality assurance program pursuant to subsection (19) ~~(18)~~ and the child welfare results-oriented accountability system pursuant to s. 409.997.

(11) The department shall conduct level 1 and level 2 background screenings of prospective adoptive parents. The background screenings must be completed within 2 weeks of a completed application from the prospective adoptive parents. The department shall provide the results of the screening to the community-based care lead agency. The background screening must be conducted concurrently with the home study of the prospective parents required under s. 409.988(1)(l).

Section 13. Paragraph (d) of subsection (5) of section 39.6225, Florida Statutes, is amended to read:

39.6225 Guardianship Assistance Program.—

(5) A guardian with an application approved pursuant to subsection (2) who is caring for a child placed with the guardian by the court pursuant to this part may receive guardianship assistance payments based on the following criteria:

(d) The department shall provide guardianship assistance payments in the amount of $4,000 annually, paid on a monthly basis, or in an amount other than $4,000 annually as determined by the guardian and the department and memorialized in a written agreement between the guardian and the department. The agreement shall take into consideration the circumstances of the guardian and the needs of the child. Changes may not be made without the concurrence of the guardian. However, in no case shall the amount of the monthly payment exceed the foster care maintenance payment that would have been paid during the same period if the child had been in licensed care at his or her designated level of care at the rate established in s. 409.145(3) ~~s. 409.145(4)~~.

Section 14. Paragraph (b) of subsection (5) of section

393.065, Florida Statutes, is amended to read:

393.065 Application and eligibility determination.—

(5) The agency shall assign and provide priority to clients waiting for waiver services in the following order:

(b) Category 2, which includes individuals on the waiting list who are:

1. From the child welfare system with an open case in the Department of Children and Families' statewide automated child welfare information system and who are either:

a. Transitioning out of the child welfare system at the finalization of an adoption, a reunification with family members, a permanent placement with a relative, or a guardianship with a nonrelative; or

b. At least 18 years but not yet 22 years of age and who need both waiver services and extended foster care services; or

2. At least 18 years but not yet 22 years of age and who withdrew consent pursuant to s. 39.6251(5)(c) to remain in the extended foster care system.

For individuals who are at least 18 years but not yet 22 years of age and who are eligible under sub-subparagraph 1.b., the agency shall provide waiver services, including residential habilitation, and the community-based care lead agency shall fund room and board at the rate established in s. 409.145(3) ~~s. 409.145(4)~~ and provide case management and related services as defined in s. 409.986(3)(e). Individuals may receive both waiver services and services under s. 39.6251. Services may not duplicate services available through the Medicaid state plan.

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

Section 15. Paragraph (b) of subsection (2) of section 409.1451, Florida Statutes, is amended to read:

409.1451 The Road-to-Independence Program.—

(2) POSTSECONDARY EDUCATION SERVICES AND SUPPORT.—

(b) The amount of the financial assistance shall be as follows:

1. For a young adult who does not remain in foster care and is attending a postsecondary school as provided in s. 1009.533, the amount is $1,256 monthly.

2. For a young adult who remains in foster care, is attending a postsecondary school, as provided in s. 1009.533, and continues to reside in a licensed foster home, the amount is the established room and board rate for foster parents. This takes the place of the payment provided for in s. 409.145(3) ~~s. 409.145(4)~~.

3. For a young adult who remains in foster care, but temporarily resides away from a licensed foster home for purposes of attending a postsecondary school as provided in s. 1009.533, the amount is $1,256 monthly. This takes the place of the payment provided for in s. 409.145(3) ~~s. 409.145(4)~~.

4. For a young adult who remains in foster care, is attending a postsecondary school as provided in s. 1009.533, and continues to reside in a licensed group home, the amount is negotiated between the community-based care lead agency and the licensed group home provider.

5. For a young adult who remains in foster care, but

temporarily resides away from a licensed group home for purposes of attending a postsecondary school as provided in s. 1009.533, the amount is $1,256 monthly. This takes the place of a negotiated room and board rate.

6. A young adult is eligible to receive financial assistance during the months when he or she is enrolled in a postsecondary educational institution.

Section 16. This act shall take effect July 1, 2020.

**The Florida Senate**

# COMMITTEE VOTE RECORD

**COMMITTEE:** Children, Families, and Elder Affairs
**ITEM:** SB 1324
**FINAL ACTION:** Favorable with Committee Substitute
**MEETING DATE:** Wednesday, January 15, 2020
**TIME:** 10:30 a.m.—12:30 p.m.
**PLACE:** 301 Senate Building

| FINAL VOTE | | | 1/15/2020 1<br>Amendment 761810 | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Yea** | **Nay** | **SENATORS** | **Yea** | **Nay** | **Yea** | **Nay** | **Yea** | **Nay** |
| X | | Bean | | | | | | |
| X | | Harrell | | | | | | |
| X | | Rader | | | | | | |
| X | | Torres | | | | | | |
| X | | Wright | | | | | | |
| X | | Mayfield, VICE CHAIR | | | | | | |
| X | | Book, CHAIR | | | | | | |
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| 7 | 0 | **TOTALS** | FAV | - | | | | |
| **Yea** | **Nay** | | **Yea** | **Nay** | **Yea** | **Nay** | **Yea** | **Nay** |

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

# CourtSmart Tag Report

**Room:** SB 301 **Case:** **Type:**
**Caption:** Senate Committee on Children, Family and Elder Affairs **Judge:**

**Started: 1/15/2020 10:31:43 AM**
**Ends: 1/15/2020 12:27:30 PM Length: 01:55:48**

**10:31:42 AM** Meeting called to order
**10:31:56 AM** Roll Call -Quorum is present
**10:32:09 AM** Chair
**10:32:19 AM** Tab 2 - SB 994 by Senator Passidoma, Guardianship
**10:33:59 AM** Questions? None
**10:33:59 AM**
**10:34:05 AM** Appearance Forms?
**10:34:15 AM** Jack McRay, AARP, waives in support
**10:34:23 AM** Olvia Babis, Public Policy Analyst, Disability Rights Florida, speaking for the bill
**10:37:01 AM** Bryan Cherry, Fla. Public Guardian Coalition, waives in support
**10:38:00 AM** Ken Kenickman, Fla. Conference for Catholic Bishops, waives in support
**10:38:11 AM** JD Peacock, III, Fla. Courts Clerks and Comptrollers, waives in support
**10:38:52 AM** Doug Franks, Advocate for the ABUSED, Earnestine Franks AAAP.net Speaking against
**10:42:14 AM**
**10:43:51 AM** James Otto, Clay County, speaking for information
**10:44:03 AM** Debate?
**10:44:06 AM** Senator Torres
**10:45:24 AM** Senator Bean
**10:46:08 AM** Senator Passidomo to close
**10:46:25 AM** Roll Call SB 994 - favorable
**10:46:57 AM** Chair
**10:47:19 AM** Tab 3 - SB 1324 by Senator Simpson, Child Welfare
**10:47:24 AM** Strike-all amendment 761810 by Senator Simpson
**10:48:48 AM** Questions? None
**10:49:08 AM** Appearance Cards on amendment
**10:49:31 AM** Dr. Mimi Graham, waive in support
**10:49:32 AM** Alan Abramowitz, ED, Statewide Guardian ad Litem Program, in support
**10:49:33 AM** Jeffrey Sharkey, President, Capital Alliance Group, Big Bend Advocacy Assoc., waives in support
**10:49:46 AM** Summer Pfeiffer, VP of Gov't Relations, Children's Home Society, waive in support
**10:49:46 AM** Appearance on amendment
**10:49:47 AM** Victoria Zepp, Chief Policy Officer, Fl. Coalition for Children, speaking for the bill
**10:49:48 AM** Jerry Paul, Safe Children Coalition, waives in support
**10:49:48 AM**
**10:49:49 AM** Lee Howarth, waive in support
**10:50:38 AM**
**10:50:45 AM** Debate?
**10:50:47 AM** Senator Harrell
**10:51:54 AM** Chair
**10:52:55 AM** Strike-all amendment is adopted
**10:53:00 AM** Back on bill as amended
**10:53:11 AM** Senator Simpson to close
**10:53:18 AM** Roll Call CS/SB 1324 - favorable
**10:53:46 AM** Tab 1 - SB 82 by Senator Bean - Individuals With Disabilities
**11:00:42 AM** Chair
**11:00:43 AM** Questions?
**11:01:22 AM**
**11:01:27 AM**
**11:01:36 AM**
**11:01:36 AM**
**11:01:37 AM**
**11:01:39 AM** Questions?
**11:01:39 AM** Senator Bean

**11:01:40 AM** Chair
**11:04:14 AM** Senator Harrell
**11:04:30 AM**
**11:05:51 AM** Senator Bean
**11:06:45 AM** Senator Harrell
**11:07:08 AM** Senator Bean
**11:08:40 AM** Senator Harrell
**11:09:15 AM** Senator Bean
**11:10:59 AM** Senator Harrell
**11:11:47 AM** Senator Bean
**11:13:01 AM** Senator Harrell
**11:13:08 AM**
**11:15:49 AM** Senator Torres
**11:16:20 AM** Senator Bean
**11:16:54 AM** Chair
**11:16:59 AM** Senator Rader
**11:17:49 AM** Senator Bean
**11:18:10 AM** Senator Rader
**11:19:17 AM** Senator Rader
**11:19:32 AM** Senator Bean
**11:20:34 AM** Senator Rader
**11:21:08 AM** Senator Bean
**11:22:36 AM** Senator Rader
**11:23:15 AM** Senator Bean
**11:24:12 AM** Chair
**11:24:48 AM** Senator Rader
**11:25:07 AM** Secretary Barbara Palmer, Director, Agency for Persons with Disabilities, speaking for information
**11:29:14 AM** Senator Harrell
**11:30:15 AM** Chair
**11:30:36 AM** Secretary Palmer
**11:31:24 AM** Senator Harrell
**11:31:53 AM** Senator Torres
**11:32:02 AM** Secretary Palmer
**11:32:37 AM** Senator Torres
**11:32:55 AM** Secretary Palmer
**11:33:55 AM** Senator Rader
**11:34:32 AM** Secretary Palmer
**11:34:52 AM** Chair
**11:34:58 AM** Laura Mohesky, Waiver Support Coordinator, Support Coordination Assoc. of Florida, speaking against
**11:39:05 AM** Dina Justice, Mom to Emily, speaking for the bill
**11:40:02 AM** Alison Tant, parent, speaking for information
**11:44:00 AM** Barbara Braun, Waiver Support Coordinator, Sarasota, FL, speaking against the bill
**11:47:13 AM** Senator Mayfield
**11:48:09 AM** Barbara
**11:49:43 AM** Suzanne Sewell, President and CEO, Fla. Assoc. of Rehabilitation, speaking for information
**11:54:36 AM** Senator Bean
**11:54:55 AM** Valerie Breen, Exec. Director, Fla. Developmental Disabilities Council, speaking against
**11:57:43 AM** Amanda Baker, Advocate, speaking for information
**12:00:55 PM** Olivia Babis, Disability Rights of Florida, speaking against
**12:05:28 PM** Kirk Hall, CEO, ARC of Florida, speaking for information
**12:08:10 PM** Ryan Chandler, Support Coordinator, Assoc. of Supp. Coord. Agencies, speaking for information
**12:10:25 PM** James Otto, Clay County, speaking for information
**12:12:13 PM** Chair - Any debate?
**12:12:19 PM** Senator Rader
**12:17:30 PM** Senator Harrell
**12:19:24 PM** Senator Wright
**12:19:52 PM** Senator Mayfield
**12:21:52 PM** Chair
**12:22:36 PM** Senator Bean to close
**12:26:49 PM** Roll Call on SB 82 - Favorable
**12:27:28 PM** Senator Mayfield moves to adjourn. Without objection, we are adjourned