By the Committee on Health and Human Services Appropriations; and Senator Peaden

603-03260-10 20101468c1

A bill to be entitled

An act relating to home and community-based services; amending s. 393.0661, F.S.; reducing the annual maximum expenditure to each client assigned by the Agency for Persons With Disabilities to tier one, tier two, tier three, and tier four level services; eliminating behavior assistant services in certain group homes as a deliverable service to eligible clients; creating s. 393.0662, F.S.; establishing the iBudget program for the delivery of home and community-based services; providing for amendment of current contracts to implement the iBudget system; providing for the phasing in of the program; requiring clients to use certain resources before using funds from their iBudget; requiring the agency to provide training for clients and evaluate and adopt rules with respect to the iBudget system; providing an effective date.

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

Section 1. Paragraphs (a), (b), (c), (d), and (f) of subsection (3) of section 393.0661, Florida Statutes, are amended to read:

393.0661 Home and community-based services delivery system; comprehensive redesign.—The Legislature finds that the home and community-based services delivery system for persons with developmental disabilities and the availability of appropriated funds are two of the critical elements in making services

available. Therefore, it is the intent of the Legislature that the Agency for Persons with Disabilities shall develop and implement a comprehensive redesign of the system.

(3) The Agency for Health Care Administration, in consultation with the agency, shall seek federal approval and implement a four-tiered waiver system to serve eligible clients through the developmental disabilities and family and supported living waivers. The agency shall assign all clients receiving services through the developmental disabilities waiver to a tier based on a valid assessment instrument, client characteristics, and other appropriate assessment methods.

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

(b) Tier two is limited to clients whose service needs include a licensed residential facility and who are authorized to receive a moderate level of support for standard residential habilitation services or a minimal level of support for behavior focus residential habilitation services, or clients in supported living who receive more than 6 hours a day of in-home support services. Total annual expenditures under tier two may not exceed $49,500 ~~$55,000~~ per client each year.

(c) Tier three includes, but is not limited to, clients requiring residential placements, clients in independent or

supported living situations, and clients who live in their family home. Total annual expenditures under tier three may not exceed $31,500 ~~$35,000~~ per client each year.

(d) Tier four is the family and supported living waiver and includes, but is not limited to, clients in independent or supported living situations and clients who live in their family home. Total annual expenditures under tier four may not exceed $13,313 ~~$14,792~~ per client each year.

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

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

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

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

4. Residential habilitation services are limited to 8 hours per day. Additional hours may be authorized for persons who have intensive medical or adaptive needs and if such hours are essential for avoiding institutionalization, or for persons who possess behavioral problems that are exceptional in intensity, duration, or frequency and present a substantial risk of harming themselves or others. This restriction shall be in effect until

the four-tiered waiver system is fully implemented.

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

6. Massage therapy, medication review, behavior assistant services provided in a standard or behavior-focus group home, and psychological assessment services are eliminated.

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

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

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

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

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

Section 2. Section 393.0662, Florida Statutes, is created to read:

393.0662 Individual budgets for delivery of home and community-based services; iBudget system established.—The Legislature finds that improved financial management of the existing home and community-based Medicaid waiver program is necessary to avoid deficits that impede the provision of services to individuals who are on the waiting list for enrollment in the program. The Legislature further finds that clients and their families should have greater flexibility to choose the services that best allow them to live in their community within the limits of an established budget. Therefore, the Legislature intends that the agency, in consultation with the Agency for Health Care Administration, develop and implement a comprehensive redesign of the service delivery system using individual budgets as the basis for allocating the funds appropriated for the home and community-based services Medicaid waiver program among eligible enrolled clients. The service delivery system that uses individual budgets shall be called the iBudget system.

(1) The agency shall establish an individual budget, referred to as an iBudget, for each individual served by the home and community-based services Medicaid waiver program. The funds appropriated to the agency shall be allocated through the

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

(a) In developing each client's iBudget, the agency shall use an allocation algorithm and methodology. The algorithm shall use variables that have been determined by the agency to have a statistically validated relationship to the client's level of need for services provided through the home and community-based services Medicaid waiver program. The algorithm and methodology may consider individual characteristics, including, but not limited to, a client's age and living situation, information from a formal assessment instrument that the agency determines is valid and reliable, and information from other assessment processes.

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

1. An extraordinary need that would place the health and safety of the client, the client's caregiver, or the public in

immediate, serious jeopardy unless the increase is approved. An extraordinary need may include, but is not limited to:

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

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

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

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

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

2. A significant need for one-time or temporary support or services that, if not provided, would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy, unless the increase, as determined by the total of the algorithm and any adjustments based on subparagraphs 1. and 3., is approved. A significant need may include, but is not limited to, the provision of environmental modifications, durable medical equipment, services to address the temporary loss of support from a caregiver, or special

services or treatment for a serious temporary condition when the service or treatment is expected to ameliorate the underlying condition. As used in this subparagraph, the term "temporary" means a period of less than 12 continuous months.

3. A significant increase in the need for services 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 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 and which cannot be accommodated within the client's current iBudget. As used in this subparagraph, the term "long-term" means a period of 12 or more continuous months.

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

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

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

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

(a) While the agency phases in the iBudget system, the agency may continue to serve eligible, enrolled clients under the four-tiered waiver system established under s. 393.065 while those clients await the transitionto the iBudget system.

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

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

(5) Rates for any or all services established under rules of the Agency for Health Care Administration shall be designated as the maximum rather than a fixed amount for individuals who receive an iBudget, except for services specifically identified

in those rules which the agency determines are not appropriate for negotiation, including, but not limited to, residential habilitation services.

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

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

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

Section 3. This act shall take effect July 1, 2010.