

By the Policy and Steering Committee on Ways and Means; the Committee on Health and Human Services Appropriations; and Senator Peadar

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1 A bill to be entitled
2 An act relating to home and community-based services;
3 amending s. 393.0661, F.S.; reducing the annual
4 maximum expenditure to each client assigned by the
5 Agency for Persons With Disabilities to tier one, tier
6 two, tier three, and tier four level services;
7 eliminating behavior assistant services in certain
8 group homes as a deliverable service to eligible
9 clients; creating s. 393.0662, F.S.; establishing the
10 iBudget program for the delivery of home and
11 community-based services; providing for amendment of
12 current contracts to implement the iBudget system;
13 providing for the phasing in of the program; requiring
14 clients to use certain resources before using funds
15 from their iBudget; requiring the agency to provide
16 training for clients and evaluate and adopt rules with
17 respect to the iBudget system; providing a contingent
18 effective date.

19
20 Be It Enacted by the Legislature of the State of Florida:

21
22 Section 1. Paragraphs (a), (b), (c), (d), and (f) of
23 subsection (3) of section 393.0661, Florida Statutes, are
24 amended to read:

25 393.0661 Home and community-based services delivery system;
26 comprehensive redesign.—The Legislature finds that the home and
27 community-based services delivery system for persons with
28 developmental disabilities and the availability of appropriated
29 funds are two of the critical elements in making services

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

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

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

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

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

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

62 (d) Tier four is the family and supported living waiver and
63 includes, but is not limited to, clients in independent or
64 supported living situations and clients who live in their family
65 home. Total annual expenditures under tier four may not exceed
66 \$13,313 ~~\$14,792~~ per client each year.

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

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

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

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

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

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88 the four-tiered waiver system is fully implemented.

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

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

97 7. The agency shall conduct supplemental cost plan reviews
98 to verify the medical necessity of authorized services for plans
99 that have increased by more than 8 percent during either of the
100 2 preceding fiscal years.

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

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

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

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

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

124 393.0662 Individual budgets for delivery of home and
125 community-based services; iBudget system established.—The
126 Legislature finds that improved financial management of the
127 existing home and community-based Medicaid waiver program is
128 necessary to avoid deficits that impede the provision of
129 services to individuals who are on the waiting list for
130 enrollment in the program. The Legislature further finds that
131 clients and their families should have greater flexibility to
132 choose the services that best allow them to live in their
133 community within the limits of an established budget. Therefore,
134 the Legislature intends that the agency, in consultation with
135 the Agency for Health Care Administration, develop and implement
136 a comprehensive redesign of the service delivery system using
137 individual budgets as the basis for allocating the funds
138 appropriated for the home and community-based services Medicaid
139 waiver program among eligible enrolled clients. The service
140 delivery system that uses individual budgets shall be called the
141 iBudget system.

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

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

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

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

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

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

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

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

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

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

191
192 However, the presence of an extraordinary need alone does not
193 warrant an increase in the amount of funds allocated to a
194 client's iBudget as determined by the algorithm.

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

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

208 3. A significant increase in the need for services after
209 the beginning of the service plan year which would place the
210 health and safety of the client, the client's caregiver, or the
211 public in serious jeopardy because of substantial changes in the
212 client's circumstances, including, but not limited to, permanent
213 or long-term loss or incapacity of a caregiver, loss of services
214 authorized under the state Medicaid plan due to a change in age,
215 or a significant change in medical or functional status which
216 requires the provision of additional services on a permanent or
217 long-term basis and which cannot be accommodated within the
218 client's current iBudget. As used in this subparagraph, the term
219 "long-term" means a period of 12 or more continuous months.

220
221 The agency shall reserve portions of the appropriation for the
222 home and community-based services Medicaid waiver program for
223 adjustments required pursuant to this paragraph and may use the
224 services of an independent actuary in determining the amount of
225 the portions to be reserved.

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

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

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

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

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

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

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

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

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

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

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

285 Section 3. This act shall take effect July 1, 2010;
286 however, the amendments to s. 393.0661(3)(b), (c), (d), and
287 (f)6., Florida Statutes, made by this act do not take effect if
288 federal law extends the enhanced Federal Medicaid Assistance
289 Percentage rate, as provided under the American Reinvestment and
290 Recovery Act (Pub. L. No. 111-5), from December 31, 2010,

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291 through June 30, 2011.