

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 Appropriations Subcommittee on Health and Human Services

BILL: SB 82

INTRODUCER: Senator Bean

SUBJECT: Individuals with Disabilities

DATE: January 27, 2020

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	<u>Delia</u>	<u>Hendon</u>	<u>CF</u>	Favorable
2.	<u>Gerbrandt</u>	<u>Kidd</u>	<u>AHS</u>	Pre-meeting
3.	<u> </u>	<u> </u>	<u>AP</u>	<u> </u>

I. Summary:

SB 82 makes operational changes to the Medicaid Home and Community-Based Services (HCBS) Waiver to improve the quality of services provided and to standardize agency processes by:

- Requiring support coordination services to be provided by qualified organizations who contract with the Agency for Persons with Disabilities (APD); and
- Requiring the Agency for Health Care Administration (AHCA) to contract with a qualified organization to perform medical necessity determinations.

The bill eliminates the criteria that APD must consider when authorizing supplemental funding for a significant additional needs request, and instead creates a standard definition of a ‘significant additional need.’ The bill requires APD to certify and document that a HCBS Waiver client has utilized all available resources prior to the submission of a significant additional needs request.

The bill requires all service providers to 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 allows AHCA to seek federal approval to implement an increased rate for Medicaid intermediate care facilities that serve individuals with developmental disabilities who have severe behavioral or mental health needs.

The bill is not expected to have a fiscal impact on state expenditures. If the bill results in any cost savings, the savings would allow the agency to address the HCBS Waiver waitlist.

The bill takes effect on July 1, 2020.

II. Present Situation:

Agency for Persons with Disabilities

Florida obtained waivers of federal Medicaid requirements to enable the provision of home and community-based services to persons at risk of institutionalization.¹ The Agency for Persons with Disabilities (APD) is responsible the provision of services to individuals with developmental disabilities² and for administering the Home and Community-Based Services (HCBS) Waiver.³ The HCBS Waiver provides services to individuals with developmental disabilities that allow them to continue to live in their home or home-like setting and avoid institutionalization.⁴ Eligible individuals must meet institutional level of care requirements.⁵

Individuals who have a developmental disability and who meet Medicaid eligibility requirements, may receive services in the community through the state's HCBS Waiver or in an institution, such as an intermediate care facility for the developmentally disabled (ICF/DD) through the state's Medicaid program.

Home and Community-Based Services Waiver (iBudget Florida)

The HCBS Waiver for individuals with developmental disabilities, known as the iBudget, provides 26 supports and services including, but not limited to, residential habilitation, behavioral services, companion services, adult day training, employment services, and physical therapy.⁶ Services provided through the HCBS Waiver enable individuals to live in the community in their own home, a family home, or in a licensed residential setting, thereby avoiding institutionalization.

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.⁷ The iBudget involves the use of an algorithm⁸ to set individual allocation amounts⁹ for each client by allocating available funding based on an assessment of the needs of each client.

¹ Rule 59G-13.080(1), F.A.C.

² A developmental disability is defined as a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid 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. *See s. 393.0612(12), F.S.*

³ Section 20.197(3), F.S.

⁴ The Centers for Medicare and Medicaid Services, Home and Community-Based Services 1915(c), available at: <https://www.medicare.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html> (last visited January 21, 2020).

⁵ *Supra* note 1.

⁶ A full list of covered services offered under Florida's HCBS Waiver can be found at: https://ahca.myflorida.com/Medicaid/hcbs_waivers/ibudget.shtml (last visited January 17, 2020).

⁷ 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).

⁸ The allocation algorithm is a mathematical formula based upon statistically validated relationships between individual characteristics (variables) and the individual's level of need for services provided through the Waiver. *See* Rule 65G-4.0213(1), F.A.C.

⁹ The allocation algorithm amount is the result of the allocation algorithm apportioned according to available funding. *See* Rule 65G-4.0213(2), F.A.C.

The APD uses an assessment tool known as the Questionnaire for Situational Information (QSI) to determine a client's needs in the areas of functional, behavioral, and physical status.¹⁰ All clients must have a QSI assessment completed prior to calculating the allocation amount. Clients can be reassessed any time there has been a significant change in the circumstance or condition that would impact any of the questions that are used as variables in the algorithm.¹¹

After a client's initial allocation amount is determined, the client and their family meet with a Waiver Support Coordinator (WSC)¹² to discuss their allocation and develop a cost plan. The cost plan is an annual document that lists all authorized services, the anticipated costs of each service and the approved provider of each service.¹³ The cost of all services within a client's cost plan must be lower than the client's allocation amount unless there is a significant additional need demonstrated.¹⁴ Every proposed cost plan is reviewed and approved by the APD.¹⁵

If the client or the client's representative feels that the needs of the client cannot be met within the allocation amount, the WSC must identify and document the additional service request and submit it to the APD. The APD is required to approve requests for increases to the allocation amount if the request meets the Significant Additional Needs criteria (see subsection below titled Significant Additional Needs Criteria).¹⁶ The APD is required to ensure that the sum of all clients' proposed expenditures do not exceed the agency's annual appropriation.¹⁷

As of October 2019, 34,919 individuals were enrolled in the iBudget program.¹⁸ In Fiscal Year 2019-2020 the Legislature appropriated \$1.2 billion for the iBudget program, including \$462.8 million in general revenue funds and \$733.6 million in federal trust funds.¹⁹

Waiver Waitlist

The APD maintains a prioritized wait list for HCBS Waiver services.²⁰ Currently, there are 21,433 people on the HCBS Waiver waitlist.²¹ Medicaid-eligible persons on the wait list can continue to receive Medicaid services offered through the Agency for Health Care Administration (AHCA).

¹⁰ Rule 65G-4.0213(18), F.A.C.

¹¹ Rule 65G-4.0214(1)(d), F.A.C.

¹² Waiver support coordinators assist Waiver clients and their families in identifying, developing, coordinating and accessing supports and services in their communities. Supports and services can be provided through a variety of funding sources such as the iBudget, third-party payers and natural supports. *See* Rule 65G-4.0213(27), F.A.C.

¹³ Rule 65G-4.0213(4), F.A.C.

¹⁴ Rule 65G-4.0215(1)(c), F.A.C. A significant additional need represents a need for additional funding that if not provided would place the health and safety of the client, their caregiver, or public in serious jeopardy. *See* s. 393.0662(1)(b), F.S.

¹⁵ The APD conducts an individual review of information submitted by a WSC, to determine if the request meets significant additional needs criteria. *See* Rule 65G-4.0213(14), F.A.C.

¹⁶ Rule 65G-4.0216(3), F.A.C. Significant additional needs criteria can be found at Section 393.0662(1)(b), F.S. and Rule 65G-4.0218, F.A.C.

¹⁷ *See* s. 393.0662(1)(c), F.S., and Rules 65G-4.0216(5), and 65G-4.0218(2), F.A.C.

¹⁸ 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).

¹⁹ *See* Specific Appropriation 245, section 3, Ch. 2019-115, Laws of Florida.

²⁰ Section 393.065(5), F.S.

²¹ Email from Jeff Ivey, Legislative Affairs Director, Agency for Persons with Disabilities, to Peter Delia, Senior Attorney, Senate Committee on Children, Families, and Elder Affairs (on file with the Appropriations Subcommittee on Health and Human Services).

Significant Additional Needs Criteria

Currently, clients can request supplemental funding, in addition to that allocated through the algorithm, that if not provided would place the health and safety of the client, the client's caregiver, or public in serious jeopardy.²² This supplemental funding, known as a 'Significant Additional Need,' is categorized as an extraordinary need, a significant need for one time or temporary support or services, or a significant increase in the need for services after the beginning of the service plan year, and a significant need for transportation services.²³

An extraordinary need may include, but is not limited to:²⁴

- 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;
- 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;
- A chronic comorbid condition; or
- A need for total physical assistance with activities such as eating, bathing, toileting, grooming, and personal hygiene.

A significant need for one-time or temporary support or services may include, but is not limited to the need for:²⁵

- 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.

A significant increase in the need for services after the beginning of the service plan year may include, but is not limited to:²⁶

- 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.

If public transportation is not an option due to the unique needs of the client or other transportation resources are not reasonably available, supplemental funding may be approved for transportation services to a waiver-funded adult day training program or employment services.²⁷

²² Section 393.0662(1)(b), F.S.

²³ Rule 65G-4.0213(23), F.A.C.

²⁴ Section 393.0662(1)(b)1., F.S.

²⁵ Section 393.0662(1)(b)2., F.S.

²⁶ Section 393.0662(1)(b)3., F.S.

²⁷ Section 393.0662(1)(b)4., F.S.

The APD is required to approve requests for increases to the allocation amount if the request meets the Significant Additional Needs criteria.²⁸ If a client's allocation amount includes significant additional needs beyond what is determined by the algorithm and the APD determines that the service intensity, frequency or duration is no longer necessary, the APD is required to adjust the services to match the current need.²⁹

Currently, the APD is required to document the information necessary to evaluate significant additional needs requests. The documentation may include the following:³⁰

- Support plans;
- QSI results;
- Cost plans;
- Expenditure history;
- Current living situation;
- Interviews with the client or the client's caregiver;
- Prescriptions;
- Data regarding the results of previous therapies and interventions;
- Assessments; and
- Provider documentation.

Currently, no additional funding for significant additional needs can be provided if the need for additional funding is not premised upon a need that arises after the implementation of the initial iBudget amount,³¹ or is created by a client's failure to ensure that funding remained sufficient to cover previously authorized services.³²

Medical Necessity

There is no federal definition of medical necessity. Instead, the federal government has left it up to each state to create its own definition of medical necessity and limit Medicaid services based on that definition.³³ Any optional service provided under Medicaid, such as home and community-based services, must be provided only when medically necessary.³⁴

Medically necessary or medical necessity is defined in Florida as medical or allied care, goods, or services furnished or ordered that meet the following conditions:³⁵

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

²⁸ Rule 65G-4.0216(3), F.A.C. Significant additional needs criteria can be found at Section 393.0662(1)(b), F.S. and Rule 65G-4.0218, F.A.C.

²⁹ Rule 65G-4.0218(4), F.A.C.

³⁰ Rule 65G-4.0218(5), F.A.C.

³¹ The iBudget amount is the total amount of funds approved by the APD. See Rules 65G-4.0213, F.A.C., and 65G-4.0216, F.A.C.

³² Rule 65G-4.0218(7), F.A.C.

³³ Memorandum to Stuart Williams, General Counsel, Agency for Health Care Administration from Tracy George, Chief Appellate Counsel, Agency for Health Care Administration (January 8, 2013) (on file with the Senate Appropriations Subcommittee on Health and Human Services).

³⁴ Section 409.906, F.S.

³⁵ 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.

Currently, the APD, with concurrence of the AHCA, may contract for the determination of medical necessity and establishment of individual budgets.³⁶ Additionally, the AHCA may implement a utilization management program designed to prior authorize home and community-based services, preauthorize high-cost or highly utilized services, or make any other adjustments necessary to comply with the limitations or directions provided for in the General Appropriations Act.³⁷

iBudget Program Deficits

In Fiscal Year 2017-2018, the APD exceeded its legislative appropriation for the iBudget by \$56.9 million. In Fiscal Year 2018-2019, the APD exceeded its legislative appropriation for the iBudget by \$107.9 million, and the APD is projected to exceed its appropriation in Fiscal Year 2019-2020 by \$134.3 million.

In 2019, the Florida Auditor General evaluated the APD's administration of the iBudget, including the effectiveness of the allocation methodology and algorithm in achieving the legislative intent of the iBudget.^{38,39} The evaluation concluded that despite statistical validity underlying the algorithm, statutory allowances for significant additional needs have prevented APD from achieving the financial management goals of the iBudget and reducing the number of individuals on the waiting list.⁴⁰

As a result of continued deficits, the 2019 Legislature directed APD, in conjunction with AHCA, to develop a plan to redesign the iBudget program and submit the plan to the Legislature.⁴¹ The plan was required to address the following areas:⁴²

³⁶ Section 393.0661(1)(b), F.S.

³⁷ Section 409.906(13), F.S.

³⁸ 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).

³⁹ The Legislature intended that the iBudget improve the financial management of the existing HCBS Waiver to avoid deficits that impeded the provision of services to individuals who are on the waiting list for enrollment in the program. *See s.* 393.0662, F.S.

⁴⁰ *Supra* note 44.

⁴¹ Ch. 2019-116, Laws of Florida.

⁴² *Id.*

- Specific steps to restrict spending to budgeted amounts based on alternatives to the iBudget and four-tiered Medicaid waiver models;
- Identification of core services that are essential to provide for client health and safety and recommend elimination of coverage for other services that are not affordable based on available resources;
- The redesign shall be responsive to individual needs and to the extent possible encourage client control over allocated resources for their needs; and
- The plan shall modify the manner of providing support coordination services to improve management of service utilization and increase accountability and responsiveness to agency priorities.

In response, the APD submitted a proposed redesign of the iBudget consisting of the following elements:⁴³

- 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;
- 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 Coordination

Waiver support coordination services are provided by waiver support coordinators (WSCs), who assist clients in gaining access to needed medical, social, educational and other services, regardless of funding source.⁴⁴ All iBudget clients are required to receive a certain level of waiver support coordination services.⁴⁵ WSCs are responsible for the ongoing monitoring of supports and services provided to clients and are tasked with ensuring that clients receive the level of services they are entitled to and need under the iBudget including:⁴⁶

- Locating, selecting and coordinating services and supports, whether paid with waiver funds or other resources;
- Documenting monthly progress of services rendered;

⁴³ 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).

⁴⁴ Rule 59G-13.080(3)(e), F.A.C.

⁴⁵ There are 3-levels of waiver support coordination services: full, enhanced and limited. The level of service requirements are described in the Agency for Health Care Administration, *Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook* (2015), available at: <http://apd.myflorida.com/ibudget/rules-regs.htm> (last visited January 19, 2020).

⁴⁶ Agency for Health Care Administration, *Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook* (2015), available at: <http://apd.myflorida.com/ibudget/rules-regs.htm> (last visited January 19, 2020).

- A minimum of two monthly contacts with or on behalf of the Waiver client, or contact with another provider to discuss progress toward achieving goals identified in the client's support plan (WSCs are expected to meet the needs of the individuals they serve regardless of the number of contacts it takes to meet those needs);
- Monitoring client's health and safety and well-being and assist them in reaching desired outcomes; and
- Maintaining client's current annual support plan, cost plan and supporting documents.

WSCs must pass a level-two background screen, meet provider qualifications⁴⁷ and requirements,⁴⁸ complete a Medicaid Provider Enrollment application, complete an APD provider application, and be assigned a Medicaid provider number.⁴⁹

WSCs enroll as either a solo⁵⁰ or an agency⁵¹ Medicaid provider.⁵² For most services under the waiver, other than support coordination, agency providers can bill at an agency rate. Waiver support coordination services, however, are billed at one rate.⁵³

Support coordination agencies have additional responsibilities to:⁵⁴

- Have a comprehensive internal quality assurance management plan (which should include a systematic method of inspecting and reviewing all required documentation and activities) to actively monitor and supervise WSCs employed by their agency;
- Provide ongoing technical assistance and training to their employees in order to ensure that they are adequately fulfilling their job requirements as a WSC and Medicaid provider; and
- Maintain personnel files documenting the qualifications of all employees, completion of all required training, and background screening results.

The APD, the AHCA, or an authorized representative of the state monitor support coordinators on an annual basis.⁵⁵ 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 client receiving services to assure outcomes are being met, adequate follow through is being done and services are satisfactory to the client.⁵⁶

⁴⁷ Qualifications include, but are not limited to, a bachelor's degree, and, at a minimum, 2-years of paid, supervised experience in developmental disabilities, special education, mental health, counseling, guidance, social work or health and rehabilitative services.

⁴⁸ Requirements include, but are not limited to, a minimum of 60 hours of pre-service training, including 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.

⁴⁹ *Supra* note 46.

⁵⁰ A solo or independent provider is a person who personally renders waiver services directly to recipients and does not employ others to render waiver services for which the rate is being paid. *See Supra* note 46 at pg. 1-10.

⁵¹ An agency provider is a business or organization enrolled to provider waiver services that has two or more employees to carry out the enrolled service, including the agency owner. An agency or group provider for rate purposes is a provider that employees staff to perform waiver services. A provider that hires only subcontractors to perform waiver services is not considered an agency provider for rate purposes. *See Supra* note 46 at pg. 1-2.

⁵² *Id.*

⁵³ Rule 59G-13.081, F.A.C.

⁵⁴ *Supra* note 46 at pg. 2-84.

⁵⁵ *Supra* note 46 at pg. A-9.

⁵⁶ *Supra* note 46.

HCBS Waiver services should be one element of the supports available to clients. Clients, families, legal representatives, WSCs, and providers are responsible for seeking non-waiver supports to augment and even replace HCBS waiver-paid services. The HCBS Waiver should be the payer of last resort.⁵⁷

Client Data Management System (iConnect)

The federal Centers for Medicare and Medicaid Services requires that all states that offer personal care and/or home health services through a waiver must utilize an electronic visit verification (EVV) system to verify when and where a service is being provided and the actual amount of time the provider spends with the customer.⁵⁸ APD has contracted with a vendor to create a central client data management system, known as iConnect. The iConnect system will provide EVV functionality, as well as electronic billing and centralization of client records.

Currently, providers bill for services through the AHCA Florida Medicaid Management Information System (FMMIS).⁵⁹

Agency for Health Care Administration

Individuals who have a developmental disability and who meet Medicaid eligibility requirements may receive services in an institution, such as an intermediate care facility for the developmentally disabled (ICF/DD) through the state's Medicaid program. The AHCA is responsible for licensing and oversight of ICF/DDs in Florida.⁶⁰ ICF/DDs provide the following services: nursing services, activity services, dental services, dietary services, pharmacy services, physician services, rehabilitative care services, room/bed and maintenance services and social services.⁶¹

While the majority of individuals who have a developmental disability live in the community, a small number live in ICF/DDs. In Florida, there are 88 privately owned ICF/DD facilities. As of April 2018, the ICF/DDs are 94.6 percent occupied, with 1,948 individuals in 2,060 possible slots.⁶²

⁵⁷ *Supra* note 46 at pg. 2-75.

⁵⁸ Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Frequently Asked Questions: Section 12006 of the 21st Century Cures Act, Electronic Visit Verification (EVV) Systems for Personal Care Services (PCS) and Home Health Care Services (HHCS)*, available at: <https://www.medicaid.gov/medicaid/home-community-based-services/guidance/electronic-visit-verification-evv/index.html> (last visited January 21, 2020).

⁵⁹ Agency for Persons with Disabilities iConnect Proposed Redraft Analysis. On file with the Senate Children, Families, and Elder Affairs Committee.

⁶⁰ See ss. 400.962 and 400.967, F.S.

⁶¹ Agency for Health Care Administration, *Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/DD) Services*, available at: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/behavioral_health_coverage/bhfu/Intermediate_Care.shtml (last visited January 21, 2020).

⁶² 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 and Families and Elder Affairs Committee).

ICF/DDs are considered institutional placements and are reimbursed for care through the AHCA Medicaid program. ICF/DDs are reimbursed based on two levels of care, which are based on the client's mobility:⁶³

- ICF 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; and
- ICF 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.

ICF/DD providers in Florida have reported an increase in the number of recipients with severe behavioral needs that require significant resources to provide appropriate care beyond what is currently provided through the level one and level two-reimbursement methodology.⁶⁴

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 APD.

Section 2 amends s. 393.066, F.S., requiring all HCBS Waiver service 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. The bill also eliminates the existing review criteria for significant additional needs requests. Such criteria has not been effective in limiting the iBudget supplemental funding increases approved by APD. Other provisions are moved to s. 393.0662, F.S.

Section 4 amends s. 393.0662, F.S., requiring that 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 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 certain reports to the Governor and the Legislature. 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 HCBS Waiver clients. The

⁶³ *Id.*

⁶⁴ *Id.*

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;
- Support coordinators to ensure client budgets are linked to respective levels of need;
- Support coordinators to avoid potential conflicts of interest; and
- WSC organizations to perform and meet all standards related to support coordination currently in statute and rule.

The bill requires that the contracts be three years in length and permits a contract to be renewed up to three times, but each renewal may not exceed one year in length. 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 directs AHCA to seek federal approval to implement an increased rate for Medicaid intermediate care facilities for the developmentally disabled that serve individuals with developmental disabilities who have severe behavioral and mental health needs.

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:

SB 82 will have 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 have hardware/software that can potentially interface with the Agency for Persons with Disabilities (APD) iConnect billing system may be required to purchase new hardware/software that can interface with iConnect, and to train staff on the use of iConnect. Service providers may also incur costs associated with dual data entry if the provider utilizes a different IT system and must manually input data into iConnect. The fiscal impact of the iConnect billing requirements on private service providers is negative but indeterminate.

C. Government Sector Impact:

The bill's requirement to centralize medical necessity determinations with a third party contractor may have a positive fiscal impact on state expenditures by decreasing the number of employees at APD that currently provide medical necessity determinations. However, this cost savings will be offset by the required increase in the contracted services category, under the Agency for Health Care Administration, to contract out this function. Any cost savings realized as a function of contracting medical necessity out to a third party would allow the agency to address the Home and Community-based Waiver waitlist.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

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

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.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.
