By Senator Bean

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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.