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 centralize medical necessity determinations of certain services; 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 Executive Office of the Governor and the chairs of the Senate Appropriations Committee and the House Appropriations Committee or their successor committees; providing requirements for such reports; requiring the Agency for Persons with Disabilities, in consultation with the Agency for Health Care Administration, to submit a certain plan to the Executive Office of the Governor, the chair of the Senate Appropriations Committee, and the chair of the House Appropriations Committee under certain conditions; requiring the agency to work with the Agency for Health Care Administration to implement such plan; 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.; providing legislative intent; defining the term "qualified organization"; requiring the Agency for Persons with Disabilities to use qualified organizations to provide support coordination services for certain clients; providing requirements for qualified organizations; providing agency duties; providing for the review and appeal of certain decisions made by the agency; authorizing the agency to adopt rules; amending s. 400.962, F.S.; requiring certain facilities that have

been granted a certificate-of-need exemption to demonstrate and maintain compliance with specified criteria; amending s. 408.036, F.S.; providing an exemption from a certificate-of-need requirement for certain intermediate care facilities; limiting the number of such exemptions the Agency for Health Care Administration may grant; providing that a specific legislative appropriation is not required for such exemption; amending s. 409.906, F.S.; requiring the agency to seek federal approval to implement certain payment rates; amending s. 1002.385, F.S.; conforming a cross-reference; 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 an additional need for medically necessary services which would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy if it is not met. The term does not exclude services for an additional need that the client requires in order to remain in the least restrictive setting, including, but not limited to, employment services and transportation services.

The agency may provide additional funding only after the determination of a client's initial allocation amount and after the qualified organization has documented the availability of nonwaiver resources.

(42) ~~(41)~~ "Support coordinator" means an employee of a qualified organization as provided in 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 and before billing, persons or entities under contract with the agency to provide services shall use agency data management systems to document service provision to clients shall use such 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 qualified organization has documented the availability of all nonwaiver resources. Upon receipt of an incomplete request for services to meet significant additional needs, the agency shall close the request.

(c) The agency shall centralize, within its headquarters,

medical necessity determinations for requested services made through the significant additional needs process. The process must ensure consistent application of medical necessity criteria. This process must provide opportunities for targeted training, quality assurance, and inter-rater reliability. ~~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.~~

(d) ~~(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.

(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 support coordination services that 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 will prevent 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 will prevent institutionalization, or for persons who have behavioral problems that are exceptional in intensity, duration, or frequency and who present a substantial risk of harm to 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 is 7.5 percent.

(h) The geographic differential for Monroe County for residential habilitation services is 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 must 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 which contain all of the following information:

(a) The financial status of home and community-based services, including the number of enrolled individuals receiving

services through one or more programs.

(b) The number of individuals who have requested services and who are not enrolled but who are receiving services through one or more programs, with a description indicating the programs under 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 committee, and the chair of the House Appropriations Committee or its successor committee 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 must 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 services to meet 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 Support coordination; legislative intent; qualified organizations; agency duties; due process; rulemaking.—

(1) LEGISLATIVE INTENT.—To enable the state to provide a systematic approach to service oversight for persons providing care to individuals with developmental disabilities, it is the intent of the Legislature that the agency work in collaboration with relevant stakeholders to ensure that waiver support coordinators have the knowledge, skills, and abilities necessary to competently provide services to individuals with developmental disabilities by requiring all support coordinators

to be employees of a qualified organization.

(2) QUALIFIED ORGANIZATIONS.—

(a) As used in this section, the term "qualified organization" means an organization determined by the agency to meet the requirements of this section and of the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook.

(b) The agency shall use qualified organizations for the purpose of providing all support coordination services to iBudget clients in this state. In order to be qualified, an organization must:

1. Employ four or more support coordinators;

2. Maintain a professional code of ethics and a disciplinary process that apply to all support coordinators within the organization;

3. Comply with the agency's cost containment initiatives;

4. Require support coordinators to ensure that client budgets are linked to levels of need;

5. Require support coordinators to perform all duties and meet all standards related to support coordination as provided in the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook;

6. Prohibit dual employment of a support coordinator if the dual employment adversely impacts the support coordinator's availability to clients;

7. Educate clients and families regarding identifying and preventing abuse, neglect, and exploitation;

8. Instruct clients and families on mandatory reporting requirements for abuse, neglect, and exploitation;

9. Submit within established timeframes all required documentation for requests for significant additional needs;

10. Require support coordinators to successfully complete training and professional development approved by the agency;

11. Require support coordinators to pass a competency-based assessment established by the agency; and

12. Implement a mentoring program approved by the agency for support coordinators who have worked as a support coordinator for less than 12 months.

(3) DUTIES OF THE AGENCY.—The agency shall:

(a) Require all qualified organizations to report to the agency any violation of ethical or professional conduct by support coordinators employed by the organization;

(b) Maintain a publicly accessible registry of all support coordinators, including any history of ethical or disciplinary violations; and

(c) Impose an immediate moratorium on new client assignments, impose an administrative fine, require plans of remediation, and terminate the Medicaid Waiver Services Agreement of any qualified organization that is noncompliant with applicable laws or rules.

(4) DUE PROCESS.—Any decision by the agency to take action against a qualified organization as described in paragraph (3)(c) is reviewable by the agency. Upon receiving an adverse determination, the qualified organization may request an administrative hearing pursuant to ss. 120.569 and 120.57(1) within 30 days after completing any appeals process established by the agency.

(5) RULEMAKING.—The agency may adopt rules to implement

this section.

Section 6. Subsection (6) is added to section 400.962, Florida Statutes, to read:

400.962 License required; license application.—

(6) An applicant that has been granted a certificate-of-need exemption under s. 408.036(3)(o) must also demonstrate and maintain compliance with the following criteria:

(a) The total number of beds per home within the facility may not exceed eight, with each resident having his or her own bedroom and bathroom. Each eight-bed home must be colocated on the same property with two other eight-bed homes and must serve individuals with severe maladaptive behaviors and co-occurring psychiatric diagnoses.

(b) A minimum of 16 beds within the facility must be designated for individuals with severe maladaptive behaviors who have been assessed using the Agency for Persons with Disabilities' Global Behavioral Service Need Matrix with a score of at least Level 4 and up to Level 6, or assessed using the criteria deemed appropriate by the Agency for Health Care Administration regarding the need for a specialized placement in an intermediate care facility for the developmentally disabled. For home and community-based Medicaid waiver clients under chapter 393, the Agency for Persons with Disabilities shall offer choice counseling to clients regarding appropriate residential placement based on the needs of the individual.

(c) The applicant has not had a facility license denied, revoked, or suspended within the 36 months preceding the request for exemption.

(d) The applicant must have at least 10 years of experience

serving individuals with severe maladaptive behaviors in the state.

(e) The applicant must implement a state-approved staff training curriculum and monitoring requirements specific to the individuals whose behaviors require higher intensity, frequency, and duration of services.

(f) The applicant must make available medical and nursing services 24 hours per day, 7 days per week.

(g) The applicant must demonstrate a history of using interventions that are least restrictive and that follow a behavioral hierarchy.

(h) The applicant must maintain a policy prohibiting the use of mechanical restraints.

Section 7. Paragraph (o) is added to subsection (3) of section 408.036, Florida Statutes, to read:

408.036 Projects subject to review; exemptions.—

(3) EXEMPTIONS.—Upon request, the following projects are subject to exemption from subsection (1):

(o) For a new intermediate care facility for the developmentally disabled as defined in s. 408.032 which has a total of 24 beds, comprising three eight-bed homes, for use by individuals exhibiting severe maladaptive behaviors and co-occurring psychiatric diagnoses requiring increased levels of behavioral, medical, and therapeutic oversight. The applicant must not have had a license denied, revoked, or suspended within the 36 months preceding the request for exemption and must have at least 10 years of experience serving individuals with severe maladaptive behaviors in this state. The agency may grant no more than three exemptions under this paragraph.

1. An exemption under this paragraph does not require a specific legislative appropriation.

2. An exemption under this paragraph terminates 18 months after the date of issuance unless the exemption holder has commenced construction. The agency shall monitor the progress of the holder of the certificate of exemption in meeting the timetable for project development specified in the application for exemption. The agency shall extend the timeframe for a project if the exemption holder demonstrates to the satisfaction of the agency that good-faith commencement of the project is being delayed by litigation or by governmental action or inaction with respect to regulations or permitting precluding commencement of the project.

3. This paragraph and subsection (6) of s. 400.962 are repealed July 1, 2022, unless reviewed and saved from repeal by the Legislature.

Section 8. Subsection (15) of section 409.906, Florida Statutes, 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:

(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. <u>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.</u>

Section 9. 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 10. This act shall take effect July 1, 2021.