65G-4.0213 Definitions.

For the purposes of this chapter, the term:

(1) Allocation Algorithm: The mathematical formula based upon statistically validated relationships between individual characteristics (variables) and the individual's level of need for services provided through the Waiver as set forth in Rule 65G-4.0214 and as provided in Section 393.0662(1)(a), F.S.

(2) Amount Implementation Meeting Worksheet (AIM): A form used by the Agency for new waiver enrollees to (a) communicate an individual's Allocation Algorithm amount, (b) identify proposed services based upon the Allocation Algorithm amount, and (c) identify additional services, if any, should the individual or their representative feel that any Significant Additional Needs of the individual cannot be met within the Allocation Algorithm amount. The Amount Implementation Meeting (AIM) Worksheet ~~(AIM)~~ – APD 2015-01, effective December 3, 2014, is hereby adopted and incorporated by reference in the rule, and may be found on the Agency's website at http://apd.myflorida.com/ibudget/docs/AIM%20Excel%20for%20Rule.pdf,

(3) Approved Cost Plan: The document that lists all waiver services that have been authorized by the agency for the individual, including the anticipated cost of each approved waiver service, the provider of the approved service, and information regarding the provision of the approved service.

(4) Extraordinary Need: Has the same meaning as provided in Section 393.0662(1)(b), F.S.

(5) iBudget Amount: total amount of funds that have been approved by the agency, pursuant to the iBudget Rules, for an individual to expend for waiver services during a fiscal year.

(6) iBudget: The home and community-based services Medicaid waiver program under Section 409.906, F.S., that consists of the waiver service delivery system utilizing individual budgets required pursuant to Section 393.0662, F.S. and under which the Agency for Persons with Disabilities operates the Developmental Disabilities Individual Budgeting Waiver.

(7) iBudget Rules: Rules 65G-4.0213 through 65G-4.0218 are the rules which implement and interpret iBudget Amounts. ~~Section 393.0662, F.S.~~

(8) Individual: a person with a developmental disability, as defined by Section 393.063, F.S., and who is enrolled in iBudget.

(9) Individual representative: The individual's parent (for a minor), guardian, guardian advocate, person holding a power of attorney for decisions regarding health care or public benefits, healthcare surrogate, a designated representative (evidenced by a written designation), or individual's advocate. The individual's Waiver Support Coordinator shall ascertain whether an individual has any of these representatives and inform the agency of the identity and contact information. ~~When the term "legal representative" is used in the iBudget Rules it means only those individuals who have legal authority to act independently for the individual, such as the individual's parent (for a minor), guardian, guardian advocate, healthcare surrogate or person holding a power of attorney for decisions regarding health care or public benefits.~~

(10)(a) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. 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;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. 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

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) 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.

(11) Questionnaire for Situational Information (QSI) effective 2-15-08: An assessment instrument used by the Agency to determine an individual's needs in the areas of functional, behavioral, and physical status. The QSI is

adopted by the Agency as the current valid and reliable assessment instrument and is hereby incorporated by reference. The QSI is available at: http://apd.myflorida.com/waiver/docs/qsi-version-4.pdf.

(12) Significant: Significant means of considerable magnitude or considerable effect.

(13) Significant Additional Needs: Need for services that if not provided would place the health and safety of the individual, the individual's caregiver, or public in serious jeopardy which are authorized under Section 393.0662(1)(b), F.S., and categorized as extraordinary need, significant need for one time or temporary support or services, or significant increase in the need for services after the beginning of the service plan year.

(14) Support plan: An individualized plan of supports and services designed to meet the needs of an individual enrolled in the iBudget. The plan is based on the preferences, interests, talents, attributes and needs of an individual.

(15) Temporary basis: A time period of less than 12 months.

(16) Waiver: The Developmental Disabilities Individual Budgeting Medicaid Home and Community Based Services Waiver (iBudget) operated by the Agency.

(17) Waiver Support Coordinator: Abbreviated as WSC, means a person who is selected by the individual to assist the individual and family in identifying their capacities, needs, and resources; 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.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662, 409.906 FS. History–New .

65G-4.0214 Allocation Algorithm.

(1) To establish the Allocation Algorithm amount for any individual who has not previously had a QSI assessment, a QSI assessment must be completed prior to calculating the allocation algorithm amount under subsection (2).

(2) To calculate the Allocation Algorithm amount for each individual, the following weighted values, as applicable, shall be summed, and the resulting total then squared:

(a) The base value for all individuals, ~~26.7080~~ 27.57204;

(b) If the individual is age 21 to 30, ~~or older, 53.1104~~ 47.84726;

(c) If the individual is age 31 or older, 48.96336

(c) If the individual resides in supported or independent living, ~~62.5319~~35.82201~~;~~

(d) If the individual resides in a licensed residential facility that is designated to provide Standard or Live-In services, 90.62940 ~~n Agency licensed foster or group home, or a non-Agency licensed congregate home, 92.1163;~~

(e) If the individual resides in a licensed residential facility with a Behavior Focus designation, 131.75764

(f) If the individual resides in a licensed residential facility with an Intensive Behavior designation, 209.45584

(e) If the individual resides in a licensed residential facility that is a ~~Residential Habilitation Center or~~ Comprehensive Transitional Education Program or provides Special Medical Home Care, 267.09947~~, 121.5095;~~

(f) The sum of the scores on the individual questions in the QSI Behavioral Status Subscale (Questions 25-30), multiplied by ~~2.5457~~0.49540;

(g) If the individual resides in the family home, ~~T~~the sum of the scores on the individual questions in the QSI Functional Status Subscale (Questions 14-24), multiplied by ~~0.4124~~0.63489;

(h) If the individual resides in supported or independent living, the sum of the scores on the individual questions in the QSI Functional Status Subscale (Questions 14-24), multiplied by 2.05291

(i) If the individual resides in supported or independent living, the sum of the scores on the individual questions in the QSI Behavioral Status Subscale (Questions 25-30), multiplied by 1.45011

(j) The individual's score on QSI Question 16, multiplied by 2.49843

(~~k~~k) The individual's score on QSI Question 18, multiplied by ~~-5.8536~~7~~.1686~~;

(~~l~~l) The individual's score on QSI Question 20, multiplied by 2.67716;

~~5.8770; and~~

(m) The individual's score on QSI Question 21, multiplied by 2.78776;

(n~~j~~) The individual's score on QSI Question 23, multiplied by ~~-~~6.35552;

(o) The individual's score on QSI Question 28, multiplied by 2.28031
(p) The individual's score on QSI Question 33, multiplied by 1.22333
(q) The individual's score on QSI Question 34, multiplied by 2.17640
(r) The individual's score on QSI Question 36, multiplied by 2.67340; and
(s) The individual's score on QSI Question 43, multiplied by 1.93039
~~7.6807~~;

(2) The squared result of the sum of the applicable values of paragraphs (1)(a) through (j) above, is the individual's Allocation Algorithm amount.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662 FS. History–New _____.

65G-4.0215 General Provisions.

(1) Medical necessity alone is not sufficient to authorize a service under the waiver unless:

(a) The individual utilizes all available State Plan Medicaid services, school-based services, private insurance, and any other resources which may be available to the individual before expending funds from the individual's iBudget Amount for support or services. As an example, State Plan Medicaid services for children under the age of 21 typically include, personal care assistance, therapies, consumable medical supplies, medical services, and nursing;

(b) The services are within waiver coverages and limitations; and

(c) The cost of the services are within the algorithm amount unless there is a significant additional need.

Failure to meet the above criteria shall result in a denial of a request for additional funding.

(2) WSCs shall coordinate with the individuals they serve to ensure that services are selected from all available resources to keep the annual cost of services within the individual's iBudget Amount while maintaining the individual's health and safety.

(3) Cost Plan Flexibility. –

(a) After the individual's proposed cost plan is approved, he or she may change the services in his or her Approved Cost Plan provided that such change does not jeopardize the health and safety of the individual and meets medical necessity.

(b) When changing the services within the Approved Cost Plan, the individual and his or her WSC shall ensure that sufficient funding remains allocated for unpaid services that were authorized and rendered prior to the effective date of this change.

(c) Individuals enrolled in iBudget will have flexibility and choice to budget or adjust funding among some services without requiring additional authorizations from the Agency, provided the overall individuals iBudget Amount is not exceeded and all health and safety needs are met. The Agency will authorize services in accordance with criteria identified in Section 393.0662(1)(b), F.S., medical necessity requirements of Section 409.906, F.S., subsection 59G-1.010(166), F.A.C., and handbook limitations adopted in Rule 59G-13.083, F.A.C., unless said handbook is superseded and replaced by a subsequently adopted handbook specifically referencing the replacement of this handbook, and the requirements of 42 CFR 440.230(d).

(d) Retroactive application of changes to service authorizations is prohibited without written approval from the agency.

(4) Consumer Directed Care Plus (CDC+): Individuals enrolled in the CDC+ program are subject to the iBudget Rules.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662, 409.906 FS. History–New _____.

65G-4.0216 Establishment of the iBudget Amount.

(1) The iBudget Amount for an individual shall be the Allocation Algorithm amount, as provided in Rule 65G-4.0214, plus any approved Significant Additional Needs funding pursuant to Section 393.0662(1)(b), F.S.

(2) The Agency will determine the iBudget Amount consistent with the criteria and limitations contained in the following provisions: Sections 409.906 and 393.0662, F.S.; and Rules 59G-13.080, 59G-13.081, and 59G-13.083, F.A.C.

(3) Significant Additional Needs Review: For new waiver enrollees the Allocation Algorithm amount is calculated and provided to the individual and the individual's WSC. The WSC will discuss the Allocation Algorithm

amount with the individual, or representative in order to determine if the individual has any Significant Additional Needs. The Agency may approve an increase to the iBudget Amount if additional funding is required to meet the Significant Additional Needs. For new enrollees the AIM Worksheet form APD 2015-01 will be completed as part of the individual review.

(4) iBudget Amounts are pro-rated as appropriate based on the length of time remaining in the fiscal year.

(5) The individual or their representative will be advised of the Agency's decision for the amount of the individual's final iBudget Amount.

(6) The Agency shall ensure that the sum of all client's projected expenditures does not exceed the Agency's annual appropriation.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662, 409.906 FS. History–New _____.

65G-4.0217 iBudget Cost Plan.

(1) Each individual's proposed iBudget cost plan shall be reviewed and approved by the Agency in conformance with the iBudget Rules and the Florida Medicaid Developmental Disabilities Waiver Services Coverage and Limitations Handbook, November 2010, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-01050, as adopted by Rule 59G-13.083, F.A.C. (5-~~1~~3-2012), which is hereby incorporated by reference.

(2) For an individual to begin receiving a specific waiver service, that service must have been listed in an Approved Cost Plan and the service authorization must have been issued to the provider prior to the delivery of service.

(3) Individuals must budget their funds so that their needs are met throughout the plan year. All individuals shall allocate iBudget funding each month for waiver support coordination services, which is a required service under the waiver.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662, 409.906 FS. History–New _____.

65G-4.0218 Significant Additional Need Funding.

(1) Supplemental funding for Significant Additional Needs (SAN) may be of a one-time, temporary, or long-term in nature including the loss of school system services due to a change in age. A WSC shall submit any requests for SAN funding on behalf of an individual. SAN funding requests must be based on at least one of the three categories, as follows:

(a) An extraordinary need that would place the health and safety of the client, the client's caregiver, or the public in immediate, serious jeopardy unless the increase is approved. An extraordinary need may include, but is not limited to:

1. 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;

2. 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;

3. 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

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

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

(b) A significant need for one-time or temporary support or services that, if not provided, would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy, unless the increase is approved. A significant need may include, but is not limited to, the provision of environmental modifications, durable medical equipment, services to address the temporary loss of support from a caregiver, or special services or treatment for a serious temporary condition when the service or treatment is expected to ameliorate the underlying condition. As used in this subparagraph, the term "temporary" means a period of fewer than 12 continuous months. However, the presence of such significant need for one-time or temporary supports or services alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm.

(c) 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 alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm.

(2) A client's iBudget shall be the total of the amount determined by the algorithm and any additional funding provided pursuant to subsection (1). A client's annual expenditures for home and community-based services Medicaid waiver services may not exceed the limits of his or her iBudget. The total of all clients' projected annual iBudget expenditures may not exceed the agency's appropriation for waiver services.

(3) SAN funding shall be approved if one or more of the requirements of subsection (1) are met which may include one or more of the situations described in Rule 65G-1.047, F.A.C., Crisis Status Criteria.

(4) To ensure that limited SAN funding is targeted to those individuals most in need whenever an individual requests SAN funding, a proposed cost plan shall be submitted indicating how the current budget allocation and requested SAN funds would be used. Documentation of attempts to locate natural or community supports, third-party payers, or other sources of support to meet the individual's health and safety needs must be submitted.

(5) If an individual's iBudget includes Significant Additional Needs beyond what was determined by the Allocation Algorithm, and the Agency determines that the service intensity, frequency or duration is no longer medically necessary, the Agency will adjust the individual's services to ensure health and safety.

(6) The Agency will request the documentation and information necessary to evaluate individuals' increased funding requests based on the individual's needs and circumstances. The documentation will vary according to the funding request and may include the following as applicable: support plans, results from the Questionnaire for Situational Information, cost plans, expenditure history, current living situation, interviews with the individual and his or her providers and caregivers, prescriptions, data regarding the results of previous therapies and interventions, assessments, and provider documentation. Paragraphs (a) through (c) set forth examples of the types of documentation the Agency utilizes in reviewing SAN funding requests in specific circumstances.

(a) For 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:

1. A documented history of significant, potentially life-threatening behaviors, such as recent attempts at suicide, arson, nonconsensual sexual behavior, or selfinjurious behavior requiring medical attention:

a. Psychological assessments/Psychiatric reports

b. Baker Act admission and discharge summaries for last 12 months

c. Behavior assessments, plans and data for last 12 months

d. If school-aged, current IEP, school behavior plan and data

e. If under 21 – a description of behavior services accessed or attempted through

f. Incident Reports, policy reports within the last 12 months

g. Behavior Summary Report from the Area Behavior Analyst

Medicaid State Plan.

2. A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a non-licensed person:

a. Supporting documentation from physician, or others that document the medically necessary situation.

b. Prescription by a physician, ARNP or physician assistant

c. List of specific duties to be performed

d. Nursing care plan (if applicable)

e. Documentation from Skilled Nursing Exception Process (if applicable)

3. A chronic comorbid condition. The term comorbid condition means a medical condition existing simultaneously but independently with another medical condition in a patient

a. Supporting documentation from physician, or others that document the

medically necessary situation.

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

a. Updated QSI

b. Documentation from caregivers

(b) For a significant need for one-time or temporary support or services that, if not provided, would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy, unless the increase is approved. A significant need includes, but is not limited to:

1. The provision of environmental modifications:

a. Documentation of approval from landlord, if home is rented

b. Documentation of ownership of the home by the client or their family

c. The appropriate number of bids per the Handbook

d. Home Accessibility Assessment if over $3500

e. Documentation of how environmental modifications would ameliorate the need

2. Durable Medical Equipment:

a. Prescription and recommendation by a licensed physician, ARNP, physician assistant, PT or OT

b. Documentation that durable medical equipment used by the client has reached the end of its useful life or is damaged, or the client's functional or physical status has changed enough to require the use of waiver-funded DME that has not previously been used.

c. Three bids for items costing $1,000 and over

3. Services to address the temporary loss of support from a caregiver:

a. Description of why caregiver can no longer provide care

b. Age and medical diagnoses of caregivers

c. Documentation from doctor(s) regarding caregiver(s) ability to provide care.

4. Special services or treatment for a serious temporary condition when the service or treatment is expected to ameliorate the underlying condition. Temporary means a period of fewer than 12 continuous months.

(c) 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:

1. Permanent or long-term loss or incapacity of a caregiver:

a. Same criteria as (b)3 above

2. Loss of services authorized under the state Medicaid plan due to a change in age:

a. Medicaid Prior Service Authorization

b. Documentation that other caregivers are not available

3. 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.

(7) Response to funding requests: Within thirty (30) days of receipt of a request for SAN funding, and adjustments in the individual's service array, the Agency shall approve, deny (in whole or in part), or request additional documentation concerning the request. If the request does not include all necessary documentation, the Agency shall provide the client and WSC with a written notice of what additional documentation is required. The client or WSC shall provide the documentation within 10 calendar days, or notify the Agency in writing that the client wishes the Agency to render its decision based upon the documentation provided. If additional documentation is requested, the deadline for the Agency's response shall be extended to sixty (60) days following the receipt of the original request. Nothing in this section prohibits the authorization of emergency services on a temporary basis through the Agency's Regional offices.

(8) No additional funding for an individual's services shall be provided if the need for the additional funding is not premised upon a new need, but is created by the individual's failure to ensure that funding remained sufficient to cover services previously authorized in accordance with subsections 65G-4.0215(2) and (~~3~~6), F.A.C.

(9) Individual and Family Supports (IFS) Funding to cover temporary emergency services is authorized when needed while requests for Significant Additional Needs are being processed.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662, 409.906 FS. History–New_____.