Notice of Change/Withdrawal

DEPARTMENT OF CHILDREN AND FAMILIES
Agency for Persons with Disabilities
RULE NOS.:RULE TITLES:

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NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed rule in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 41 No. 84, April 30, 2015 issue of the Florida Administrative Register.

65G-4.0213 Definitions.

For the purposes of this chapter, the term:

(1) through (2) No change.

(3) Amount Implementation Meeting Worksheet (AIM): A form used by the Agency for new waiver enrollees, and upon recalculation of an individual's algorithm, 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 – APD 2015-01, effective 12-3-2014, 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,

(4) No change.

(5) Client Advocate: has the same meaning as provided in s. 393.063(6), F.S., and includes legal counsel if designated by individual or the individual's representative.

(6) through (11) No change.

(12) Individual representative: The individual's parent (for a minor), guardian, guardian advocate, a designated person holding a power of attorney for decisions regarding health care or public benefits, designated attorney, or a healthcare surrogate. or in the absence of any of the above, a medical proxy as determined under s. 765.401, F.S. 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.

(13) through (14) No change.

(15) Natural Support: Unpaid supports that are or may be provided voluntarily to the individual in lieu of Waiver services and supports. Any determination of the availability of natural supports includes, but is not limited to consideration of the individual's caregiver(s) age, physical and mental health, travel and work or school schedule, responsibility for other dependents, sleep, and ancillary tasks necessary to the health and well-being of the client.

(16) Person-centered planning - A planning approach based on the recipient's perspective rather than that of a program or resource used to identify the services and supports necessary to meet the recipient's needs involving the recipient and significant people in the recipient's life. The most important goals and outcomes are identified as well as the supports needed to achieve them.

(16) renumbered (17) No change.

(18) QSI Assessor – means an Agency employee who has been certified by the Agency in the administration of the QSI.

(19)~~(17)~~ Service Authorization - An Agency notification ~~document~~ that authorizes the provision of specific waiver services to an individual and includes, at a minimum, the provider's name and the specific amount, duration, scope, frequency, and intensity of the approved service.

(20)~~(18)~~ Service Families: Eight categories that group services related to: Life Skills Development, Supplies and Equipment, Personal Supports, Residential Services, Support Coordination, Therapeutic Supports and Wellness, Transportation and Dental Services. The Service Families include the following services:

(a) Life Skills Development, which includes:

1. Life Skills Development Level 1 (~~formerly known as~~ companion services);

2. Life Skills Development Level 2 (~~formerly known as~~ supported employment); and

3. Life Skills Development Level 3 (~~formerly known as~~ adult day training).

(b) through (d) No change.

(e) Waiver Support Coordination~~, which includes:~~

~~1. Limited Support Coordination;~~

~~2. Full Support Coordination; and~~

~~3. Enhanced Support Coordination.~~

(f) through (h) No change.

(19) renumbered (21) No change.

(22)~~(20)~~ Significant Additional Needs (SANs): Need for additional funding 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. Examples of SAN that may require long-term support include, but are not limited to, any of the following:

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 non-licensed person;

c. A chronic comorbid condition. As used in this subparagraph, the term "comorbid condition" means a diagnosed medical or mental health condition existing simultaneously but independently with another medical or mental health condition in a patient;

d. A need for total physical assistance with activities of daily living such as eating, bathing, toileting, grooming, dressing, and personal hygiene;~~.~~

e. Permanent or long-term loss or incapacity of a caregiver;~~,~~

f. Loss of services authorized under the state Medicaid plan or through the school system due to a change in age; ~~,~~

g. Significant change in medical, behavioral or functional status;

h. Lack of a meaningful day activity needed to foster mental health, ~~or~~ prevent regression, or engage in meaningful community life and activities;~~.~~

i. One or more of the situations described in Rule 65G-1.047, Crisis Status Criteria;

j. Risk of abuse, neglect, exploitation or abandonment;~~.~~

k. Need for transportation to and from a waiver-funded adult day training program site or a waiver-funded supported employment site that cannot be accommodated with the funding authorized by the client's support plan without affecting the health and safety of the client, public transportation is not an option due to the unique needs of the client, and no other transportation resources are reasonably available.

(23)~~(21)~~ Support plan: An individualized and person-centered 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, including the availability of natural supports.

(22) through (23) renumbered (24) through (25) No change.

(26)~~(24)~~ Waiver Support Coordinator (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 with person-centered planning.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662, 409.906 FS. History–New July 1, 2015.

65G-4.0214 Allocation Algorithm.

(1) No change.

(a) The QSI assessor shall ~~should~~ arrange for a face to face meeting with the individual or the individual's representative ~~and the WSC~~. The WSC shall attend the face to face meeting upon request of the individual or the individual's representative. If the individual or the individual's representative is not capable of fully responding to all of the assessment questions, at least one participant with day-to-day knowledge of the individual's care should participate.

(b) No change.

(c) Upon receiving QSI results if the individual or their representative identifies an ~~as~~ error in the QSI results the WSC shall notify the Agency in writing setting forth the details of the error. At any time, the individual or WSC can prepare a statement to be maintained in individual's Central File identifying any concerns with the QSI assessment score or responses. If any of the challenged responses are considered as variables in determining the individual's algorithm, a new ~~corrected~~ assessment may be requested from the agency. The agency shall reevaluate the QSI outcome and inform the WSC of the result of the reevaluation who must in turn notify the individual ~~and WSC in writing of any denial of a request for reevaluation,~~ or the individual's representative ~~any reassessment resulting in no change to the challenged score, and give the individual an opportunity to request a fair hearing~~.

(d) The individual or WSC may request a reassessment any time there has been a significant change in circumstance or condition that would impact any of the questions used as variables in the algorithm determination. The Agency shall arrange for a reassessment within 60 days of the request and notify the individual and WSC of the results within 30 days from the administration of the QSI.

(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, 27.5720 ~~27.57204~~;

(b) If the individual is age 21 to 30, 47.8473 ~~47.84726~~;

(c) If the individual is age 31 or older, 48.9634 ~~48.96336~~;

(d)~~(c)~~ If the individual resides in supported or independent living, 35.8220 ~~35.82201~~;

(e)~~(d)~~ If the individual resides in a licensed residential facility that is designated to provide Standard or Live-In residential habilitation services, 90.6294 ~~90.62940~~;

(f)~~(e)~~ If the individual resides in a licensed residential facility with a Behavior Focus designation, 131.7576 ~~131.75764~~;

(g)~~(f)~~ If the individual resides in a licensed residential facility with an Intensive Behavior designation, 209.4558 ~~209.45584~~;

(h)~~(e)~~ If the individual resides in a licensed residential facility that is a Comprehensive Transitional Education Program or provides Special Medical Home Care, 267.0995 ~~267.09947~~;

(i)~~(f)~~ The sum of the scores on the individual questions in the QSI Behavioral Status Subscale (Questions 25-30), multiplied by 0.4954 ~~0.49540~~;

(j)~~(g)~~ If the individual resides in the family home, the sum of the scores on the individual questions in the QSI Functional Status Subscale (Questions 14-24), multiplied by 0.6349 ~~0.63489~~;

(k)~~(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 2.0529 ~~2.05291~~;

(l)~~(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 1.4501 ~~1.45011~~;

(m)~~(j)~~ The individual's score on QSI Question 16, multiplied by 2.4984 ~~2.49843~~;

(n)~~(k)~~ The individual's score on QSI Question 18, multiplied by 5.8537 ~~5.85369~~;

(o)~~(l)~~ The individual's score on QSI Question 20, multiplied by 2.6772 ~~2.67716~~;

(p)~~(m)~~ The individual's score on QSI Question 21, multiplied by 2.7878 ~~2.78776~~;

(q)~~(n)~~ The individual's score on QSI Question 23, multiplied by 6.3555 ~~6.35552~~;

(r)~~(o)~~ The individual's score on QSI Question 28, multiplied by 2.2803 ~~2.28031~~;

(s)~~(p)~~ The individual's score on QSI Question 33, multiplied by 1.2233 ~~1.22333~~;

(t)~~(q)~~ The individual's score on QSI Question 34, multiplied by 2.1764 ~~2.17640~~;

(u)~~(r)~~ The individual's score on QSI Question 36, multiplied by 2.6734 ~~2.67340~~; and

(v)~~(s)~~ The individual's score on QSI Question 43, multiplied by 1.9304 ~~1.93039~~.

(2) The squared result of the sum of the applicable values of paragraphs (2)(a) through (v) ~~(s)~~ above, is the individual's Allocation Algorithm Amount.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662 FS. History–New July 1, 2015.

65G-4.0215 General Provisions.

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

(a) With the assistance of the WSC t~~T~~he individual must utilize ~~utilizes~~ all available State Plan Medicaid services, school-based services, private insurance, natural supports, 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 must be ~~are~~ within waiver coverages and limitations; and

(c) The cost of the services must be ~~are~~ within the Allocation Algorithm Amount unless there is a significant additional need demonstrated.

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

(2) No change.

(3) Cost Plan Flexibility

(a) through (b) No change.

(c) Individuals enrolled in iBudget will have flexibility and choice to budget or adjust funding among the following services without requiring additional authorizations from the Agency, provided the individual's overall iBudget Amount is not exceeded and all health and safety needs are met:

1, Life Skills Development 1

2. Life Skills Development 2

3. Life Skills Development 3, within ~~at~~ the approved ~~1 to 10~~ ratio.

4. Durable Medical Equipment;

5. Adult Dental.

6. Personal Emergency Response Systems

7. Environmental accessibility adaptations,

8. Consumable Medical Supplies,

9 Transportation.

10. Personal Supports up to ~~if below~~ $16,000

11. Respite up to ~~if below~~ $5,000

Medically necessary services will be authorized by the Agency for covered services not listed above if the cost of such services are within the individual's iBudget Amount and in accordance with 65G-4.0215(1). 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., the authority under 42 CFR 440.230(d), ~~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 entitled~~ the iBudget Rules, ~~Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook,~~ and the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, (Effective November 2010), which is hereby incorporated by reference and available at https://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/53/Default.aspx ~~requirements of 42 CFR 440.230(d)~~.

(d) Retroactive application of changes to service authorizations is prohibited without written approval from the Agency. In limited circumstances, an exception may be made for a retroactive service authorization by the Agency regional office to correct an administrative error or to consider a health and safety risk and emergency situations.

(e)~~(d)~~ Service authorization and any modifications to it must be received by the provider prior to service delivery. This includes changes to the authorization as a result of individuals redistributing funds within their existing cost plan. ~~Service authorizations will not be approved retroactively. In limited circumstances, an exception may be made on a case by case basis by the Agency regional office to correct an administrative error or to consider a health and safety risk and emergency situations.~~

(4) Consumer Directed Care Plus (CDC+): Individuals enrolled in the CDC+ program are subject to the iBudget Rules 65G-4.0214, 4.0215(1),(2) &(6), 4.0216, 4.0217, 4.0218.

(5)(a) iBudget Waiver providers must have applied through the Agency for Persons with Disabilities to ensure that they meet the minimum qualifications to provide iBudget Waiver services. iBudget Waiver providers must also be enrolled as a Medicaid provider though the Agency or Healthcare Administration. However providers do not have to provide Medicaid State Plan services in order to provide waiver services. To enroll as a provider for iBudget Waiver Services, the provider must first submit an application to the Agency or Persons with Disabilities using the Regional iBudget Provider Enrollment Application – Waiver Support Coordinator (WSC) – APD 2015-02, effective date 7-1-2015, for waiver support coordinator applications, or the Regional iBudget Provider Enrollment Application – Non-WSC – APD 2015-03, effective date 7-1-2015, for all other provider applications. These forms are hereby incorporated by reference and are available at http://apdcares.org/providers/enrollment/. The Agency for Persons with Disabilities will review the application, request ~~requesting~~ missing documentation, and issue a decision about whether the provider meets the qualifications to provide services. The qualifications to provide services are identified in the handbook adopted in Rule 59G-13.083, F.A.C.~~, unless said handbook is superseded and replaced by a subsequently adopted handbook specifically entitled the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook~~

(b) If a waiver provider wishes to expand by providing ~~from solo to agency enrollment status, provide~~ additional services, ~~or~~ expand services geographically, or expand from solo to agency, the provider must notify the Agency regional office ~~serving the geographic area in which expansion is requested~~ by submitting an Provider Expansion Request form –APD 2015-04, effective date 8-20-2013, which is hereby incorporated by reference and is available at http://apdcares.org/providers/enrollment/. The Agency regional office must approve any expansion prior to the provision of expanded services. Before the Agency regional office approves a provider for expansion, the Agency regional office must determine that the provider meets the provider qualifications and has:

1. An 85% or higher on their last Quality Assurance Organization (QIO) report. If a provider does not have a history of a QIO review, this does not prevent consideration for expansion;
2. No identified alerts (i.e., background screening, medication administration, and validation);
3. No outstanding billing discrepancies or plan of remediation;
4. No adverse performance history in their home region; and
5. No open investigations or referrals to AHCA and DCF.

Agency staff shall check with the provider's home regional office to determine whether there is a history of complaints filed and logged on the remediation tracker, any open investigations or referrals to AHCA's Medicaid Program Integrity (MPI) or the Attorney General's Medicaid Fraud Control Unit (MFCU), or the Department of Children & Families (DCF). The Agency ~~regional office~~ shall make ~~conduct~~ the determination required under this paragraph in not more than 90 ~~30~~ days.

(6)(a) When a individual is enrolled in the iBudget, that individual remains enrolled in the waiver position allocated unless the individual becomes disenrolled due to one of the following conditions:

1. The individual or individual’s representative chooses to terminate participation in the waiver.
2. The individual moves out-of-state.
3. The individual loses eligibility for Medicaid benefits and this loss is expected to extend for a lengthy period.
4. The individual no longer needs waiver services.
5. The individual no longer meets level of care for admission to an ICF/IID.
6. The individual no longer resides in a community-based setting (but moves to a correctional facility, detention facility, defendant program, or nursing home or resides in a setting not otherwise permissible ~~permissalbe~~ under waiver requirements.
7. The individual is no longer able to be maintained safely in the community.
8. The individual becomes enrolled in another home and community-based services (HCBS) Waiver.

If an individual is disenrolled from the waiver and becomes eligible for reenrollment within 365 days that individual can return to the waiver and resume receiving waiver services. If waiver eligibility cannot be re-established or if the individual who has chosen to disenroll has exceeded this time period, the individual cannot return to the waiver until a new waiver vacancy occurs and funding is available. In this instance, the individual is added to the waitlist of individuals requesting waiver participation. The new effective date is the date eligibility is re-established or the individual requests re-enrollment for waiver participation.

(b) Providers are responsible for notifying the individual's WSC and the Agency if the provider becomes aware that one of these conditions exists. If an ~~a~~ individual, family member, or individual representative refuses to cooperate with the provision of waiver services (such as refusing to develop a cost plan or support plan, participation in a required QSI assessment or other approved agency needs assessment tool, or refuses to annually sign the waiver eligibility worksheet, required to establish a level of care) the Agency will review the circumstances ~~on a case by case basis~~ to determine if the individual should ~~can~~ be removed from the waiver for failing to comply with ~~, as the waiver requires these~~ specific ~~documents for continued waiver~~ eligibility~~.~~ requirements. Any such decision by the Agency shall provide written notice to the individual, the individual's representative and the WSC, at least 30 days before terminating services. Individuals denied services shall have the right to a fair hearing. Individuals are exempted from this provision if they do not have the ability to give informed consent and do not have a guardian or individual representative. The Agency shall not remove an individual from the waiver due to non-compliance if it directly impacts the individual's health, safety, and welfare.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662, 409.906 FS. History–New July 1, 2015.

65G-4.0216 Establishment of iBudget Amount.

(1) through (2) No change.

(3) Significant Additional Needs Review: Each time an ~~For new waiver enrollees the~~ Allocation Algorithm A~~a~~mount is calculated ~~and provided to the individual and the individual's WSC.~~ T~~t~~he WSC will discuss the Allocation Algorithm A~~a~~mount with the individual, or individual's representative and, if applicable, the client advocate, in order to determine if the individual has any Significant Additional Needs. The Agency will conduct an Individual Review to determine whether services requested meet health and safety needs and waiver coverage and limitations. In the event a WSC does not submit a request for SANs and the individual, the individual's representative or the client advocate disagrees with the WSC's failure to submit a SAN funding request, or if ~~the WSC shall submit in writing its reasons for not requesting SANs funding to the Agency~~ the individual~~,~~ or the individual's representative or ~~and the~~ client advocate~~.~~ ~~The~~ are unsatisfied with the request submitted, the individual~~,~~ or the individual's representative ~~or the client advocate~~ may submit their own SANS request by email to the applicable Agency regional office ~~in writing to the~~. The Agency shall ~~the reasons for their disagreement. The Agency may~~ approve an increase to the iBudget Amount if additional funding is required to meet the Significant Additional Needs subject to the provisions of the iBudget rules ~~For new enrollees the~~. The AIM Worksheet form APD 2015-01 will be completed as part of the Individual Review. The Agency, upon completion of its review shall notify in writing the individual, the WSC and the client advocate, if any, of its decision.

(4) through (5) No change.

(6) The Agency shall ensure that the sum of all clients' ~~client's~~ projected expenditures do ~~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 July 1, 2015.

65G-4.0217 iBudget Cost Plan.

(1) When an individual's iBudget Amount is determined, the WSC must submit a cost plan proposal that reflects the specific waiver services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the provider of those services and supports, including natural supports. The cost plan is derived from person centered planning.

(2) 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, (effective November 2010), which is hereby incorporated by reference, and

available at https://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/53/Default.aspx. ~~http://www.flrules.org/Gateway/reference.asp?No=Ref-01050, as adopted by Rule 59G-13.083, F.A.C. (5-3-2012), which is hereby incorporated by reference.~~ Any conflict between the handbook and these iBudget Rules shall be resolved in favor of these Rules.

(3) through (4) No change.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662, 409.906 FS. History–New July 1, 2015.

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 Medicaid State Plan or 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) through (c) No change.

(2) No change.

~~(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) through (5) renumbered (3) through (4) No change.

(5)~~(6)~~ The Agency will request the documentation and information necessary to evaluate an individual's ~~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. through 2. No change.

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

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

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

4. No change.

(b) through (c) No change.

(7) through (9) renumbered (5) through (7) No change.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662, 409.906 FS. History–New July 1, 2015.