Agency for Persons with Disabilities
iBudget Rules

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, F.A.C., and as provided in Section 393.0662(1)(a), F.S.

(2) Allocation Algorithm Amount: The result of the Allocation Algorithm apportioned according to available funding.

(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 is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-07071.

(4) 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.

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

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

(7) Handbook: Means the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, which is hereby incorporated by reference, and is available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-07072, as adopted by Rule 59G-13.070, F.A.C. (effective 9-3-2015).

(8) Health and Safety: Includes both mental and physical health and safety.

(9) 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.

(10) 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.

(11) iBudget Rules: Rules 65G-4.0213 through 65G-4.0218, F.A.C., are the rules which implement and interpret iBudget Amounts.

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

(13) 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 Section 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.

(14) Individual Review – Agency review of information submitted by a WSC, to determine if the request meets significant additional needs criteria.

(15)(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 individual, the individual’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.

(16) 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.

(17) Person-centered planning – a planning approach directed by an individual with long term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The individual or family determines the other participants in this process for the purposes of assisting the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting and to facilitate health, safety, and well-being.

(18) 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://www.flrules.org/Gateway/reference.asp?No=Ref-07075.

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

(20) Service Authorization – An Agency notification 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.

(21) 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 (companion services);

2. Life Skills Development Level 2 (supported employment); and,

3. Life Skills Development Level 3 (adult day training).

(b) Supplies and Equipment which includes:

1. Consumable Medical Supplies;

2. Durable Medical Equipment and Supplies;

3. Environmental Accessibility Adaptations; and,

4. Personal Emergency Response Systems (unit and services).

(c) Personal Supports, which includes:

1. Services formerly known as in-home supports, respite, personal care and companion for individuals age 21 or older, living in their own home or family home and also for those at least 18 but under 21 living in their own home; and,

2. Respite Care (for individuals under 21 living in their family home).

(d) Residential Services, which includes:

1. Standard Residential Habilitation;

2. Behavior-Focused Residential Habilitation;

3. Intensive-Behavior Residential Habilitation;

4. Live-In Residential Habilitation;

5. Specialized Medical Home Care; and,

6. Supported Living Coaching.

(e) Waiver Support Coordination.

(f) Therapeutic Supports and Wellness, which includes:

1. Private Duty Nursing;

2. Residential Nursing;

3. Skilled Nursing;

4. Dietician Services;

5. Respiratory Therapy;

6. Speech Therapy;

7. Occupational Therapy;

8. Physical Therapy;

9. Specialized Mental Health Counseling;

10. Behavior Analysis Services; and,

11. Behavior Assistant Services.

(g) Transportation; and,

(h) Dental Services, which consists of Adult Dental Services.

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

(23) 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. In addition, the term includes a significant need for transportation services as provided in paragraph 65G-4.2018(1)(d), F.A.C. Examples of SANs 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, personal hygiene, lifting, transferring or ambulation;

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, prevent regression or engage in meaningful community life and activities;

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

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

(24) 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.

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

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

(27) 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 7-7-16.

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).

(a) The QSI assessor shall arrange for a face to face meeting with the individual or the individual's representative. The WSC shall attend the face to face meeting with consent 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) A copy of the completed QSI evaluation and scores shall be provided to the individual and WSC.

(c) Upon receiving QSI results if the individual or their representative identifies an 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 error is identified in the QSI assessment the agency shall review the error to determine if any adjustments are needed. The agency shall inform the WSC of the result of the review and provide a revised Allocation Algorithm Amount, if appropriate, within 15 working days of notification of the error. The WSC shall in turn notify the individual or the individual's representative.

(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 at the earliest possible time in accordance with the circumstances, complete the reassessment, and notify the individual and

WSC of the results within 60 days of the request for reassessment. This section shall not be construed to require the Agency to wait for the completion of a QSI in order to address an emergency situation of the individual.

(2) To calculate the Allocation Algorithm 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;

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

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

(d) If the individual resides in supported or independent living, or the individual resides in a licensed facility and does not receive residential habilitation services, 35.8220;

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

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

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

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

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

(j) 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;

(k) 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;

(l) 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;

(m) The individual’s score on QSI Question 16, multiplied by 2.4984;

(n) The individual’s score on QSI Question 18, multiplied by 5.8537;

(o) The individual’s score on QSI Question 20, multiplied by 2.6772;

(p) The individual’s score on QSI Question 21, multiplied by 2.7878;

(q) The individual’s score on QSI Question 23, multiplied by 6.3555;

(r) The individual’s score on QSI Question 28, multiplied by 2.2803;

(s) The individual’s score on QSI Question 33, multiplied by 1.2233;

(t) The individual’s score on QSI Question 34, multiplied by 2.1764;

(u) The individual’s score on QSI Question 36, multiplied by 2.6734; and,

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

(3) The squared result of the sum of the applicable values of paragraphs (2)(a) through (v) above, then apportioned according to available funding, is the individual’s Allocation Algorithm Amount.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662 FS. History–New 7-7-16.

65G-4.0215 General Provisions.

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

(a) With the assistance of the WSC the individual must utilize 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 within waiver coverages and limitations; and,

(c) The cost of the services must be 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) 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 the 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 the approved 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 $16,000;
11. Respite up to $10,000.

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 subsection 65G-4.0215(1), F.A.C. The Agency shall 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., Handbook limitations, and the authority under Rule 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) 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.

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

(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 through 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, which is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-07073 or the Regional iBudget Provider Enrollment Application – Non-WSC – APD 2015-03, effective date 7-1-2015, for all other provider applications, which is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-07074. These forms are hereby incorporated by reference. On the application providers must identify the counties where they intend to provide services. The Agency for Persons with Disabilities will review the application, request 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.

(b) If a waiver provider wishes to, expand by providing additional services, expand services geographically, or expand from solo to agency, the provider must notify the Agency regional office 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://www.flrules.org/Gateway/reference.asp?No=Ref-07076. 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 unresolved billing discrepancies or plan of remediation;
4. No adverse performance history relating to the health and safety of individuals served; and,
5. No open investigations or referrals to the Agency for Health Care Administration (AHCA) and the Department of Children and Families (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 DCF. The Agency shall make the determination required under this paragraph in not more than 90 days.

(6)(a) When an 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 under waiver requirements.

7. The individual is no longer able to be maintained safely in the community.

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 any of the conditions of paragraph (a) or (c) exists.

(c) If an individual, family member, or individual representative refuses to cooperate with the provision of waiver services in any of the following ways: develop a cost plan or support plan, participate in a required QSI assessment or other approved agency needs assessment tool, or refuse to annually sign the waiver eligibility worksheet that establishes a level of care, then the Agency will review the circumstances to determine if the individual should be removed from the waiver for failing to comply with specific 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 7-7-16.

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, F.A.C., plus any approved Significant Additional Needs funding as provided in Rule 65G-4.0218, F.A.C.

(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-13.070, F.A.C.

(3) Significant Additional Needs Review: Each time an Allocation Algorithm Amount is calculated the WSC will discuss the Allocation Algorithm Amount 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. The AIM Worksheet form APD 2015-01 must be completed as part of the Individual Review and submitted to the Agency within 30 days of receipt of the new Allocation Algorithm Amount. The Agency will issue a decision of the iBudget Amount within 30 days of receipt of the AIM Worksheet form. The individual or their representative will be advised of the Agency's decision for the amount of the individual's final iBudget Amount within 30 days. If additional documentation is requested, the deadline for the Agency's response shall be extended to 60 days following the receipt of the original

request. 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 individual or the individual's representative or client advocate are unsatisfied with the request submitted, the individual or the individual's representative may submit the SANs request to the applicable Agency regional office. The Agency shall 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. 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) iBudget Amounts are pro-rated as appropriate based on the length of time remaining in the fiscal year.

(5) The Agency shall ensure that the sum of all clients' projected expenditures do not exceed the Agency's annual appropriation.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662, 409.906 FS. History–New 7-7-16.

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 proposal 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 Handbook. Any conflict between the Handbook and these iBudget Rules shall be resolved in favor of these rules.

(3) 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.

(4) 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 7-7-16.

65G-4.0218 Significant Additional Need Funding.

(1) Supplemental funding for Significant Additional Needs (SANs) 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. SANs funding requests must be based on at least one of the four 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, personal hygiene, lifting, transferring or ambulation.

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.

(d) A significant need for transportation services to a waiver-funded adult day training program or to a waiver-funded supported employment where such need cannot be accommodated within the funding authorized by the client’s iBudget amount without affecting the health and safety of the client, where public transportation is not an option due to the unique needs of the client, and where no other transportation resources are reasonably available. However, such increases may not result in the total of all clients’ projected annual iBudget expenditures exceeding the agency’s appropriation for waiver services.

(2) 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) For any SANs request, the WSC shall 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 request should also include an explanation of why additional funding is needed, and any additional documentation appropriate to support the request. If there are any concerns about the accuracy of the QSI results the WSC shall submit this information as well. The cost plan proposal shall be submitted indicating how the current budget allocation and requested SANs 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 also be submitted.

(4) 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 match the current need.

(5) The Agency will request the documentation and information necessary to evaluate an individual's 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 SANs 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 self-injurious 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 the Medicaid State Plan.

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

g. Behavior Summary Report from the Area Behavior Analyst.

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 or mental health condition existing simultaneously but independently with another medical or mental health condition in a patient:

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, personal hygiene, lifting, transferring or ambulation.

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 subparagraph (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.

(6) Response to funding requests: Within 30 days of receipt of a request for SANs 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 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 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. If the client has not received a notice from the Agency approving, denying or requesting additional information within 60 days, the client or WSC may notify the Agency in writing of such failure to issue a timely notice and the Agency shall have 20 days from receipt of the Notice to approve or deny the request. Failure of the Agency to issue this Notice within 20 days shall mean the requested funding for services are authorized as of the 21st day, and the client and service providers may treat the authorization as an approval.

(7) No additional funding for an individual's services shall be provided if the need for the additional funding is not premised upon a need that arises after the implementation of the initial

iBudget Amount, or 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), F.A.C.

(8) 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 7-7-16.