

65G-4.0210 Definitions.

(1) ABC: The Allocation, Budgeting, and Contracts information technology system used by the agency to maintain demographic, services, budget, and other data.

(2) Allocation Algorithm: The mathematical formula based upon statistically validated relationships between client characteristics (variables) and the client's level of need for services provided through the Waiver. To calculate the allocation algorithm for an individual.

(a) The following weighted values, as applicable, shall be summed, and the resulting total then squared:

1. The base value for all individuals, 26.7080;
2. If the individual is age 21 or older, 53.1104;
3. If the individual resides in supported or independent living, 62.5319;
4. If the individual resides in an APD-licensed foster or group home, or a non-APD licensed congregate home, 92.1163;
5. If the individual resides in a Residential Habilitation Center or Comprehensive Transitional Education Program, 121.5095;
6. The sum of the scores on the individual questions in the QSI Behavioral Status Subscale (Questions 25-30), multiplied by 2.5457;
7. The sum of the scores on the individual questions in the QSI Functional Status Subscale (Questions 14-24), multiplied by 0.4124;
8. The individual's score on QSI Question 18, multiplied by 7.1686;
9. The individual's score on QSI Question 20, multiplied by 5.8770; and
10. The individual's score on QSI Question 23, multiplied by 7.6807;

(b) The squared result of the sum of (a)1.-10., above, is the individual's Allocation Algorithm Amount, the annual dollar amount for the client's iBudget, subject to the following conditions:

1. The total of all clients' projected annual iBudgets may not exceed the Agency's annual appropriation for Waiver services;
2. If, during the calculation of an individual's iBudget Allocation Algorithm Amount, the sum of all Waiver clients' Allocation Algorithm Amounts exceeds the annual appropriation, the Agency shall adjust that individual client's Allocation Algorithm Amount by the factor of the annual appropriation divided by the total of all clients' Allocation Algorithm Amounts. For purposes of this subsection, the Agency's "annual appropriation" means the annual amount appropriated by the Legislature for DD Waiver Services reduced by the amount reserved by the Agency pursuant to Section 393.0662(1)(b), F.S.

(3) Allocation Implementation Meeting (AIM) Work Sheet: A form used by the Agency to communicate a client's (a) existing annualized cost plan detailing approved services, if any, (b) proposed services based upon the target iBudget Florida allocation, and (c) the request for additional services, if any, should the individual or their representative feel that any extraordinary or health and safety needs of the individual cannot be met within the target iBudget Florida allocation. The AIM worksheet, Form 1B-1, Version 4-1-13, 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>, and <http://apd.myflorida.com/ibudget/docs/AIM%20Instructions%20for%20Rule.pdf>.

(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 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 client advocate. The individual's Waiver Support Coordinator shall ascertain whether a client has any of these representatives and inform the agency of the identity and contact information. When the term "legal representative" is used in these rules it means only those individuals who generally have legal authority to act independently for the client, 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.

(6) Existing annualized cost plan: The annualized total amount of funding authorized by the Agency for the approved cost plan immediately prior to the new period for which a budget allocation is being developed. This amount shall exclude one-time expenses or any services which were authorized during the year and the authorization has expired. Only clients who are receiving waiver services will have an existing annualized cost plan.

(7) Extraordinary Need: Extraordinary Need is only considered when establishing the initial iBudget for a client. An extraordinary need would place the health and safety of the client, the client's caregiver, or the public in immediate, serious jeopardy without the provision of services or supports that would relieve the immediate, serious jeopardy and the iBudget Florida allocation algorithm amount is insufficient to fund, and includes:

(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 condition, for example a condition included in the International Statistical Classification of Diseases and Related Health Problems (commonly referred to as the ICD), existing simultaneously but independently with another medical condition in a patient;

(d) A need for total physical assistance. That the individual must have assistance to complete daily activities such as eating, bathing, toileting, grooming, and personal hygiene;

(e) A need caused by characteristics intrinsic to a client's diagnosed condition, or the natural progression of their diagnosed condition.

(f) A need for additional services or supports resulting from the unique circumstances or condition of the caregiver;

(g) A need which is caused by the client's specific age change which eliminates eligibility for services provided by State Plan Medicaid for Children (at the age of 21), the Foster Care system (at the age of 18), or the Educational System (up to age 22);

(h) Any other need for services or supports without which the health and safety of the client or the client's caregiver, or the public safety would be in immediate, serious jeopardy.

A temporary or episodic change in client needs (for example a change in caregiver status, or living setting) does not qualify as an extraordinary need. As a point of information, temporary or one time needs are addressed by Rule 65G-4.027, F.A.C., as are changes of extended duration after the iBudget is established.

(8) Final iBudget Allocation: The amount of funds that has been approved by the agency, pursuant to the iBudget Florida Rules, for an individual to expend for waiver services during a fiscal year.

(9) iBudget Florida: The waiver service delivery system that uses individual budgets and under which the Agency for Persons with Disabilities operates the Developmental Disabilities Individual Budgeting Waiver.

(10) iBudget Florida Rules: Rules 65G-4.0210 through 4.0212, 4.022, 4.024, and 4.027, F.A.C., are the rules which implement and interpret the iBudget Florida allocation algorithm and methodology required by Section 393.0662, F.S. References within the iBudget Florida Rules to "these rules" shall mean the iBudget Florida Rules.

(11) Individual: a person with a developmental disability, as defined by Section 393.063, F.S. and as applied by the iBudget Florida Rules, who is enrolled in iBudget Florida. Individuals are also referred to as "clients" in this rule.

(12) Medical Necessity or Medically Necessary: A set of conditions for determining the need for and appropriateness of Medicaid-funded services for an enrolled client. To determine if a service is a Medical Necessity or Medically Necessary, the medical or allied care, goods, or services furnished or ordered must meet the following conditions:

(a) Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

(b) Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the client's needs;

(c) Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;

(d) Be reflective of the level of service that can be safely furnished, for which no equally effective and more conservative or less costly treatment is available, statewide; and

(e) Be furnished in a manner not primarily intended for the convenience of the client, the client's caretaker, or the provider.

Medical Necessity alone is not sufficient to authorize a service under the Waiver. Individuals must use all available services authorized under the state Medicaid plan, school-based services, private insurance and other benefits, and any other resources that may be available to them before using funds from their iBudget allocations to pay for support and services. Failure to comply with this requirement shall result in denial of the service request. The determination of medical necessity is used for all decisions made regarding services, extraordinary needs, and supplemental funding.

(13) Natural Supports: Refers to services or supports that are available from the individual's family members, neighbors, or friends and for which no payment for the service or support is provided. A consideration of the availability of natural supports includes, but is not limited to consideration of the client'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.

(14) Questionnaire for Situational Information (QSI): An assessment instrument used by APD to determine an individual's needs in the areas of functional, behavioral, and physical status. The QSI has been adopted by the Agency in subsection 65G-4.0026(2), F.A.C., as the current valid and reliable assessment instrument.

(15) 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) 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) Support Coordination, which includes:

1. Limited Support Coordination;
2. Full Support Coordination; and
3. Enhanced 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.

(16) Significant: Applies to a significant change in circumstance or a significant need. Significant means of considerable magnitude or considerable effect.

(17) Supplemental funding: Funding granted after the beginning of the fiscal year or the date of the individual's final iBudget Allocation. Such funding shall be for temporary or permanent changes in service needs or for one-time needs that are medically necessary.

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

(19) Target Allocation: The allocated budget amount, in dollars, based upon the allocation algorithm and any other information the Agency has regarding the client's characteristics that could increase the Target Allocation, which is provided to the client as an initial suggested budget amount starting point.

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

(21) Waiver: The Developmental Disabilities Individual Budgeting Medicaid Home and Community Based Services Waiver (iBudget Florida) and the Four Tier Medicaid Home and Community Based Services Waivers operated by APD.

(22) Waiver Support Coordinator: Abbreviated as WSC, means a person who is designated by the Agency to assist individuals and families in identifying their capacities, needs, and resources, as well as finding and gaining access to necessary supports and services; coordinating the delivery of supports and services; advocating on behalf of the individual and family; maintaining relevant records; and monitoring and evaluating the delivery of supports and services to determine the extent to which they meet the needs and expectations identified by the individual, family, and others who participated in the development of the support plan.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662 FS. History--New 10-2-13.

65G-4.0211 General Provisions.

(1) The Agency will provide clients of home and community-based waiver services for persons with developmental disabilities with an iBudget Florida allocation as required by Section 393.0662, F.S. The Agency will determine the iBudget Florida allocation consistent with the criteria and limitations contained in the following provisions: Sections 409.906(13) and 393.0662, F.S.; and Rules 59G-13.080, 59G-13.081, 59G-13.082 and 59G-13.083, F.A.C. These criteria include:

(a) The client's needs in functional, medical, and behavioral areas, as reflected in the client's assessment using the assessment instrument known as the Questionnaire for Situational Information (QSI), the client's support plan, and existing annualized cost plan.

(b) The client's existing annualized cost plan, if any, that has been developed through Agency evaluation of client characteristics, the Agency approved assessment process, support planning information, and the Agency's prior service authorization process.

(c) The client's current living setting;

(d) The availability of supports and services from other sources, including Medicaid state plan and other federal, state and local programs as well as natural and community supports;

(e) If a client with documented behavioral, medical or functional needs chooses a less costly service to address those needs, the Agency will consider the need for those services in determination of the client's iBudget allocation.

(f) The Agency shall ensure that the sum of all individual budgets does not exceed the Agency's annual appropriation; and

(g) WSCs shall coordinate with their clients to ensure that services are selected from all available resources to keep the annual cost of services within the client's Final iBudget Allocation while maintaining the client's health and safety.

(2) As part of the assessment process, the Questionnaire for Situational Information 4.0 (Version 2-15-08)(QSI) is hereby adopted by the Agency as a valid and reliable assessment instrument. The QSI is available at: <http://apd.myflorida.com/waiver/qsiversion-4.pdf>, or <http://apd.myflorida.com/waiver/>.

(3) The client must utilize all available State Plan Medicaid services, school-based services, private insurance, and any other resources which may be available to the client before expending funds from the client's iBudget Florida allocation for support or services. As an example, State Plan Medicaid services for children under the age of 21 typically include, but are not limited to, personal care assistance, therapies, consumable medical supplies, medical services, and nursing. A client shall not be provided waiver services that duplicate available State Plan Medicaid Services for which the client is eligible.

(4) Within 5 working days of a client's request the WSC shall submit a request to the Agency to review a client's iBudget Florida allocation when a client has a significant change in circumstance or condition that impacts on the client's health, safety, or welfare or when a change in the client's support plan is required to avoid institutionalization. At that time a new QSI assessment will be conducted, if requested. The information identifying and documenting a significant change in circumstance or condition that necessitates additional funding must be submitted by the client's WSC to the appropriate Agency Area office for determination.

(5) The agency will request and review documentation and information necessary to evaluate individuals' increased funding requests. The requested documentation will vary according to the funding request and may include the following as applicable: support plans, results from the Questionnaire for Situational Information, documentation from reviews by contracted prior service authorization vendors, 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.

(6) Response to funding requests: Within thirty (30) days of receipt of a request for supplemental 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.

(7) Consumer Directed Care Plus (CDC+): Clients enrolled in the CDC+ program are subject to these rules as they are transitioned onto the iBudget Florida system.

65G-4.0212 Establishing the Final iBudget Allocation Amount.

Subsections (1) and (3) of this rule apply to all clients receiving an initial iBudget allocation. Subsections (2), (4) and (5) of this rule apply only to those clients transitioning to iBudget from one of the agency's other Waivers.

(1) To establish the client's Allocation Algorithm Amount, following steps will be followed:

(a) For any client who has not previously had a QSI assessment, a QSI assessment must be completed prior to calculating the allocation algorithm amount under paragraph (b).

(b) An Allocation Algorithm Amount shall be calculated for the client.

(2) This subsection is only applicable to clients transitioning to iBudget Florida from an existing Waiver. In order to reduce the amount of any decrease due solely to the transition to iBudget Florida, an Individual's Allocation Algorithm amount shall be adjusted, if necessary, as provided in this subsection. If a client or their representative do not participate in the process set out in subsections (1), (2) and (3) of this rule, the Agency will complete all other steps to determine the client's final iBudget Allocation based upon the information it has available to it.

(a) If the Allocation Algorithm Amount from paragraph (1)(b) is greater than the client's existing annualized cost plan amount, the Allocation Algorithm Amount will be reduced to the amount of the client's existing annualized cost plan.

(b) The total annual dollar amount for only the following services which are included in the client's existing annualized cost plan shall be calculated (resulting in the "sum"): Adult Day Training, Behavior Services, Consumable Medical Supplies, Durable Medical Equipment, In-Home Supports, Nursing Services, Occupational Therapy, Personal Care Assistance, Physical Therapy, Residential Habilitation, Respiratory Therapy, Special Medical Home Care, Supported Employment, Supported Living Coaching, and Support Coordination. If this sum is greater than the result in paragraph (a), then the result in paragraph (a) will be replaced by this sum.

(c) If after the procedures in paragraphs (a) and (b), the resulting amount is less than the individual's existing annualized cost plan, but is within \$1,000, the Allocation Algorithm Amount will be adjusted to equal the existing annualized cost plan amount.

(d) If the Allocation Algorithm Amount from paragraph (1)(b) would result in a reduction of over 50% of the client's existing annualized cost plan amount, the Allocation Algorithm Amount will be increased to be equal to 50% of the client's existing annualized cost plan amount.

(e) After the adjustments required by paragraphs (a), (b), (c) and (d) are made, if any, the resulting amount is the Target Allocation.

(f)1. Any increase or decrease to a client's existing annualized cost plan caused solely by the transition to an iBudget Florida allocation is limited to no more than 50% of the difference between (i) the client's Allocation Algorithm Amount from subsection (1) paragraph (b) of this rule together with any Extraordinary Needs approved under subsection (3) of this rule, and (ii) the client's existing annualized cost plan, as provided in Section 393.0662(3)(b), F.S.

2. If a client's reduction caused solely by the transition to an iBudget Florida allocation is greater than the limit in subparagraph (f)1., the remaining deficit shall be available in addition to the client's Final iBudget Allocation, for only one year beginning on or before October 1, 2013.

(3) Extraordinary Needs Review: The Agency shall consider extraordinary needs as identified in subsection 65G-4.0210(7), F.A.C. After the computation and adjustments in this rule resulting in the Target Allocation, the Target Allocation will be provided to the client and the client's Waiver Support Coordinator. The WSC will discuss the Target Allocation with the client, or representative in order to determine if extraordinary or health and safety needs can be met within the Target Allocation. The Target Allocation amount may be adjusted according to extraordinary needs as provided in this subsection.

(a) For all individuals whose Target Allocation represents a potential reduction to the individual's existing annualized cost plan, the Agency will conduct an individual review to provide the individual an opportunity to discuss the Target Allocation through the Allocation Implementation Meeting (AIM). The AIM worksheet (form) shall be completed as follows as part of that individual review:

(b) Existing Annualized Cost Plan. This section of the AIM form is to be completed in its entirety by the WSC prior to the discussion with the client or the client's representative, if the client has an existing annualized cost plan. This section of the AIM form reflects the client's existing annualized cost plan services for the cost plan as it exists immediately prior to the iBudget implementation.

1. If the client does not have a Waiver cost plan, this section of the AIM form will not be completed.

2. When this section is to be completed, the following fields in the form shall be completed with the information indicated which has been retrieved from the ABC database:

- a. SERVICE – enter the current tiered waiver name of each approved service.
- b. BEGIN DATE – enter the date that the service plan began.
- c. END DATE – enter the end date of that service plan.
- d. RATE – enter the current rate for that service.
- e. CURRENT UNITS enter the number of units on the approved annualized service plan.
- f. ALLOCATIONS – this will be populated from the rate and the current units.
- g. ANNUALIZED UNITS – enter the total approved units for a full year.
- h. ANNUALIZED ALLOCATIONS – the dollar amount sum for the Annualized Units.

(c) Proposed Annualized iBudget Services (Based on Target Allocation). This section should be completed by the WSC prior to the discussion with the client or their representative to show options for arranging current services within the target allocation. The WSC may complete multiple versions to assist the individual in seeing the possibilities. The following fields in the form shall be completed:

1. SERVICE – Enter the iBudget service name. NOTE: If natural or community resources are considered in addition to iBudget waiver services, these should be included to demonstrate the total array of services.
2. BEGIN DATE – Enter the iBudget Begin Date.
3. END DATE – Enter the end of the cost plan year.
4. RATE – Enter the iBudget rate for the iBudget service.
5. CURRENT UNITS – enter the number of units that would be possible within the iBudget target allocation for the balance of the cost plan year.
6. ANNUALIZED UNITS – For plans not beginning at the start of the cost plan year, the annualized number of units should be entered here.
7. ANNUALIZED ALLOCATIONS – the dollar amount sum for the Annualized Units.

If the individual or their legal representative agrees that the service needs can be met within the Target Allocation, this becomes their final iBudget Florida allocation. A final proposed cost plan should be identified with a written notation by the WSC to the Agency that this is the choice of the individual or their legal representative. The right to due process is retained even if the Target Allocation is accepted, and acceptance alone of a reduced iBudget allocation shall not be used at any administrative hearing as evidence of lack of need.

(d) Recommended Annualized iBudget Services. If the individual or their representative feels that the extraordinary or health and safety needs of the individual cannot be met within the Target Allocation, this section must be completed. All columns are to be completed by the WSC, with input from the individual or their representative, to show the services that are felt to be necessary to maintain the person's health and safety and to demonstrate these health and safety concerns constitute an extraordinary need that would be present absent the requested services.

1. The WSC will gather the documentation needed to demonstrate a client's extraordinary needs, and medical necessity for newly requested services (if any), for the Proposed Annualized iBudget and discuss with APD staff why the Target Allocation is insufficient to meet the health and safety needs of the individual. If the WSC or client has concerns about the accuracy of the criteria used for determination of the client's algorithm, this shall also be addressed by verifying the accuracy of the criteria used with the client in the review by APD staff.

2. The AIM Signature Page and all versions of the cost plan demonstration pages shall be submitted to the agency with the justification documents.

(e) The AIM Signature Page. The AIM Signature Page is to be completed and reviewed with each individual or their representative. During the transition to iBudget Florida, this page is not required unless the client's final iBudget allocation is less than their existing annualized cost plan.

1. Complete the upper portion in its entirety, including the annualized iBudget target allocation, and the pro-rated target allocation, if appropriate.

2. The first two sections of the AIM Cost Plan demonstration pages should be completed prior to meeting with the individual or their representative.

3. Note the points discussed with the each individual or their representative and all options that were considered.

4. The individual or their representative is required to sign the form to document that they have discussed the AIM worksheet with the WSC. If the client or representative does not sign the form, the WSC shall document why no signature was recorded.

a. This is not an agreement to accept, or an acceptance or rejection of, the iBudget Target Allocation. Signing the worksheet only confirms that the discussion of the AIM worksheet occurred and that their iBudget Target Allocation was explained, along with options for accepting the targeted amount or for requesting consideration of restoration of all or part of the approved annualized tiered waiver cost plan.

b. The right to a fair hearing is not affected by the client's or their representative's signature on this form, and hearing rights and a hearing request form will be provided with the final notice of their iBudget allocation.

5. Once the AIM worksheet is complete under this subsection, it shall be filed in the client's Central Record and a copy provided to the Agency.

(f) Once the completed AIM worksheet has been reviewed, the Agency will not approve an increase to an individual's iBudget Florida allocation if the Agency determines that the individual has other resources or supports available to meet the health and safety needs of the client or the client's caregiver. The Agency shall only approve an increase to an individual's iBudget Florida allocation if the client has extraordinary needs, that is the health and safety needs of the client, the client's caregiver, or the public would be in immediate serious jeopardy unless the increase is approved. The Agency's decision on extraordinary needs shall be based on the documentation provided through the AIM process, as well as the Agency's internal review.

(g) An extraordinary need, as defined in subsection 65G-4.0210(7), F.A.C., and applied in the iBudget Florida Rules, must be demonstrated through the AIM review process for any Final iBudget Florida Allocation to exceed the client's existing annualized cost plan amount.

(h) iBudget Florida allocations are pro-rated as appropriate based on the length of time remaining in the fiscal year at the time of transition.

(i) Once the iBudget Florida cost plan is authorized, an individual may use his or her budget for any services for which he or she meets the criteria in these rules as long as the individual's health and safety needs are met in conformance with Rule 65G-4.024, F.A.C., the Cost Plan Changes rule.

(j) The individual or their representative will be sent a notice advising them of the Agency's decision for the amount of the client's final iBudget Allocation.

(4) During an individual's transition to iBudget Florida from another Waiver, services that appear on an individual's current authorized cost plan shall be pre-approved by type and intensity to the extent of an individual's iBudget Florida allocation, unless the individual's situation has changed such that he or she no longer qualifies for the service types. The frequency, scope, or duration of such service types is determined by the individual and the WSC once the final iBudget allocation has been approved. Pre-approval of types and intensities of services permits an individual to choose such pre-approved services at the frequency, scope, and duration that can be accommodated within his or her budget allocation on a proposed cost plan for review by the agency. Therefore, pre-approval of a service type or intensity does not guarantee that an individual's proposed cost plan containing those services will be approved, nor does it guarantee that the frequency, scope, or duration of pre-approved services listed on the individual's proposed cost plan will be approved. The agency will build a cost plan for any individual who fails to cooperate in developing an iBudget cost plan.

(5) Transition to the iBudget from another Waiver.

(a) The Agency's transition to iBudget Florida shall be completed no later than June 30, 2013, but this completion date shall not affect the determination of what is the first year a client receives an iBudget funding amount for any recipient transitioning to the iBudget Waiver.

(b) For purposes of this rule, only for individuals who had been receiving Waiver services and are transitioning to iBudget Florida, "Target iBudget Florida Allocation" means the sum of the allocation algorithm amount, in dollars, and the adjustments in subsection (2) of this rule. The transition provisions in this rule only apply to individuals who previously were receiving Waiver services administered by the Agency (for example the Tier waivers).

65G-4.022 The iBudget Florida Cost Plan.

(1) Each individual's initial iBudget Florida cost plan shall be reviewed and approved by the Agency in conformance with these rules and the Florida Medicaid Developmental Disabilities Waiver Services Coverage and Limitations Handbook, November 2010, available at <http://www.apd.myflorida.com/waiver/hcbs/>, as adopted by Rule 59G-13.083, F.A.C. (5-13-2012), which is hereby incorporated by reference.

(2) For an individual to begin receiving a specific waiver service, that service must have been listed in a cost plan that has been reviewed and approved by the agency, and the service authorization must have been issued to the provider prior to the delivery of service.

(3) Requested cost plan changes must detail funding for the requested services through the entire fiscal year or portion of year the individual is enrolled in iBudget Florida, regardless of when the cost plan is submitted. The total amount of services requested to be authorized for the fiscal year may not exceed the individual's current budget allocation for that fiscal year. If services are requested to meet needs that cannot be met within the client's existing iBudget Allocation, the WSC must seek a new calculation of the algorithm amount under subsection 65G-4.024(5), F.A.C., or supplemental funding under Rule 65G-4.027, F.A.C.

(4) Individuals shall use all available services authorized under the State Plan Medicaid, school-based services, private insurance and other benefits, and any other resources that may be available to them before using funds from their iBudget allocations to pay for support and services. Failure to comply with this subsection shall result in denial of the supplemental funding request.

(5) 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.

(6) 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 noncompliance with Rule 65G-4.024, F.A.C.

(7) At the time of the annual support plan review the agency shall conduct a medical necessity review of the iBudget allocation annual amount and the specific services that are authorized in the iBudget cost plan to ensure all services continue to meet the eligibility criteria for the service and to ensure that any one time, or temporary services are not continued if they are no longer needed. This review shall be completed within 15 business days of the receipt of the annual support plan and cost plan submitted by the Waiver Support Coordinator. The reviews shall be conducted by agency staff that have been trained in the medical necessity criteria.

65G-4.024 Cost Plan Changes.

Cost Plans are changed according to provisions of this rule:

(1) After the individual's initial 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.

(2) 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.

(3) Cost Plan Flexibility. Clients enrolled in iBudget Florida will have flexibility and choice to budget or adjust funding among many service families without requiring additional authorizations from the agency, provided the overall client iBudget allocation is not exceeded and all health and safety needs are met. Clients may adjust funding among the following service families without prior authorization from the agency: (a) Life Skills Development; (b) Supplies and Equipment; (c) Personal Supports; (d) Transportation; and (e) Dental. All other services families require prior approval from the agency before making a funding change, these services include Residential Services, Support Coordination, and Wellness and Therapeutic Supports.

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

(5) When an individual's situation changes significantly during the fiscal year such that the allocation algorithm, would generate a lesser amount of funding (for example, if the individual moves from a licensed residential facility to a family home), the individual's budget allocation will be recalculated as provided in these rules and adjusted on a pro-rata basis to reflect his or her new situation. When an individual's situation changes during the fiscal year such that the allocation algorithm would generate a greater amount of funding, the individual may request that their budget allocation be recalculated by the Agency as provided in these rules and adjusted on a pro-rata basis to reflect his or her new situation. The Agency shall recalculate any allocation algorithm and budget allocation promptly upon request. Any request under this provision shall be made as required by subsection 65G-4.0211(4), F.A.C. A new iBudget allocation for the client is calculated under the provisions of these iBudget Rules.

(6) If a client no longer meets medical necessity to receive a particular service, the agency shall notify the client of the intent to reduce or remove the authorization for that service or level of service. The Agency shall also adjust the client's Final iBudget Allocation, as necessary to reflect this change.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662 FS. History--New 10-2-13.

65G-4.027 Supplemental Cost Plan Funding.

(1) Supplemental funding may be of a one-time, temporary, or long-term nature. Significant changes to the need for funding for a client may be a one-time or temporary need, or the need may be long term, meaning a period of 12 months or more. Significant changes may create needs for services which cannot be accommodated within the client's iBudget Florida allocation. However, the presence of a significant need for one-time or temporary, or for long-term or permanent, supports or services alone do not warrant an increase in the iBudget Florida allocation to the client.

(2) A WSC shall submit any requests for supplemental funds on behalf of an individual. To receive supplemental funds, individuals shall meet criteria described below as well as the other requirements provided in these rules.

(3) Supplemental funding shall only be granted if the following conditions of either paragraph (a) or (b) are met, and the requirements of subsection (4) are met.

(a) 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; or

(b) 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 or condition, including, but not limited to, permanent or long-term loss or incapacity of a caregiver, loss of services authorized under the State Plan Medicaid or the school system 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.

(4) Supplemental funding shall be approved if one or more of the requirements of subsection (3) are met and the individual is in one or more of the following situations described in paragraphs (a), (b), (c), (d), (e), (f), and (g) of this subsection; Credible evidence is required to support an individual's meeting the relevant indicators of the situation.

(a) The individual is currently homeless, which includes but is not limited to living in a homeless shelter, or living with relatives in an unsafe environment. Relevant indicators include:

1. Without immediate provision of additional waiver services, the health and safety of the individual are in serious jeopardy;
 2. The individual has no shelter available and needs emergency placement by the Agency or another state agency;
 3. Alternative funding or other federal, state, local, community, and other resources are not available for other placement and services to the individual;
 4. The individual temporarily is staying with friends or relatives but residence is not expected to last more than several weeks;
 5. The individual's caregiver has no legal obligation to provide shelter to the applicant and the caregiver's commitment to shelter the applicant is low;
 6. Factors affecting the individual's safety in the current setting include risk of physical abuse of the individual or risk of insufficient supervision and support;
 7. The home has insufficient room to shelter the individual, or the individual must share a room in an inappropriate living arrangement, based on the ages, genders, and conditions of the persons sharing the room;
 8. The individual's desire for placement creates a reasonable expectation that the individual will be cooperative with placement;
 9. Violence or illegal activities within the individual's current living environment by the individual or others have required the intervention of local or state law enforcement authorities;
 10. Complaints of neglect, exploitation, or abuse of the individual to Protective Services, or other adverse environmental conditions affecting the individual, have been investigated and confirmed pursuant to Chapter 39, Part II, or Section 415.104, F.S.;
- or
11. The individual requires services of greater intensity.

(b) The individual has an increase or onset of behaviors that, without provision of immediate waiver services, may create a life-threatening situation for the individual or others, or that may result in bodily harm to the individual or others requiring emergency medical care from a physician. Relevant indicators include:

1. Without an immediate increase in waiver services, the health and safety of the individual or others in the household is in serious jeopardy;

2. The individual's injury to self or others is frequent or intense;

3. The individual or others are at risk for serious injury or permanent damage;

4. There is documentation of medical treatment for the individual's injury to self or others;

5. No other supports are available to address the individual's behaviors;

6. Other attempted behavioral assessments and interventions have proven ineffective;

7. The relative ages, sexes, and sizes of the aggressor and the subjects of aggression place the subjects of aggression at risk of injury;

8. The caregiver has insufficient ability to control the individual;

9. The ages or disabilities of the individual or caregiver exacerbate the problems;

10. Violence or illegal activity within the individual's current living environment by the individual or others has required the intervention of local or state law enforcement authorities;

11. Complaints of neglect, exploitation, or abuse of the individual, or other adverse environmental conditions affecting the individual have been investigated by Protective Services and confirmed pursuant to Chapter 39, Part II, or Section 415.104, F.S.; or

12. The individual requires services of greater intensity.

(c) The individual's current caregiver is in extreme duress and is no longer able to provide for the applicant's health and safety because of illness, injury, or advanced age. The individual needs immediate waiver services to remain living with the caregiver or to relocate to an alternative living arrangement. Relevant indicators include:

1. Without immediate provision of additional waiver services, the individual's health and safety are in serious jeopardy;

2. Other potential caregivers, such as another parent, stepparent, brother, sister or other relative or person, are unavailable or are unwilling or unable to provide care;

3. The caregiver's physical or mental condition prevents the provision of adequate care;

4. The caregiver is deceased, facing imminent death, or permanently disabled;

5. The caregiver's age impairs the caregiver's ability to provide sufficient care to the individual;

6. The caregiver cannot provide sufficient care because of the age or size of the individual, or the physical, functional, or behavioral demands of the individual;

7. The caregiver's economic situation is unstable and unlikely to improve as a result of the care-giving demands of the individual;

8. The caregiver's obligations to the needs of other dependents prevent the caregiver from providing the individual with adequate care, or the caregiver's obligation of care to the individual places other dependents at risk of insufficient care;

9. Violence or illegal activities within the individual's current living environment by the individual or others has required intervention by local or state law enforcement authorities;

10. Complaints of neglect, exploitation, or abuse of the individual, or other adverse environmental conditions affecting the individual have been investigated by Protective Services and confirmed pursuant to Chapter 39, Part II, or Section 415.104, F.S.; or

11. The individual requires services of greater intensity.

(d) A change in age that will result in a loss of services funded or otherwise provided from sources other than the waiver, such as State Plan Medicaid or the school system.

(e) The individual experiences a documented significant change in medical or functional status that would necessitate increased service utilization or a need for a more costly service. Examples of such changes are:

1. A deterioration in medical condition that requires that the individual receive services at a greater intensity or in a different setting to ensure that individual's health or safety; or

2. Onset of a health, environmental, behavioral, or medical condition that requires that the individual receive services at a greater intensity or in a different setting to ensure the individual's health or safety.

(f) The individual has documented serious, acute dental needs requiring prompt attention.

(g) The durable medical equipment used by the individual has reached the end of its useful life or is damaged, or the individual's functional or physical status has changed enough to require the use of waiver-funded durable medical equipment that had not previously been used; and the individual cannot fund the entire amount of the purchase from his or her budget allocation without jeopardizing health and safety.

(5) To ensure that limited supplemental funding is targeted to those individuals most in need:

(a) Whenever an individual requests supplemental funding, a proposed cost plan shall be submitted indicating how the current budget allocation and requested supplemental 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.

(b) The maximum amount of supplemental funds that may be granted to an individual is that amount required beyond the individual's current budget allocation to meet the health and safety needs of the client or the client's caregiver, or to ensure public safety, that are not able to be adequately met through other sources of support.

(c) Supplemental funds may be approved for a specific time period and for specific supports and services and, if so, may not be used outside of this time period or for another purpose without agency approval. If after 90 calendar days temporary or one-time supplemental funds have not been used and will not be needed to meet health and safety needs, the authorization for supplemental funds expires.

(d) The services for which the supplemental funding is being specifically requested must be Medically Necessary.

(e) To avoid risks to health and safety while allowing budget flexibility, individuals shall not receive supplemental funding in situations when the need could be addressed by re-budgeting funds. In those instances, funds shall be re-budgeted from services that have flexibility within their Service Families, and which meet the need for which supplemental funding is requested.

(f) Supplemental funding may not be provided for purposes including: addressing temporary loss of support from a caregiver due to reasons including but not limited to caregiver vacation; accommodating a preference for a more intense level of service when a less intense level of service will meet health and safety needs; when an individual has a single incident or a minor change in circumstance which does not jeopardize health and safety; routine dental procedures; solely for the convenience of the caregiver; or due to provider scheduling issues.

(6) If an individual's budget allocation includes additional supplemental funding beyond what was determined by the Allocation Algorithm, and the agency determines that the additional funding is no longer medically necessary, according to these rules, the agency will adjust the individual's budget allocation on a pro-rata basis to the amount actually needed to ensure health and safety.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662 FS. History--New 10-2-13.