agency for persons with disabilities
State of Florida

September 30, 2019

The Honorable Bill Galvano
Senate President
409 The Capitol
404 South Monroe Street
Tallahassee, Florida 32399

The Honorable Jose Oliva
Speaker of the House
420 The Capitol
402 South Monroe Street
Tallahassee, Florida 32399

Dear President Galvano and Speaker Oliva:

The Agency for Persons with Disabilities (APD) and the Agency for Health Care Administration (AHCA) are respectfully submitting the following iBudget Florida waiver redesign plan for legislative consideration, pursuant to Section 26, Chapter 2019-116, Laws of Florida.

Thank you for your favorable consideration.

Barbara Palmer
APD Director

Mary C. Mayhew
AHCA Secretary

Attachment

2019 iBudget Waiver Redesign

Submitted by:

Agency for Persons with Disabilities

Agency for Health Care Administration

September 30, 2019

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EXECUTIVE SUMMARY

The original intent of the Medicaid program was to provide critical health coverage to extremely low-income families, elderly, and individuals with disabilities. Individuals with intellectual and developmental disabilities are often in need of, and dependent on, state-provided services from shortly after birth and often until their death. This is often referred to as the true long-term care system. For far too long individuals with intellectual and developmental disabilities were largely served in institutional settings. Over the last twenty years states around the country have worked to reduce institutional settings in favor of supporting individuals in their homes and in their communities. In Florida, the Medicaid iBudget waiver is the program that funds and supports those home and community-based services to provide medically necessary supports to individuals with intellectual and developmental disabilities in living, learning, and working in their communities. The iBudget waiver program serves individuals with autism, cerebral palsy, spina bifida, intellectual disabilities, Down syndrome, Prader-Willi syndrome, Phelan-McDermid syndrome, and children age 3-5 who are at a high risk of a developmental disability. The services provided by the iBudget waiver program include support coordination, residential services, personal support services, therapeutic services, and life skills development services. The iBudget waiver program currently serves over 34,500 individuals. There are also over 21,000 individuals on the waiting list. The state general revenue expenditures for Fiscal Year 2017-18 were $448.5 million and the projected expenditures for FY 2018-19 are $483.4 million. Total expenditures and appropriations with the federal Medicaid matching funds for Fiscal Year 2017-18 are $1.17 billion and $1.11 billion, respectively. Total projected expenditures and appropriations with the

federal Medicaid matching funds for Fiscal Year 2018-19 are $1.24 billion and $1.14 billion, respectively.

Since full implementation of the iBudget waiver program in 2013, the expenditures for the program have increased to the point that the expenditures exceed the appropriation. The reason for the increased expenditures is the changing service needs of the waiver clients. The primary causes for changes in waiver client service needs are:

- Aging clients requiring more services
- Aging caregivers no longer able to provide care

The waiver services with the highest expenditure increases are:

- Residential Habilitation (group homes) services (38% of all expenditures)
- Personal Supports (personal care) services (26% of all expenditures)
- Adult Day Training (meaningful day activities) services (7% of all expenditures)

The iBudget waiver program is not included in the Social Services Estimating Conference (SSEC). Therefore, the increase in iBudget waiver program expenditures is not a part of the Medicaid expenditure projections provided to the Legislature by the SSEC.

To address the budget shortfall, the following measures could be taken by the Legislature:

- Fully fund the future growth of the iBudget waiver program
- Immediately implement:
    - Inclusion of the iBudget waiver program in the SSEC
    - A behavior health Intermediate Care Facility service rate
    - Individual caps for waiver clients
    - Budget transfers from the Medicaid State Plan to the iBudget waiver

program for waiver clients turning 21

    - Expansion of the Medicaid Assistive Care Services program to include waiver group homes
    - Service limitations on Life Skills Development services
    - Centralization of the Significant Additional Needs process
    - Restructure support coordination services
- Long-Term:
    - Implement the Next Generation – Questionnaire for Situational Information (NG-QSI) as the waiver assessment tool and budget allocation tool
- Implement significant rate cuts and service cuts

INTRODUCTION

From Cradle to Grave:

A Glance at Developmental Disabilities in Florida

The People Behind the Growth in Service Needs

The success of Florida's iBudget waiver program is strongly supported by empirical evidence. The iBudget waiver program provides tens of thousands of our most vulnerable citizens with the opportunity to lead meaningful and productive lives within their communities. It is also well documented that the iBudget waiver program has experienced increased costs over the years. This programmatic growth is not the result of fraud, mismanagement, or waste but is directly attributable to the changing needs and life circumstances of waiver enrollees. Their increased needs extend from birth to death. Although it may be tempting to look at financial growth solely in terms of dollars and cents, it is important for legislators, policymakers, and the general public to understand that there is a human being with a unique situation behind each and every cost plan increase approved by the Agency for Persons with Disabilities (APD).

The following real-life situations represent just a handful of the tens of thousands of individuals served by APD over the past several years; their stories are told from a first-person perspective to help the reader understand and appreciate the circumstances faced by actual iBudget waiver enrollees with increased service needs.

Louis

I am a 46-year-old man with cerebral palsy and a profound intellectual disability. I live alone with my 84-year-old mother. My dad died almost 20 years ago, and my mom has no other family in the area. I use a wheelchair to get around our apartment. My mom has to lift me in and out of my wheelchair every day. Lately, she can no longer lift me on her own, so I have to sit in a dirty diaper all day long until my personal care provider gets here after dinner to change me and give me a bath. I need funding for more personal supports and to make our apartment easier to get around in my wheelchair.

Robert

I am a 22-year-old man with autism and an intellectual disability. My father left our family a couple of years ago because he could not deal with my behaviors, so I just live here with my mom and my little brother. When I get angry, I attack everyone around me, which is why my mother and little brother sleep in one room and I sleep by myself. Most of the anti-psychotic medications prescribed by my psychiatrist have caused me to gain lots of weight, so I now weigh around 250 pounds. My mom says that all of her friends and relatives are afraid of me, so no one ever comes by to visit or help us. My mom locks me in my bedroom whenever she needs to go to the bathroom or take a shower, so I don't run away or hurt my little brother. She can't work anymore because I'm too old for school and there is no one around to watch me. I need more funding for behavioral services, personal supports, and a day program.

Steven

I am a 32-year-old man with an intellectual disability. For as long as I can remember, I have lived alone with my mom. Three days ago, my mom fell and died in the kitchen. I did not know how to use the phone or call for help. After three days, one of the neighbors was worried about us and called the police to check on us. The police found me in the kitchen trying to wake my mom up. I need more money because I am going to move into a group home.

Rachel

I am a 35-year-old woman living with my mother and stepfather. I am totally dependent on others for all activities of daily living. I have severe spasticity in my upper and lower extremities and must be positioned carefully to avoid falls or skin breakdown. My mother has been my primary caregiver, but she also cares for my stepfather who has dementia, is non-ambulatory, and requires total care. My mom has had health issues for several months and is overwhelmed with caring for us. I went into a group home for respite care when my mother was hospitalized and the staff at the group home found me severely underweight with six pressure ulcers. The group home staff also noticed redness and warmth in my leg, for which a CT scan was completed, and it was determined that I had a fracture that occurred several weeks ago. I need more funds in my budget for nursing and personal supports for when I go back home.

Leah

I am a 42-year-old woman living with my father. My mother died of a heart attack a few years ago, so my father takes care of me when our personal care provider is not here. However, my father just had a hip replacement and, as he ages, it is becoming more difficult for him to meet all of my needs. I have an intellectual disability, seizure disorder, spastic quadriplegia, scoliosis, am legally blind, and have contractures of the arms and legs. I am totally dependent on others for all self-care. My food must be pureed so I don't choke when I eat. My wheelchair must be propelled by others and I cannot tolerate being in an upright position. I need additional funds for more personal supports, adult dental care, consumable medical supplies, and personal care items.

Timothy

I am a 43-year-old man with Down syndrome who has lived in a group home for the past five years. When I first moved into the group home, I could do a lot of things for myself, such as making simple meals, using the bathroom, taking a shower, and working part-time at Publix. About a year ago, I began having problems at work and was forgetting how to do many of my household chores. I was diagnosed with early onset dementia (which is very common for people with Down syndrome). I need more funding for residential habilitation and companion services so that my group home can provide me with the additional support I now need.

Floridians deserve the opportunity to live their American dream – A success story

Meet 55-year-old Missy. She enjoys swimming, aerobics, dancing, and going to the theater to watch plays. She also has significant developmental disabilities. Missy is one of the original Floridians who made the groundbreaking decision in 1982 to live in her community by enrolling in Florida's Medicaid waiver, rather than moving to an institution. For more than 30 years, the waiver has allowed her to live in her own home, have a long-standing career with Walmart, and be an active citizen in her Tallahassee community. If she had been born 10 or 20 years earlier, Missy likely would have spent her days in an institution with fewer opportunities to be engaged in her community, costing the state millions of dollars.

There are thousands of similar stories of people with intellectual or developmental disabilities who, because of the waiver, start their own businesses, perform in community theater, live independently, are recognized as star employees at their jobs, and the like.

In short, the waiver allows individuals with developmental disabilities to live their American dream.

The Waiver Program

The waiver program is a proven system for better care at a lower cost

After Florida joined the national trend to move away from institutionalization in the early 1980s, Floridians were given the opportunity to waive their right to an institution and instead receive needed services in their family home, in their own home, or in a group home. These individuals enjoyed a better quality of life with the waiver, and the state saved billions of dollars. Institutional care is a mandatory Medicaid service that must be

provided if requested. Florida set up the infrastructure to deliver services in these varied living settings, but continues to struggle with addressing the growth in service needs.

Florida has been extremely frugal with spending on individuals with disabilities, ranking 50th out of 51 in the nation (including the District of Columbia) in Total Fiscal Effort, spending less than $2 per $1,000 of statewide personal income for Intellectual/Developmental Disability (IDD) services. Florida also spends comparatively less on the annual cost of care in a group home (46th) and supported living (44th)[1]. On average, APD spends about $35,000 per person per year on the waiver, as compared to an institutional cost of about $135,000 per person per year.

As of July 1, 2019, 19,465 (56%) waiver clients lived in the family home, 5,268 (15%) lived in their own home, and 9,999 (29%) lived in a licensed residential facility in the community.

Floridians say the waiver is working for them

APD held a public forum on July 17, 2019, to receive input on ways to improve the iBudget waiver program. APD received hundreds of emails and letters regarding the iBudget waiver program. The overwhelming themes were: 1) managed care will not work for this population and 2) core services are different for every individual, so eliminating services is not a realistic option. Parents, self-advocates, Waiver Support Coordinators, and providers shared that the waiver has allowed clients to have a better quality of life. Of the nearly 1,000 people who offered their testimonials, all of them said the waiver should not

[1] The State of the States in Intellectual and Developmental Disabilities: 2017, 11th Edition http://www.stateofthestates.org/

be eliminated. The waiver is working for families, allowing their loved ones to live a full life in their community.

The Drivers of Increased Growth in Service Needs

People with disabilities move to Florida daily, and their caregivers are likely seniors

"When I had cancer, I wasn't afraid of dying, myself; I was afraid of, 'Who is going to take care of my son?' And that's what I would lay in the hospital thinking about." This heartbreaking sentiment from Susan Wallitsch, parent of an adult with autism, is echoed by many parents of APD clients.

Demand for waiver services is increasing. Florida is home to more caregivers over age 60 who are caring for people with developmental disabilities than any other state in the country[2]. Parents who are losing the ability to care for themselves are still trying to take care of their adult children with serious medical and behavioral issues.

The state of Florida promotes itself as a great place to live. As a result, families are moving to Florida at an increasing rate, many with children with disabilities. APD receives calls virtually every day from families who have moved to Florida with a child with a disability and are requesting services.

The service needs of people with disabilities are rising dramatically

The life expectancy of Florida's population is increasing, which includes individuals with disabilities. Unlike many other populations, the needs of someone with a developmental disability are lifelong and will increase as they age; the need for services and the

[2] The State of the States in Intellectual and Developmental Disabilities: 2017, 11th Edition http://www.stateofthestates.org/

associated costs will never go away. More children are being born with autism and other developmental disabilities than ever before. Between 2016 and 2018, the prevalence of autism increased by 15%.[3] These individuals need significant services and supports from state government, which has a legal and moral responsibility to ensure their health and safety. The need for services continues to increase because of the increasing number of children with developmental disabilities who will need services and have yet to reach the adult system, and because of aging caregivers who will no longer be able to take care of their adult children.

As individuals with developmental disabilities and their caregivers become less able to provide natural supports, programmatic costs increase every year, just like other Medicaid-funded programs. Their ongoing service needs span a lifetime.

[3] Centers for Disease Control and Prevention https://www.cdc.gov/media/releases/2018/p0426-autism-prevalence.html

GOALS

The 2019 Implementing Bill requires the redesign of the iBudget waiver program to:

- Improve budget predictability;
- Maintain or improve the services needed for health and safety;
- Ensure flexibility of clients to select services that meet their needs; and
- Improve the support coordination services that promote management of service utilization.

CURRENT SITUATION

The Florida iBudget waiver program for individuals with intellectual and developmental disabilities provides a community-based alternative to institutional care. These services not only enable individuals to remain in their communities, they are also less expensive to the state. On average the annual individual cost of waiver services ($35,000) is considerably lower than institutional care ($135,000). The iBudget waiver program serves individuals with autism, cerebral palsy, spina bifida, intellectual disabilities, Down syndrome, Prader-Willi syndrome, Phelan-McDermid syndrome, and children age 3-5 who are at a high risk of a developmental disability. The services provided by the iBudget waiver program include support coordination, residential services, personal support services, therapeutic services, and life skills development services. The iBudget waiver program currently serves over 34,500 individuals. There are also over 21,000 individuals on the waiting list.

All 34,500 waiver clients are eligible for institutional care.
*If all 34,500 invoked their entitlement to institutional care, it would be an additional cost to the state of **$3.4 billion** annually.*

The Florida waiver program has gone through several changes since its inception in 1982. The changes have usually been made in response to court rulings or to address deficit spending. The changing service needs of waiver clients over time, due to clients aging, caregivers aging, and other life events, are the primary reasons for the growth in waiver program expenditures.

Although enrollment on the waiver is not an entitlement, once enrolled on the waiver, federal regulations and court rulings have established that clients are entitled to those services that have been determined medically necessary for them to be able to continue to reside in the community. These requirements have effectively prevented APD from containing waiver costs. The result has been iBudget waiver program deficits in recent years. Even though the iBudget waiver program is not included in the Social Services Estimating Conference (SSEC), APD has been able to project future waiver expenditures and has submitted Legislative Budget Request (LBR) issues to address the projected deficits.

HISTORY OF WAIVER

We have come too far to return to an antiquated model

The implementation of Florida's Medicaid waiver in 1982 marked a new era in caring for people with developmental disabilities. Before that landmark decision, Floridians born with "mental retardation" were herded into archaic institutions.

Thankfully, in the early 1960s President John F. Kennedy and others recognized these conditions as inhumane and backwards. Medical professionals and advocates worked for decades to shift from a one-size-fits-all institutional warehouse approach to seeing each individual as worthy of being treated with respect and dignity and provided an opportunity to remain in the community.

The state entered into a Home and Community-Based Services (HCBS) waiver agreement in 1982 with the federal Centers for Medicare & Medicaid Services (CMS), then called the Health Care Financing Administration, to provide community options in lieu of building more institutional placements for individuals with developmental disabilities. As part of the waiver, Florida agreed to provide 26 services to eligible Floridians. While the waiver is not an entitlement program, the waiver agreement requires the state to continually provide medically necessary services to all individuals on the waiver.

The purpose of the Florida waiver as defined in the approved waiver agreement is "to promote and maintain the health of eligible recipients with developmental disabilities; to minimize the effects of illness and disabilities through the provision of needed supports and services to delay or prevent institutionalization; and to foster the principles of self-

determination as a foundation for supports and services. The intent of the waiver is to provide an array of services from which eligible recipients may choose, which allow them to live as independently as possible in their own home or in the community and to achieve productive lives as opposed to residing in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) or other institutional settings."

Since 1982, the waiver program has gone through many changes. During the 1990s, the waiver was expanded to serve more individuals and to provide more service options to individuals on the waiver. The 1999 Prado-Steinman settlement agreement resulted in offering waiver enrollment to everyone on the waiting list, providing full funding for medically necessary services requested, and due process rights for individuals.

During the 2000s, the Consumer-Directed Care Plus program was launched to allow individuals to have more flexibility in how to spend budgeted funds and to be able to hire family members to be caregivers. A standard rate structure was implemented, and thousands of individuals were enrolled on to the waiver. The waiver began running a deficit and service rates were reduced, services were eliminated or reduced, and a four-tier waiver system was implemented to contain costs.

During the 2010s, funds were provided to address past deficits and the iBudget waiver program was implemented to provide more flexibility to waiver clients on the use of their allocated funds and as a cost containment measure. The iBudget waiver program introduced an allocation methodology and algorithm to determine the iBudget amount to be provided to each waiver client based upon the budget amount appropriated for the program. Using this methodology, the iBudget waiver program was to remain within appropriation. The iBudget waiver program was fully implemented in 2013. Since then,

there have been multiple court cases and rule challenges that have resulted in more funding for more clients. The 2013 Moreland ruling[4] required the iBudget amounts of 6,000 individuals be restored to pre-iBudget levels. The 2013 Wheaton settlement[5] agreement required the timely processing of requests for additional funding amounts. The 2014 iBudget rule challenge required that 14,000 individuals have their iBudget amounts increased to the individuals' algorithm amounts. In addition, each year thousands of existing waiver clients request additional funding to address their changing service needs. The majority of the requests are granted because medical necessity can be established for the services.

Because of court decisions and requests for additional funds for medically necessary services, the iBudget allocation methodology and algorithm have not been successful in containing costs as originally envisioned.

Medicaid was created to serve people with disabilities, the elderly, and those living in extreme poverty. We cannot forget how far we've come. We must make the commitment to effectively meet the needs of these vulnerable individuals in the community today, tomorrow, and beyond.

[4] Moreland, et all. v. Palmer (U.S.N.D.FL. Case No. 4:12-cv-00585-MW/CAS)
[5] Wheaton v. Palmer (U.S.N.D.FL. Case No. 4:13cv179-MW/CAS)

WAIVER OVERVIEW

There are over 34,500 individuals in the iBudget waiver program and there are over 21,000 on the waiting list for the iBudget waiver program. The purpose of the iBudget waiver program is to provide medically necessary services to individuals that allow them to live in their communities rather than in institutions. Waiver services should augment the natural supports available to the individual through family members and the community. Each individual on the waiver must select a Waiver Support Coordinator, paid through the waiver, to assist them in fully utilizing the natural supports and community resources available to them. Individuals enrolled in the iBudget waiver program should receive services that enable them to:

- Have a safe place to live;
- Have a meaningful day activity;
- Receive medically necessary medical and dental services;
- Receive medically necessary supplies and equipment; and
- Receive transportation required to access necessary waiver services.

Seventy-one percent (71%) of all individuals enrolled in the iBudget waiver program live with their families or in their own homes. Twenty-nine percent (29%) live in community residential facilities licensed by APD. Living in the community is not only beneficial to the client and their family, on average it is also more cost effective than institutional care.

APD was directed by the Legislature to design and implement the current iBudget waiver program because “improved financial management of the existing home and community-based Medicaid waiver program is necessary to avoid deficits.” The key budgetary components of the iBudget waiver program are a statistically valid algorithm for “the equitable allocation of available funds based on the client’s level of need” and a reserve

amount of the waiver appropriation for “needs that cannot be accommodated within the funding determined by the algorithm and having no other resources, supports, or services available to meet the need.” APD uses a Significant Additional Needs (SAN) process to provide additional funding to individuals who cannot fund their medically necessary services within their existing allocation[6]. The premise of the iBudget waiver program is that the appropriation will be distributed among the waiver clients based upon level of need and they will have the flexibility to use the funds to choose which services would best meet their needs. Implicit in the statute is the agency will deny additional funding to clients once all of the appropriated funds are distributed among the waiver clients. However, federal regulations[7] prohibit states from denying coverage of “medically necessary” services that fall under a category covered in their Medicaid plans. Further, court rulings[8] have held that states may not deny “medically necessary” services to waiver clients solely based on budget availability.

The primary reason waiver expenditures rise each year is over time individuals with developmental disabilities and their caregivers become less able to provide natural supports, thus more waiver services are needed for the individual to continue living in their community. The cost of the increased service needs of waiver clients has always outpaced funding allocations. Most Medicaid-funded programs have annual increased costs. In Florida, the SSEC provides the Legislature and others with projections of future spending for the Medicaid-funded programs; however, the iBudget waiver program is not included in the conference.

[6] Section 393.0662(1)(a), Florida Statutes, and Rule 65g-4.0214, Florida Administrative Code
[7] See Appendix F
[8] See Appendix F

Because of this exclusion, there is no formal method, other than Legislative Budget Request issues and the Surplus/Deficit report, to communicate to the Legislature the projections of future waiver spending. Another difference between the iBudget waiver program and the other Medicaid programs is enrollment in the iBudget waiver program is not an entitlement. However, once on the waiver, clients are entitled to those services that have been determined medically necessary for them to continue to reside in the community. The primary reasons for the growth in iBudget waiver program expenditures are changing service needs due to clients aging, caregivers aging, and other life events.

Because of the increased need for medically necessary services for existing waiver clients, the iBudget waiver program had a deficit for the 2018-2019 fiscal year. In the event of a deficit, the 2019 Implementing Bill directs APD to work with AHCA to develop a plan to redesign the iBudget waiver program.

WAIVER REDESIGN PLAN

The plan to redesign the iBudget waiver program will address the budgetary challenges of the current iBudget waiver program, while retaining services and flexibility for waiver clients and improving support coordination services. The plan changes some existing processes, introduces some cost limitations, utilizes other funding sources, and expands services in other agencies to better serve APD clients.

The changes in existing processes should result in better understanding and prediction of the growth in client services and costs. The cost limitations should reduce the level of growth in waiver expenditures. The utilization of other funding sources will reduce waiver expenditures but may not reduce expenditures at the state level. Expanding some services of other agencies will provide needed services to APD clients and avoid the need for some waiver services.

Key elements of the plan are:

1. Include the iBudget waiver program in the Social Services Estimating Conference to better project and communicate future waiver expenditures;

2. Eliminate the iBudget algorithm and allocation process, and replace them with an assessment tool capable of determining client service needs and funding based upon assessment results (Note: This element can only be implemented when the revised assessment tool has been adopted);

3. Centralize the process of determining medical necessity for significant additional needs requests for services to ensure consistency in application of criteria;

4. Restructure support coordination services to improve management of service utilization, increase use of natural supports, increase accountability and responsiveness by implementing a robust training and certification process;

5. Implement an individual cap that is consistent with the new intermediate care facility (ICF) rate (institutional care) for individuals with severe behavioral needs;

6. Implement service limitations for Life Skills Development services;

7. Expand the number of APD group homes that qualify for the AHCA Medicaid Assistive Care Services (ACS) to reduce iBudget waiver program residential costs;

8. Allow for the transfer of budget authority from AHCA to APD for individuals enrolled on the waiver turning 21 who previously received services through the Medicaid State Plan;

9. Implement an ICF service and rate in the AHCA Medicaid program to serve individuals with severe behavioral needs who require services beyond the limits of the iBudget waiver program;

10. Increase the resources available to the Department of Children and Families (DCF) Florida Assertive Community Treatment (FACT) and Community Action Team (CAT) programs in order to serve individuals with comorbid mental health and developmental disabilities to address issues early and avoid the need for more costly services; and

11. Appropriate funding sufficient to provide medically necessary services in the most appropriate setting for all enrolled waiver clients.

Description of Key Plan Elements

1. Include the iBudget Waiver Program in the Social Services Estimating Conference

Including the iBudget waiver program in the Social Services Estimating Conference will have Legislative and Governor's Office economists analyzing waiver service utilization and expenditures. This will add a level of rigor that has not been available previously and should provide decision-makers with an assurance of the validity of the figures.

This change will require action by the conference principals.

2. Replace iBudget Algorithm with New Assessment Tool

The allocation methodology and algorithm are not serving their intended purpose because of federal regulations and court rulings that services cannot be denied based on budgetary constraints.

The Next Generation – Questionnaire for Situational Information (NG-QSI) is a comprehensive assessment tool that has been developed for APD and is currently being updated and validated. The NG-QSI will replace APD's current assessment tool, the Questionnaire for Situational Information (QSI). The functional, physical, behavioral, and demographic information collected by the NG-QSI assessment tool will be used to identify needs on an individual basis and assist with budget predictability and service identification while maintaining the flexibility that is part of the existing iBudget waiver program. The

NG-QSI will also assess the level of natural supports available to clients, including the age of the caregiver, living situations, and other support needs. The NG-QSI will enable waiver support coordinators (WSCs) to better coordinate services that address health and safety risks of clients.

A comprehensive needs assessment is the first step in identifying client needs and correlating those needs to waiver service delivery. According to the Human Services Research Institute, the use of assessment-informed budgeting promotes equity in services for individuals with unique needs and is used in thirty-one (31) other states[9].

Implementation of the NG-QSI will enhance budget predictability of current service needs and future service needs using the data collected.

This change will require statutory and rule changes.

3. Centralize the Significant Additional Needs Determination Process

Centralizing the process of making medical necessity determinations of services requested through the SANs process will allow for more consistent application of medical necessity criteria. Currently the SANs process is decentralized in local APD offices, making it difficult to ensure consistent application of medical necessity criteria for requested services. Having all of the SANs reviewers in one location will allow for targeted training, quality assurance, and inter-rater reliability. Centralization will also allow all requests for medical and behavior-related services to be reviewed by a nurse or behavior analyst.

[9] Making Self-Direction a Reality by Human Services Research Institute

Centralization of the SANs process will ensure that waiver clients receive the medically necessary services they need to remain in the community. APD has the statutory authority to make this change and is currently in the process of implementing.

4. Restructure Support Coordination Services

Restructuring support coordination services will improve training and increase accountability. Waiver Support Coordinators (WSCs) serve a critical role in the iBudget waiver program. WSCs are independent, enrolled service providers who are responsible for guiding waiver clients through the iBudget waiver program to ensure that they fully utilize their natural supports and only receive those waiver services that are medically necessary for the client to remain in the community.

APD will implement a comprehensive and standardized competency-based curriculum to promote quality support coordination services. Although WSCs are required to complete training prior to rendering support coordination services, there is no specific authority for APD to require WSCs to demonstrate minimum competency to perform the job or pass a competency-based assessment before providing services. Additionally, although there are certain training topics that are required before support coordination services can be provided, WSCs are able to obtain training outside of APD and there are no standards to measure the qualifications of trainers nor to assess the value in the content delivered. A comprehensive and standardized competency-based curriculum for WSCs will help APD ensure that WSCs have a clear understanding of the job they perform and that they have the knowledge and skills to appropriately serve APD clients.

APD will implement a rating system for WSCs based upon established objective performance measures. APD will seek broader authority to sanction poor performing WSCs. This change will require statutory and rule changes.

5. Implement Individual Caps on Waiver Costs

Implement an individual cap that is consistent with the new proposed intermediate care facility (ICF) rate (institutional care) for individuals with severe behavioral needs ($205,000 annually). There is a federal requirement[10] that the average per person cost of waiver programs be cost neutral as compared to the average per person cost of providing services in institutional settings. States may choose to apply an "individual cost limit" through the waiver. To date, Florida has chosen to apply cost neutrality using the average per person cost.

By changing to individual cost limits at the institutional level, waiver clients with costs above the $205,000 annual amount will either need to reduce their waiver expenditures to come within the cap, possibly by leveraging community natural supports, or they will need to seek services from another source such as entering an ICF by invoking their entitlement. If the cost of an individual's waiver services exceeds this amount, then the community may not be the most appropriate setting for them to receive their services.

Clients Impacted: 85 based upon FY 2017-18 waiver expenditures

Estimated Waiver Savings:

$2.4 million if all 85 were able to reduce expenditures to the cap

[10] Section 1915(c)(2)(D) of the Social Security Act

$19.9 million if all 85 withdrew from the waiver and entered an ICF

NOTE: AHCA would incur additional costs for any individual that chose to enter an ICF.

This change will require CMS approval, rule changes, and statutory changes.

6. Impose Service Limitations on Life Skills Development Services

Imposing service limitations on Life Skills Development services (Companion services, Supported Employment services, and Adult Day Training services) will restrict any combination of the services to 1,440 hours annually or the equivalent of 30 hours per week for 48 weeks. This is a reasonable annual amount of these services and was the limit in place prior to implementation of the iBudget waiver program.

Clients Impacted: 1,557 based upon FY 2017-18 waiver expenditures

Estimated Savings: $2.6 million

This change will require rule changes and possible statutory changes.

7. Allow APD Group Homes to Qualify for Assistive Care Service Payments

Allowing APD group homes to qualify for the AHCA Medicaid Assistive Care Services (ACS) will reduce iBudget waiver program residential costs. ACS under the Florida Medicaid State Plan provides health support and assistance with activities of daily living and self-administration of medication. At this time, APD licensed group homes are not included in the list of providers who can bill for ACS. Amending the requirements to allow APD group homes to bill for ACS services will allow shifting a portion of residential habilitation costs from the waiver to AHCA without impacting clients or their services. The

iBudget waiver residential habilitation rates would be reduced by the ACS amount (currently $12.25 per client/day), and the providers will bill the waiver and the ACS program for the residential services rendered.

Clients Impacted: No impact on waiver clients

Estimated Waiver Savings: $40 million

NOTE: AHCA would incur additional costs.

This change will require rule changes and statutory changes.

8. Transfer Budget Authority from AHCA to APD for Waiver Clients Turning 21

Transfer of budget authority from AHCA to APD for individuals enrolled on the waiver turning 21 will address a cost driver of the iBudget waiver program. All waiver clients under age 21 qualify for the AHCA Early and Periodic Screening Diagnosis and Treatment (EPSDT) program. EPSDT requires AHCA to offer a robust service package to meet all of the medically necessary service needs of Medicaid recipients under the age of 21. When individuals on the waiver turn 21, these services are still needed for their health and safety but are no longer available through the general Medicaid program and the cost shifts to iBudget waiver program. These costs include expensive services such as nursing, personal care, therapies, behavioral services, medical supplies, etc.

Annually transferring budget authority from AHCA to APD for these individuals will address the increased waiver costs.

Clients Impacted: 800 annually

Estimated Savings: $4.5 million annual additional budget authority

Statutory changes and appropriations changes are required.

9. **Implement an Intermediate Care Facility Payment Rate for Individuals with Severe Behavioral Needs (AHCA)**

Implementing an ICF service and rate in the Medicaid program to serve individuals with intensive maladaptive behaviors will provide another residential option for individuals with a developmental disability and maladaptive behaviors.

The current reimbursement methodology for ICFs is based on medical and physical needs and is not inclusive of individuals with intensive behavioral needs. Many people with severe behavioral needs may require constant one-on-one and sometimes two-on-one staffing. Therefore, many ICF providers are unable to serve individuals with intensive maladaptive behaviors because they do not have the capacity to appropriately provide the care they need. This lack of ICFs able to meet the needs of some individuals with developmental disabilities limits their choice of residential settings. Creating a new ICF payment rate will provide individuals with an additional option from which to choose.

APD will collaborate with AHCA and submit LBRs as necessary to develop additional capacity, which will increase the number of available choices for this population. This change will require CMS approval, rule changes, and statutory changes.

10. **Increase Resources for DCF Florida Assertive Community Treatment and Community Action Team Programs**

Increase the resources available to the Department of Children and Families (DCF) Florida Assertive Community Treatment (FACT) and Community Action Team (CAT) programs in order to serve individuals with comorbid mental health and developmental

disabilities. FACT and CAT teams provide a 24-hour-a-day, seven-days-a-week, multidisciplinary approach to deliver comprehensive care to people where they live, work or go to school, and spend their leisure time. APD recommends expansion of these existing DCF programs to serve APD clients with co-occurring mental health issues and severe maladaptive behaviors to avoid duplication of services across agencies.

The FACT and CAT teams are self-contained clinical units that assume responsibility for directly providing the majority of treatment, rehabilitation, and support services to identified individuals with serious psychiatric disabilities such as schizophrenia, schizoaffective disorder, bipolar disorder, major depression, and personality disorders. These individuals are at high risk of repeated psychiatric admissions and have typically experienced prolonged inpatient psychiatric hospitalization or repeated admissions to Baker Act[11] facilities. Many are involved in the criminal justice system and face the possibility of incarceration.

In order to prevent and reduce the number of Baker Act admissions, extended hospitalizations, and encounters with law enforcement, APD proposes revisions to the existing eligibility criteria for the FACT and CAT programs to include individuals with developmental disabilities who also have a co-occurring mental health diagnosis. It is also recommended that the teams be expanded to include members with training and experience working with individuals with developmental disabilities.

[11] The Baker Act (sections 494.451 through 494.47892, Florida Statutes) allows for an individual to be involuntarily committed for examination for possible mental illness; or is in danger of becoming a harm to self or others. Commitment may be ordered by law enforcement officials, physicians, mental health professionals, or judges.

Providing these services to waiver clients during their mental health episodes will reduce the need for more costly waiver services. This change will require rule changes and statutory changes.

11. Appropriate Sufficient Funding to Provide Medically Necessary Services

Funding should be appropriated at a level sufficient to provide medically necessary services in the most appropriate setting for all clients. Although the elements of this waiver redesign plan address a portion of the growth in services and costs, they do not address the entire estimated amount. Providing additional funding for medically necessary services is an investment by the state of Florida in individuals with developmental disabilities to allow them to continue to live, learn, and work in their communities. The return on investment is the quality of life provided to the waiver recipients and the cost avoidance of providing their services in much more costly institutional settings.

This change will enhance budget predictability while preserving services and client flexibility.

Appendix A

Waiver Redesign Plan

Key Components

Redesign Key Components

	Redesign Key Components	Change to Consider	Maximum Service Limits	Total Number of Clients *	Total Clients Affected *	Potential Waiver Savings *	Cost Shift	Implementation Timeline
1	Social Services Estimating Conference (SSEC)	Include the iBudget Waiver program in SSEC to provide the Legislature with projections for the program	N/A	N/A	N/A	N/A	N/A	FY 2020-21
3	Medical Necessity Determination/ Significant Additional Needs (SAN)	Centralize the process of SANs determination of medically necessary services to ensure consistency in application of criteria	N/A	34,500	34,500	Unknown	N/A	▪ Implement inter-rater reliability and peer review process by Jan 2020
4	Support Coordination	Improve performance and increase accountability for Waiver Support Coordinators	N/A	34,500	34,500	N/A	N/A	▪ Handbook Rule amendment: Approximately 6 months ▪ Amend Florida Statute: FY 2020-21
5	Individual Cost Limit at Institutional Level	Implement an annual cap at the individual level for all living settings	Individual cap at the level of the AHCA Proposed Specialized Intermediate Care Facility (ICF) rate: 100% = $205,130	34,500	85	$19,870,370 if all left waiver for an ICF $2,434,320 if all remained on waiver with cap limitation	Possible	▪ Waiver amendment: Approximately 6 months ▪ Handbook Rule amendment: Approximately 6 months ▪ Amend Florida Statute: FY 2020-21
6	Life Skills Development	Combination of companion, supported employment, and adult day training services not to exceed 1,440 hours annually	1,440 hours annually	18,593	1,557	$2,570,210	N/A	▪ Waiver amendment: Approximately 6 months ▪ Rate Rule amendment: Approximately 6 months ▪ Handbook Rule amendment: Approximately 6 months ▪ Amend Florida Statute: FY 2020-21
7	Residential Habilitation	Expand the number of agency group homes that qualify for the AHCA Medicaid Assistive Care Services (ACS) to reduce waiver program residential costs	N/A	9,000	No client impact	$40,000,000	Cost shift to AHCA	▪ Assistive Care Services Rule amendment: Approximately 6 months ▪ State Plan amendment: Approximately 6 months ▪ iBudget Rate Rule Change: Approximately 6 months
8	Medicaid State Plan (MSP) Services Budget Transfer for Aging Out	Allow budgetary transfer from AHCA to APD for waiver clients aging out of MSP services upon turning 21	N/A	Approx. 800 Annually	Approx. 800 Annually	Approx. $4-5 Million Each Year	Fund transfer from AHCA to APD	FY 2020-21
10	Florida Assertive Community Treatment (FACT) and Community Action Team (CAT) Pilot	Increase the resources available to the DCF FACT and CAT teams in order to serve individuals with comorbid mental health and developmental disabilities to address issues early and avoid more costly services in the future	N/A	34,500	34,500	Unknown	N/A	Implementation can occur once the FACT and CAT teams have the training and/or resources to serve individuals with comorbid mental health and developmental disabilities

*Client Counts and Potential Savings Amounts are based upon Fiscal Year 2017-18 expenditure data.

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Redesign Key Components - Require Legislative Budget Request Issue

	Redesign Key Components	Change to Consider	Maximum Service Limits	Total Number of Clients	Total Clients Affected	LBR Issue	Cost Shift	Implementation Timeline
2	Next Generation-Questionnaire for Situational Information (NG-QSI)	Eliminate iBudget algorithm and allocation process. Implement the NG-QSI assessment tool capable of determining client needs and funding based on assessment results	N/A	34,500	34,500	$120,000 APD FY 2020-21 LBR Non-Recurring	N/A	• Waiver amendment: Approximately 6 months • Rule amendment: Approximately 6 months • Amend Florida Statute: FY 2020-21 • Fully implement by FY 2023-24
9	Specialized ICF Rate	Implement an ICF service and rate in the Medicaid program to serve individuals with intensive maladaptive behaviors	$562 per person per day	187	187	$38,363,421 AHCA FY 2020-21 LBR Recurring	Possible	FY 2020-21

Appendix B

Next Generation –

Questionnaire for Situational Information

Assessment tools are a federal requirement of waiver programs.[12] Assessment tools are used by states to assess the functional, physical, and behavioral levels of individuals with intellectual and developmental disabilities to determine what services the individual may require for daily living. The Agency for Persons with Disabilities' (APD) current assessment tool is the Questionnaire for Situational Information (QSI) which was implemented in 2008. The QSI does not collect many important pieces of information that are useful in determining the service needs of individuals, as well as available natural supports and caregiver age. Such information is important in determining current and future needs.

In 2015, APD began the development of a new assessment tool that will address the shortcomings of the current assessment tool. The Next Generation – Questionnaire for Situational Information (NG-QSI) will be the assessment tool for APD once it has been validated and adopted, which is estimated to occur in 2022. The information collected by the NG-QSI assessment tool will be used to identify service needs on an individual basis and assist with budget predictability while maintaining the flexibility that is part of the existing iBudget waiver program. The NG-QSI will also assess the level of natural supports available to clients, including the age of the caregiver, the individuals' living situations, and other support needs. The NG-QSI will enable waiver support coordinators (WSCs) to better coordinate services to address health and safety risks of the individuals served.

The NG-QSI will collect seven groups of information called domains. The domains are:

[12] 42 CFR 441.301(b)(1)

- **Domain 1.0** – **General Information** (e.g., identifying information, eligibility, demographics, and legal information)
- **Domain 2.0** – **Supports and Services** (e.g., living arrangement, anticipated changes in living arrangements, information about a family caregiver, as well as present supports)
- **Domain 3.0** – **Wellness and Health Maintenance** (e.g., any medical condition that requires care and treatment, wellness and health maintenance services, and rating of different aspects of the person's health situation)
- **Domain 4.0** – **Daily Living Skills** (e.g., essential living skills and community living skills the person may have and use, as well as supports the person may require)
- **Domain 5.0** – **Lifestyle, Valued Roles, and Social Integratio**n (e.g., everyday activities, choices, and social integration)
- **Domain 6.0** – **Behavior Concerns** (e.g., maladaptive behaviors that the person may have experienced over the past 12 months. Rates the impact such behaviors may have had on the person's care, treatment, and life choices. Areas assessed are self-injurious behavior, aggression towards others, damage to property, inappropriate sexual behavior, elopement/running away, and other maladaptive behavior(s).
- **Domain 7.0** – **Level of Support** (Contains scoring rubrics for daily living, wellness and health maintenance, and behavior that are used to assign

level of support for the person. All calculations are made electronically based upon information collected in Domains 3.0, 4.0, and 6.0.

Collection of this information is the first step in identifying individual needs and correlating those needs to waiver service delivery. Other states have used assessment-informed budgeting to promote equity in services for individuals with unique needs according to the Human Services Research Institute (HSRI)[13]. In fact, the state of Louisiana has placed in administrative code the allocation of resources using a needs-based assessment[14].

Implementation of the NG-QSI will enhance budget predictability of current service needs and possibly future service needs using the data collected.

[13] Making Self-Direction a Reality by Human Services Research Institute
[14] Title 50, Public Health – Medical Assistance, Louisiana Administrative Code https://www.doa.la.gov/pages/osr/lac/books.aspx

Appendix C

Centralization of

Significant Additional Needs Process

Centralization of the Significant Additional Needs (SAN) Process

Goal:

Process SAN requests efficiently and consistently with proper consideration for the provision of medically necessary services within allocations.

Analysis:

The workgroup evaluated the SAN process and determined that there is no significant benefit from conducting SANs reviews locally. Since the process is essentially a file review, there are more benefits from conducting the reviews centrally.

Proposal:

Move the SANs process to the State Office. Encourage regional staff to provide input to the SAN reviewer when appropriate, as is the current practice.

Action Items:

For this proposal to be implemented, the following steps are being taken:

1. Specifically define what will be centralized.
2. Determine the number of State Office staff that would be required to complete the SANs process. .
3. Work with HR to develop Position Descriptions and to recruit new employees, potentially using Talent Science in the hiring process.
4. Develop and implement a thorough training program for all SANs reviewers.
5. Work with IT to ensure system and reporting requirements are changed so that workflow is appropriately captured and that the process will be compatible with iConnect.
6. Implement ongoing inter-rater reliability testing and retraining processes.

Benefits:

1. Better control and consistency of decisions
2. Consistent training and supervision
3. Reduce subjectivity of SANs reviews
4. Streamlined SANs process, ensuring compliance with time requirements
5. Enable changes in the SANs process as proposed by other work groups to be implemented more quickly and efficiently
6. Enhance the ability to have appropriate clinical staff making medical necessity determinations
7. Enable regional staff to concentrate on other processes
8. Ensure equitable distribution of SANs-related workload
9. Eliminate issue of regional staff defending decisions made by State Office staff in fair hearings, as all witnesses for fair hearings would be drawn from State Office SANs reviewers

Appendix D

Medical Necessity

The iBudget Handbook is incorporated by reference into AHCA Rule 59G-13.070, Florida Administrative Code[15] Pages 1-1 through 1-2 state the following:

Federally Approved - Purpose of Waiver

The iBudget waiver provides home and community-based supports and services to eligible persons with developmental disabilities living at home or in a home-like setting. The iBudget waiver program is funded by both federal and matching state dollars.

Individuals enrolled in the iBudget waiver should receive services that enable them to:

- Have a safe place to live,
- Have a meaningful day activity,
- Receive medically necessary medical and dental services,
- Receive medically necessary supplies and equipment, and
- Receive transportation required to access necessary waiver services.

This waiver reflects use of an individual budgeting approach and enhanced opportunities for self-determination. The purpose of this waiver is to:

- Promote and maintain the health and welfare of eligible individuals with developmental disabilities,
- Provide medically necessary supports and services to delay or prevent institutionalization, and
- Foster the principles of self-determination as a foundation for services and supports.

Providing an array of services, from which eligible recipients can choose, allows them to live as independently as possible in their own home or in the community and achieve productive lives. Eligible recipients can choose between the iBudget waiver or an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

The iBudget waiver enhances each recipient's opportunity for participant direction by providing greater choice among services within the limits of an individual budget. To facilitate this, similar services are grouped in service families.

[15] https://ahca.myflorida.com/medicaid/review/specific_policy.shtml

Page 1-8 includes the following requirement:

MEDICAL NECESSITY – Health and Safety in the Community

In accordance with Rule 59G-1.010, F.A.C., "[T]he medical or allied care, goods, or services furnished or ordered must:

(a) 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 not equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider."

"(c) 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."

Appendix E

Federal Requirements

Federal HCBS Waiver Services Requirements

The State entered into a Home and Community-Based Services (HCBS) Waiver agreement with the Federal Centers for Medicare & Medicaid Services (CMS) to provide 26 services to eligible Florida recipients. The following court rulings require that services be provided to waiver clients if medical necessity is established.

Garrido v. Dudek, 731 F. 3d 1152 (11th Cir. 2013)

The court ruled that federal regulations provide that each service "must be sufficient in amount, duration, and scope to reasonably achieve its purpose;" however, the state Medicaid agency "may place appropriate limits on a service based … on medical necessity." 42 C.F.R. § 440.230. The Medicaid Act and associated implementing regulations grant states the authority to set reasonable standards for the terms "necessary" and "medical necessity." 42 U.S.C. § 1396a(a)(17); 42 C.F.R. § 440.230(d).

The waiver agreement with CMS requires the state to provide medically necessary services to all waiver enrollees; per the provisions found in 42 U.S.C. § 1396a(a)(10), 42 U.S.C. § 1396a(a)(17) and 42 U.S.C. § 440.230(d), states are prohibited from denying coverage of "medically necessary" services that fall under a category covered in their Medicaid plans.

Alvarez v. Betlach 2012, WL10861543 (D. Arizona 2012)

The court ruled that states must provide medically necessary home health services to individuals entitled to those services under 42 U.S.C. § 1396a(a)(10)(D), irrespective of cost.

Moore ex rel. Moore v. Reese 637 F.3d 1220, 1259 (11th Cir. 2011)

The court ruled that "However pressing budgetary burdens may be, we have previously commented that cost considerations alone do not grant participating states a license to shirk their statutory duties under the Medicaid Act."

As defined in 65G-4.0213, F.A.C., a Significant Additional Need (SAN) is a 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.

Wheaton Settlement

The settlement requires APD to adhere to reasonable timeframes for processing requests for additional iBudget waiver services.

Appendix F

Improve Waiver Support Coordination Performance and Increase Accountability

Improve Waiver Support Coordinator Performance and Increase Accountability

The Waiver Support Coordinator (WSC) role is critical to the success of the iBudget waiver program by ensuring that the waiver client fully utilizes community and natural supports, and receives medically necessary services timely. WSCs must interact with families, self-advocates, providers, and the community at large to ensure that the health and safety needs of waiver clients are met. The Agency for Persons with Disabilities (APD) must ensure that the WSCs are fully trained and prepared to perform their duties in order for the iBudget waiver program to be successful.

Consumers, families, and providers are dependent upon WSCs for waiver service authorizations, support, and assistance. Comprehensive and effective competency-based training are required to equip WSCs with the knowledge and information they need to effectively meet the needs of their waiver clients. Also, meaningful consequences are needed for poor performing WSCs and technical assistance must be available for those WSCs who wish to improve.

Recommendations:

1. Develop and implement a comprehensive and standardized competency-based curriculum for WSCs to be required statewide to ensure that quality services are provided to consumers served by the iBudget waiver.

2. Establish and implement an objective and easily quantifiable scorecard as a means of providing feedback to WSCs on their performance, and as a tool for self-advocates, families, and guardians to use when selecting a WSC. Examples of measures to consider for the scorecard:

    a. Meeting established timeframes for WSC duties and other assignments, such as Support Plan development, SANs submissions, updates of demographics, etc.
    b. Timely responses to APD requests for information regarding a consumer's health, safety, and wellbeing
    c. Ensuring consumers maintain Medicaid eligibility
    d. Timely follow-up on incident reports

3. Request statutory authority and work with AHCA to expand APD's authority to develop a system of accountability that imposes a range of meaningful consequences for those WSCs who have repeated instances of poor performance.

   Poor performance includes, but is not limited to:

   a. Performance issues addressed in APD Policy/Operating Procedure #4-0014
   b. Performance issues that result in severe disruption for the consumer
   c. Performance issues that result in unnecessary expenditures of Individual and Family Supports funds for covered waiver services

   Recommended sanctions include, but are not limited to, the following:

   a. Required retraining
   b. Plans of Remediation
   c. Fines
   d. Reductions in caseloads
   e. Reductions in counties served
   f. Moratoriums on serving additional clients
   g. Termination of a WSC agency or solo support coordinators from Medicaid for poor performance

4. Establish well-defined criteria for WSCs who are dually employed, including hard limits on various elements, such as the number of hours that are acceptable to be working in another job. It is also recommended that the role of a backup WSC be more clearly defined.

5. Establish specific caseload limits for WSC agency heads so that they are available to provide support, training, and guidance to their WSCs, as well as to address complaints and manage their agencies.

Appendix G

1915(c) I/DD Waiver Research

1915(c) I/DD Waiver Research

General waiver information, including how to implement cost limits within a 1915(c) waiver, is located within the *1915(c) Instructions, Technical Guide, and Review Criteria*: http://www.nasuad.org/sites/nasuad/files/Updated%20Waiver%20Instructions.pdf

The Kaiser Family Foundation report on quality and outcomes across all 50 states is available at: https://www.kff.org/report-section/states-focus-on-quality-and-outcomes-amid-waiver-changes-long-term-services-and-supports-reforms/

A comprehensive listing of 1115, 1915(b), and 1915(c) waivers throughout the country is available at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html

A comprehensive review was performed of the waivers serving individuals with intellectual and developmental disabilities throughout the country. In many states, multiple waivers serve this population. Some states have waivers specifically for children with these disabilities and serve adults through a different waiver with different services.

During this review, the goal was to assess whether there are any states that operate waivers for people with intellectual and/or developmental disabilities that impose cost limits. There are 11 states that impose cost limits within at least one 1915(c) waiver. These states are:

1. Montana
2. Missouri
3. North Carolina
4. Ohio
5. Oklahoma
6. Pennsylvania
7. South Carolina
8. Tennessee
9. Texas
10. Washington
11. Wyoming

There are seven states that utilize a managed care approach. These states are:

1. Arizona
2. Iowa
3. Kansas
4. Michigan
5. North Carolina
6. Tennessee
7. Wisconsin

Oregon's Waivers that serve the DD/ID population:

1. **OR Children's HCBS**
    - 1915(c)
    - No cost limit
    - Children with DD/ID ages 0 – 17
    - Less than 8,000 participants
    - Services: employment path services, supported employment - individual employment support, waiver case management, discovery/career exploration services, environmental safety modifications, family training - conferences and workshops, specialized medical supplies, supported employment - small group employment support, vehicle modifications

2. **OR Behavioral Model**
    - 1915(c)
    - No cost limit
    - Children with DD/ID ages 0 – 17
    - Less than 200 participants- the state limits the number of participants that it serves at any point in time during the waiver year.
    - Services: waiver case management, environmental safety modifications, family training, individual directed goods and services, special diets, specialized medical supplies, vehicle modifications

3. **OR Adult HCBS**
    - 1915(c)
    - No cost limit
    - Age 18 – no max
    - 7,805 participants
    - Services: employment path services, supported employment - individual employment support, waiver case management, direct nursing, discovery/career exploration services, environmental safety modifications, family training - conferences and workshops, financial management services, special diets, specialized medical supplies, supported employment - small group employment support, vehicle modifications

4. **Comprehensive DD Waiver**
    - 1915(b)(4)
    - No cost limit
    - This waiver provides case management for recipients enrolled in the state's five 1915(c) HCBS waivers.

New Mexico's Waivers that serve the DD/ID population:

1. **NM Developmental Disabilities Waiver Program**
    - 1915(c)
    - No cost limit
    - Persons with ID/DD/Autism ages 0 – no max
    - Less than 5,000 participants
    - Services: Provides case management, community integrated employment, customized community supports, living supports, respite, nutritional counseling, occupational therapy for adults, physical therapy for adults, speech and language therapy for adults, supplemental dental care, adult nursing, assistive technology, behavioral support consultation, crisis support, customized in-home supports, environmental modifications, independent living transition service, intense medical living supports, non-medical transportation, personal support technology/on-site response service, preliminary risk screening and consultation related to inappropriate sexual behavior, socialization and sexuality education

2. **NM Mi Via – ICF/MR**
    - 1915(c)
    - No cost limit
    - Self-directed model
    - Persons with ID/DD/Autism ages 0 – no max
    - Less than 2,000 participants
    - Services: Consultant/support guide, customized community group supports, employment supports, home health aide services, homemaker/direct support services, respite, skilled therapy for adults, personal plan facilitation, behavior support consultation, community direct support, emergency response services, environmental modifications, in-home living supports, individual directed goods and services, nutritional counseling, private duty nursing for adults, specialized therapies, transportation

Tennessee's Waivers that serve the DD/ID population:

1. **Tennessee Self-Determination Waiver (0427.R03.00)**
   The Self-Determination Waiver Program serves children and adults with intellectual disabilities and children under age six with developmental delays who qualify for and, absent the provision of services provided under the Self-Determination waiver, would require placement in a private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

The Self-Determination Waiver Program affords persons supported the opportunity to directly manage selected services, including the recruitment and management of service providers. Participants and families (as appropriate) electing self-direction are empowered and have the responsibility for managing, in accordance with waiver service definitions and limitations, a self-determination budget affording flexibility in service design and delivery.

The Self-Determination Waiver Program serves persons who have an established non-institutional place of residence where they live with their family, a non-related caregiver or in their own home and whose needs can be met effectively by the combination of waiver services through this program and natural and other supports available to them. The Self-Determination Waiver does not include residential services such as supported living.

The Self-Determination Waiver offers a continuum of services that are designed to support each person's independence and integration into the community, including opportunities for employment and work in competitive integrated settings and engage in community life. A person-centered planning process is used to identify services to be included in each waiver participants Individual Service Plan, based on the waiver participant's individually identified goals and need for specific services to advance toward, achieve or sustain those goals.

Provides respite, nursing services, nutrition services, occupational therapy, physical therapy, specialized medical equipment and supplies and assistive technology, speech, language, and hearing services, adult dental services, behavior services, behavioral respite services, community participation supports, employment and day services, environmental accessibility modifications, facility-based day supports, individual transportation services, intermittent employment and community integration wrap-around, non-residential homebound support services, orientation and mobility services for impaired vision, personal assistance, personal emergency response systems, semi-independent living services, supported employment - individual employment support, and supported employment - small group employment support for individuals w/ID ages 0 - no max age and DD ages 0-5.

Cost Limit Lower Than Institutional Costs.

This cost limit was established at the inception of the Self-Determination Waiver Program. The target population for this waiver is persons who live with their family, a non-related caregiver or in their own home. These are individuals who have support systems in place, and this waiver is intended to support, but not supplant, that natural caregiving system. Because many of the support needs are met by family and other caregivers, based on the state's experience in this program, this level of service is sufficient to meet the needs of this target population.

However, should the person's needs change, or should the natural support system collapse, provisions exist for the individual to transition to the Employment and Community First CHOICES program, which offers a more comprehensive package of benefits, when needed.

The cost limit specified by the state is:

Specify dollar amount: $30,000

2. Tennessee Comprehensive Aggregate Cap (CAC) (0357.R03.00)

The Comprehensive Aggregate Cap (CAC) Waiver serves individuals with intellectual disabilities who are former members of the certified class in the United States vs. the State of Tennessee, et al. (Arlington Developmental Center), former members of the certified class in the United States vs. the State of Tennessee, et al. (Clover Bottom Developmental Center), persons discharged from the Harold Jordan Center following a stay of at least 90 days, and individuals transitioned from the Statewide Waiver (#0128) upon its renewal on January 1, 2015, because they were identified by the state as receiving services in excess of the individual cost neutrality cap established for the Statewide Waiver. These are individuals who have been institutionalized in a public institution, were part of a certified class because they were determined to be at risk of placement in a public institution, or have significant services/support needs consistent with that of the population served in a public ICF/IID and who qualify for and, absent the provision of services provided under the CAC waiver, would require placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

The CAC Waiver offers a continuum of services that are designed to support each person’s independence and integration into the community, including opportunities for employment and work in competitive integrated settings and engage in community life. A person-centered planning process is used to identify services to be included in each waiver participants Individual Service Plan, based on the waiver participant’s individually identified goals and need for specific services to advance toward, achieve or sustain those goals.

Provides residential habilitation, respite, support coordination, nursing services, nutrition services, occupational therapy, physical therapy, specialized medical equipment and supplies and assistive technology, speech, language, and hearing services, behavior services, behavioral respite services, community participation supports, dental services, employment and day services, environmental accessibility modifications, facility-based day supports, family model residential support, individual transportation services, intensive behavioral residential services, intermittent employment and community integration wrap-around

supports, medical residential services, non-residential homebound support services, orientation and mobility services for impaired vision, personal assistance, personal emergency response system, semi-independent living, supported employment - individual employment support, supported employment - small group employment support, supported living, and transitional case management for individuals w/ID ages 0 - no max age.

No Cost Limit. The state does not apply an individual cost limit.

3. Tennessee Statewide HCBS Waiver (0128.R05.00)

The Statewide Home and Community-Based Services Waiver serves children and adults with intellectual disabilities and children under age six with a developmental disability who qualify for and, absent the provision of services provided under the Statewide Waiver, would require placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

The Statewide Waiver offers a continuum of services that are designed to support each person's independence and integration into the community, including opportunities for employment and work in competitive integrated settings and engage in community life. A person-centered planning process is used to identify services to be included in each waiver participants Individual Service Plan, based on the waiver participant's individually identified goals and need for specific services to advance toward, achieve or sustain those goals.

Provides residential habilitation, respite, support coordination, nursing services, nutrition services, occupational therapy, physical therapy, specialized medical equipment and supplies and assistive technology, speech, language, and hearing services, adult dental services, behavior services, behavioral respite services, community participation supports, employment and day services, environmental accessibility modifications, facility-based day supports, family model residential support, individual transportation services, intensive behavioral residential services, intermittent employment and community integration wrap-around supports, medical residential services, non-residential homebound support services, orientation and mobility services for impaired vision, personal assistance, personal emergency response systems, semi-independent living, supported employment - individual employment support, supported employment - small group employment support, supported living, and transitional case management for individuals w/DD ages 0 - 5, and w/IID ages 0 - no max age.

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services

furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver.

Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Consistent with the special terms and conditions of the state's approved 1115 demonstration and the June 2015 guidance issued by CMS, Tennessee utilizes tiered standards in its HCBS programs, working to ensure minimum compliance across settings in its Section 1915(c) waivers while closing all new enrollment into these waivers and directing all new HCBS enrollment into the Employment and Community First CHOICES program. For persons currently enrolled in the Statewide Waiver program, prior to entrance into the Statewide Waiver Program, an individualized assessment of need was conducted by the DIDD intake staff. The purpose of this assessment was to identify the service needs and to project the total cost for the services in order to determine whether the person's needs could be satisfactorily met in a manner that assures the individual's health and welfare.

Other safeguard(s):
Should a change in the participant's condition or circumstances post-entrance to the waiver require the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, TennCare and DIDD will first work with the Independent Support Coordinator and with the participant's MCO to determine whether additional services and supports needs can be met through covered or cost-effective alternative services available through the managed care program, allowing the person to continue participation in the waiver program. If, following such coordination efforts, it is determined that the participant's health and welfare cannot be assured in the waiver, TennCare and DIDD will work with the individual to facilitate transition to another more appropriate LTSS program or service. This includes the Managed Long-Term Services and Supports Program, Employment and Community First CHOICES. Notice of disenrollment, including the right to fair hearing, would be issued. The applicant would have 30 days to request a fair hearing from TennCare. Fair hearings regarding disenrollment from an HCBS waiver are conducted in accordance with the Uniform Administrative Procedures Act. However, a person enrolled in this waiver shall not be disenrolled if the sole reason the cost cap would be exceeded is a change in the reimbursement methodology that is required under the terms of the Statewide Transition Plan in order to achieve compliance with the federal HCBS Settings Rule.

Missouri's Waivers that serve the DD/ID population:

1. **Missouri AIDS (0197.R05.00)**
   Provides waiver personal care, attendant care, private duty nursing, specialized medical supplies for individuals w/HIV/AIDS ages 21 - no max age.

   No Cost Limit. The state does not apply an individual cost limit.

2. **Missouri Independent Living (0346.R04.00)**
   Provides case management, personal care, financial management services, environmental accessibility adaptations, and specialized medical equipment and supplies for individuals with physical disabilities ages 18-64.

   No Cost Limit. The state does not apply an individual cost limit.

3. **Missouri Children with DD (MOCDD) (4185.R05.00)**

   GOAL: Establish and maintain a community-based system of care for children with developmental disabilities that includes a comprehensive array of services that meets the individualized support needs of children to allow them to remain at home with their families rather than enter an institution, group home, or other out-of-home care.

   OBJECTIVES: 1) provide families choice between ICF/ID institutional care and comprehensive, cost-effective community-based care; 2) maintain and improve a community-based system of care that diverts children from institutional care and residential care; 3) maintain and improve community-based care so services are sufficient to support children living at home with their family; and 4) provide choice and flexibility within a community-based system of care.

   Children in this waiver are living at home with their family but require services and supports so that family members can continue employment and primary caregivers can access relief. This waiver allows certain State MO HealthNet eligibility requirements to be waived so that children targeted for participation may be determined MO HealthNet eligible. In Missouri, the income and resources of a child's parents must be considered in determining the child's financial eligibility for MO HealthNet when the child lives in the home with the parents. This requirement called "deeming parental income to the child: is waived for children who participate in the waiver. For these children, financial eligibility for MO HealthNet is determined solely on the income and resources of the child.

   The waiver is administered by the Division of Developmental Disabilities (DD) through an interagency agreement with the Department of Social Services, the Single State Medicaid Agency. Division of DD has 6 Regional Offices with 5

satellite offices (herein referred to as Regional Offices) that are the gatekeepers for the waiver. The Regional Offices determine eligibility, provide case management, and other administrative functions including quality enhancement, person centered planning, and operation of prior authorization and utilization review processes. Through contracts administered by the Department of Mental Health, SB-40 Boards (public entities) and other Targeted Case Management (TCM) entities provide limited waiver administration functions (case management) in coordination with Regional Offices and oversight from the Division of DD.

Service delivery methods in this waiver include provider-managed (for all waiver services); and there is a self-directed option for personal assistant and community specialist.

Each waiver provider has a contract with the Division of DD. Division of DD Regional Offices authorize services to the providers. Providers must bill through the Division of DDs prior authorization system. The Division of DD submits the qualified bills to the Medicaid claim processing fiscal agent. The Medicaid MMIS pays the providers directly for services provided.

Provides day habilitation, in home respite, personal assistant, support broker, applied behavior analysis, assistive technology, community integration, community specialist, crisis intervention, environmental accessibility adaptations-home/vehicle modification, individualized skill development, out of home respite, person centered strategies consultation, specialized medical equipment and supplies (adaptive equipment), and transportation for children with ID, DD 0-17 yrs.

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver.

Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

In advance of enrollment in the waiver, the needs of the individual and how best to meet the needs are identified. From this assessment, a support plan is developed that specifies the amount, frequency, and duration of all services that are needed to assure health and safety. All potential sources for meeting the needs will be explored such as private insurance, other federal programs, state and local programs as well as non-paid support provided by family and friends. The total

cost of needed services through the waiver will be compared to the average cost of ICF/ID care.

If enrollment in the waiver is denied the applicant is notified writing that they have an opportunity to request a fair hearing.

Other safeguard(s):
Participants in this waiver are not eligible for MO HealthNet due to parental income and resources without access to the waiver. Therefore, they will not be eligible for another waiver. Other safeguards: 1) Most have private insurance and are encouraged to keep their private insurance coverage. Children whose parents have or have access to private insurance are encouraged to apply for the DSS Health Insurance Premium Payment Program; and 2) participants are children under the age of 18 whose family members usually assist with some of the care without compensation. If an individual cap was met and additional services were needed, the Regional Office may consider using state funds to meet the additional need, may refer the family to a local County SB-40 Board for funds to meet the additional need, and may refer the individual to other services in the community.

4. Missouri Partnership for Hope (0841.R02.00)
PROGRAM PURPOSE: The purpose is to prevent or delay of institutional services for individuals who require minimal services in order to continue living in the community. The waiver will offer prevention services to stabilize individuals primarily living with family members who provide significant support, but are not able to meet all of the individual's needs.

GOALS: To increase access to waiver services for children and adults at the local level in participating counties.

OBJECTIVES: The objectives of the waiver are: 1) to increase the capacity of the State to meet the needs of individuals at risk of institutionalization who require minimal supports to continue living in integrated community settings; 2) to partner with local County Boards through Intergovernmental Agreements in the administration and funding of waiver services; and 3) to implement preventive services in a timely manner in order that eligible participants may continue living in the community with their families.

ORGANIZATIONAL STRUCTURE: The waiver is administered by the Division of Developmental Disabilities (DD) through an interagency agreement with the Department of Social Services, the Single State Medicaid Agency. Through intergovernmental agreements specific waiver administrative tasks are delegated to the boards or other not for profit entities that contract with the Division of DD to provide Targeted Case Management (TCM) services of the participating counties with oversight by the Division of DD, which is the operating agency.

SERVICE DELIVERY METHODS: While traditional service delivery methods will be used, participant-directed services will be an option. As the operational agency for the waiver, the Division of DD's method of service delivery in this waiver is the same as that in 1915(c) waivers operated by this division. Service delivery methods include both provider-managed and participant-directed. Services that may be participant-directed or by an authorized representative are personal assistant, support broker, and community specialist. The state operational agency is responsible eligibility determination, provider credentialing and contracting, prior authorization, claim submission, claim payment, technical assistance and oversight to local agencies, and quality enhancement.

Provides day habilitation, personal assistant, prevocational services, supported employment, dental, support broker, applied behavior analysis (ABA), assistive technology, career planning, community integration, community specialist, community transition, environmental accessibility adaptations-home/vehicle modification, family peer support, individualized skill development, job development, occupational therapy, person centered strategies consultation, physical therapy, professional assessment and monitoring, specialized medical equipment and supplies (adaptive equipment), speech therapy, temporary residential service, and transportation for individuals w/autism, ID, DD ages 0 - no max age.

Cost Limit Lower Than Institutional Costs.

The individual support plan (ISP) must validate the individual's annual need for waiver services can be met at a cost of $12,362 or less, or up to $15,000 if the participant meets criteria..

The basis for the limit is that individuals participating in this waiver live with family members, have a strong and stable system of natural supports, have support needs that do not warrant participation in either the Community Support or Comprehensive waiver, or have funding from other public programs that in combination with waiver services ensures the individuals have sufficient services and supports to assure their health and safety. Individuals in the PfH waiver will be eligible for MO HealthNet State plan services and will be assisted in accessing those services first. More costly residential services are not included in this waiver.

Individuals are assessed prior to entering this waiver and annually to identify their needs and estimate the cost of waiver services necessary to meet the needs. When additional needs may arise that exceed the cost limits of a particular Division of DD waiver (e.g., Partnership for Hope Waiver) the planning team will support the individual to obtain additional waiver resources to meet the need. If the estimated cost of waiver services exceeds the limit initially or after entering the

waiver, the individual is considered for participation in another DD waiver that that can meet their need that does not have a cap.

The regional offices of the operating agency report to the operating agency's central office if the cap becomes too low to meet the needs of a significant number of current participants and/or prospective participants. The cap will be adjusted by amendment if it is determined the cap is not sufficient to meet the needs of a growing number of participants or as a result of system changes such as a statewide provider rate increase.

The cost limit specified by the state is:

Specify dollar amount: $12,362

5. Missouri Medically Fragile Adult (40190.R04.00)

The Medically Fragile Adult Waiver (MFAW) will provide home and community-based services to participants with serious and complex medical needs who have reached the age of 21 and are no longer eligible for home care services available under Early Periodic Screening Diagnosis and Treatment (EPSDT), known as Healthy Children and Youth (HCY) in Missouri.

Goals are to: 1) Provide for cost-effective home and community-based services for participants as a cost effective alternative to Intermediate Care Facility for Individuals with Intellectual Disabilities(ICF/IID) placement and 2) Ensure that necessary safeguards have been taken to protect the health and welfare of participants receiving services under the Medically Fragile Adult Waiver.

Objectives include: 1) Provide individual choice between ICF/IID institutional care and comprehensive community based care in a cost effective manner, 2) Maintain and improve a community based system of care that diverts participants from institutional care and residential care, 3) Ensure the adequacy of medical care and services provided through case management, 4) Monitor each participant's condition and continued appropriateness of participation through quarterly home visits by Department of Health and Senior Services (DHSS), Bureau of Special Health Care Needs (BSHCN) RN, and 5) Monitor provider provision of service through care plan reviews and documentation that identifies the participant’s progress, the implementation of services, and the appropriateness of the services provided.

The waiver is administered by the BSHCN through an interagency agreement with the Single State Medicaid Agency, Department of Social Services, MO HealthNet Division (DSS, MHD). BSHCN provides service coordination services for participants served by the Waiver.

Waiver services are accessed through referral to BSHCN RN for those participants who reach the age of 21, meet the criteria of the waiver and desire to remain in their homes. Referrals are also accepted from health care providers, families, other state agencies and other sources. The BSHCN RN completes assessments for waiver eligibility. A committee comprised of the BSHCN Bureau Chief and Program Manager makes the final determination of eligibility and services available.

Participants and/or responsible parties are provided with a list of service providers available in the area in which they live. Participants and/or responsible parties may choose their provider and may change providers at any time. Services are prior authorized by the BSHCN RN and are subject to approval by the State Medicaid Agency, MHD. Providers are paid directly through the MO HealthNet MMIS system.

Provides waiver attendant care, private duty nursing, and specialized medical supplies for individuals who are medically fragile ages 21 – no max age and w/DD ages 21 - no max age.

No Cost Limit. The state does not apply an individual cost limit.

6. **Missouri Aged and Disabled (0026.R07.00)**
   Provides adult day care, basic respite, homemaker, advanced respite, chore, and home delivered meals for aged individuals ages 65 - no max age and physically disabled ages 63-64.

   No Cost Limit. The state does not apply an individual cost limit.

7. **Missouri Adult Day Care (1021.R01.00)**
   Provides adult day care for individuals with physical and other disabilities ages 18-63.

   Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver.

   Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The InterRAI Home Care (HC) assessment is a reliable person-centered assessment that informs and guides comprehensive care and service planning in community-based settings. It focuses on the person's functioning and quality of life by assessing needs, strengths, and preferences. This assessment is a comprehensive assessment that identifies supports and services that may be needed to allow an individual to remain in the community. The InterRAI HC can be used to assess persons with chronic needs for care, as well as with post-acute care needs (e.g., after hospitalization or in a hospital at home situation). The participant would be notified of their right to a fair hearing if enrollment is denied.

Other safeguard(s):

DSDS will inform the participant of other options and make referrals to other available services in the community. Other alternatives may also include State Plan Personal Care or nursing home care.

Appendix H

Report on Managed Care for

Persons with Developmental Disabilities

MANAGED CARE FOR PERSONS WITH DEVELOPMENTAL DISABILITIES
A Synthesis of Recent Reports

WHAT IS MEDICAID MANAGED CARE?

Medicaid Managed Care (MMC) programs have become prevalent in state health systems. In 2017, CMS reported 82% of Medicaid recipients were in managed care programs with 69% in comprehensive managed care plans.[16]

State Medicaid programs use three main types of managed care delivery systems[17]:

> **Comprehensive risk-based managed care.** In such arrangements, states contract with managed care organizations (MCOs) to cover all or most Medicaid-covered services for their Medicaid enrollees. Plans are paid a capitation rate—that is, a fixed dollar amount per member per month—to cover a defined set of services.
>
> **Primary care case management (PCCM).** In a PCCM program, each enrollee has a designated primary care provider who is paid a monthly case management fee to assume responsibility for managing and coordinating his or her basic medical care. Individual providers are not at financial risk and continue to be paid on a fee-for-service basis for delivering services.
>
> **Limited-benefit plans.** Some states contract with limited-benefit plans to manage specific benefits, such as inpatient mental health or substance abuse benefits, non-emergency transportation, oral health, or disease management.

States are increasingly relying on managed care programs approaches inclusive of long-term care and supports (LTSS), however use of managed care for people with intellectual and developmental disabilities is far more limited. **In this summary, programs described are primarily comprehensive risk-based managed care.**

VARIATIONS OF APPROACHES AMONG STATES

MLTSS programs can operate under several Medicaid authorities[18]. States may pursue different Medicaid authorities based on the different types of flexibility they provide and on other changes a state wishes to make to its Medicaid program. States must get approval from the Centers for Medicare & Medicaid Services (CMS) to deliver services through a managed care program, to provide Home and Community-Based Services (HCBS), or both.

- Section 1115 waiver authority is the most common approach used for MLTSS. States have used this authority to waive comparability and statewideness

[16] 2017 Managed Care Enrollment Data from Medicaid.gov web site
[17] MACPAC.gov
[18] MACPAC (2018), page 56)

requirements related to eligibility, benefits, service delivery, and payment methods. States often use this authority when an MLTSS program is rolled into a broader managed care system that may have many other demonstration components. Section 1115 waivers allow states to receive simultaneous approval for the delivery of services through managed care and to provide HCBS. Currently, most Section 1115 waivers must be renewed every five years.

- States may also implement MLTSS by combining a managed care authority and an HCBS authority. For example, states can combine Section 1915(b) waiver authority, which allows states to achieve certain managed care goals and restrict beneficiary choice of providers, with Section 1915(c) waiver authority, which allows states to develop HCBS waiver services. Currently, Section 1915(b) waivers must be renewed every two years, or every five years if individuals who are dually eligible for Medicare and Medicaid are included. Section 1915(c) waiver authority is used for fee for service (FFS) and MLTSS to provide HCBS. States can also use a combination of Section 1915(a) and Section 1915(c) authorities; the combination allows states to implement voluntary managed care plans that include HCBS.

- Finally, states can use Section 1932(a) authority, which allows states to implement mandatory managed care for all populations except individuals dually eligible for Medicaid and Medicare, American Indians and Alaska Natives, and children with special health care needs (including children eligible for Medicaid on the basis of involvement with the child welfare system) through a state plan amendment (SPA). Section 1932(a) SPAs must be paired with a Section 1915(c) waiver to operate an MLTSS program.

THE GOALS OF MANAGED CARE FOR PERSONS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

States implement MLTSS for a variety of reasons. In a recent survey of twelve[19] states with MLTSS, states reported that their goals included:

- **Rebalancing Medicaid LTSS Spending**. A key goal for all states was rebalancing Medicaid long-term services and supports spending toward home and community-based settings and providing more options for people to live in and receive services in the community. Many states have specific rebalancing targets, as well as financial incentives for MLTSS plans to meet them. Eight states reported that they were making progress toward their rebalancing goals, which aligns with national trends in MLTSS rebalancing.

- **Improving Member Experience, Quality of Life, and Health Outcomes**. All states wanted to improve consumer health and satisfaction/quality of life. While it

[19] Arizona, Florida, Iowa, Kansas, Massachusetts, Minnesota, New Jersey, New Mexico, Rhode Island, Tennessee, Texas, and Virginia. Dobson (2017) cited in MACPAC (2018) page 55.

can be challenging to attribute improvements in health outcomes solely to MLTSS programs, seven states reported improved consumer health. Nine states said that they collect data on quality of life, and 10 states collect data on consumer and family satisfaction. Among states reporting outcomes, MLTSS consumers had improved quality of life and high levels of satisfaction. One challenge highlighted by states was that fielding the surveys used to collect these data is time and labor-intensive.

- **Reducing Waiver Waiting Lists and Increasing Access to Services**. MLTSS programs may reduce or eliminate waiting lists for waiver services. Six states said they wanted to reduce waiting lists, while others focused on increasing access to services. Some states successfully eliminated waiting lists, while other states addressed waiting lists by prioritizing applicants by level of need. Some states reinvested savings achieved through implementing MLTSS to decrease the number of people on waiting lists.

- **Increasing Budget Predictability and Managing Costs**. MLTSS programs' use of capitated payments can help improve budget predictability. The programs also have the potential to achieve savings by: rebalancing LTSS spending; managing service use; and avoiding unnecessary hospitalizations or institutional placements. Five states identified Medicaid cost containment as a goal and seven states identified budget predictability as a goal. While states report they are "bending the cost curve," inadequate data are a barrier to states' ability to demonstrate these outcomes.[20]

Another recent review of state documents, including waiver applications, fact sheets, contracts, and state websites, identified similar goals. The most frequently cited MLTSS goals were related to improved participant outcomes (67% of MLTSS programs reviewed), followed by increased access to HCBS and improved care coordination (both 46%), increased efficiency (41%), and improved consumer choice (15%). [21]

USE OF MANAGED CARE FOR PERSONS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

In 2018, Truven Health Analytics produced a 2017 updated inventory of state Medicaid Long-Term Service and Supports (MLTSS) programs[22]. This report updated a series of prior reports by Truven documenting the growth of MLTSS.

A June 2018 report by Health Management Associates (HMA) examined the Truven 2017 update report. The HMA report was prepared for the American Network of Community Options and Resources (ANCOR)[23]. The HMA report noted that of the 25 states identified by Truven as operating a MLTSS program in 2017, only ten states currently enrolled

[20] Dobson (2017) cited in MACPAC (2018) page 55.
[21] Lewis, E. et al (2018) cited in MACPAC (2018) page 55.
[22] Lewis, E. et al (2018)
[23] Lewis, S. et al (2018)

people with Intellectual and Developmental Disabilities (I/DD) in MLTSS, and most use an approach other than mandatory statewide programs contracted to commercial multi-state Managed Care Organizations (MCOs).

States Serving Adults with Intellectual and Developmental Disabilities through Managed Care from Two Reports

State	Truven 2017 Covers Adults with I/DD including ICF and HCBS	Truven 2017 Covers Adults with I/DD including HCBS but not ICF	HMA 2018 States with Current MLTSS-I/DD Programs	HMA 2018 States with Emerging MLTSS-I/DD Efforts
Arizona	X		X	
Arkansas				X
Iowa	X		X	
Kansas	X		X	
Michigan		X	X	
New York	X			X
North Carolina	X		X	
Pennsylvania	X			
Rhode Island		X		
Tennessee		X	X	
Texas				X
Wisconsin	X		X	

In addition to coverage of adults, the Truven report indicates that 11 states serve children in MLTSS programs; however, the report does not specify whether this coverage includes children with intellectual and developmental disabilities.

Of the ten states enrolling people with intellectual and developmental disabilities, HMA found that, "***To date, only Kansas and Iowa have contracted with large national commercial managed care plans with mandatory enrollment statewide for nearly all beneficiaries with I/DD for all services, inclusive of Home and Community-Based Services (HCBS).***"

The experiences of Kansas and Iowa underscore the importance of proceeding with caution.

Kansas implemented a fully capitated statewide managed care system (KanCare) in 2013 with people with I/DD delayed until early 2014. The program operates under an 1115 waiver with seven 1915(c) waivers operating concurrently. According to HMA, providers in Kansas report that while they are making some progress in working with MCOs, the program has not achieved the stated goals for people with I/DD. Employment outcome improvements have not been achieved and waiting lists have grown.

Media reports indicated that state audits are unable to come to conclusions regarding the program due to lack of data integrity and reliability. A report in Governing magazine noted

that a recent audit found that, “the state’s data is so bad, there’s no way to know [whether KanCare is working].”

In 2017, CMS denied Kansas’ request to renew their 1115 waiver and issued a corrective action plan. The state subsequently operated under a temporary extension. In December 2017, the state submitted an 1115 renewal titled KanCare 2.0. On June 22, 2018, the Governor’s Office announced that contracts had been awarded to three MCOs. These included two existing MCOs and one new entity, Aetna Better Health of Kansas. The previous contract with Amerigroup ended. Information from the state indicates that the new MCO contracts will provide key improvements including greater oversight and accountability.

CMS approved the state’s section 1115 waiver on December 18, 2018, with technical corrections issued on January 15, 2019. The current waiver approval is for January 1, 2019 through December 31, 2023. The Special Terms and Conditions (STC) continue section 1915(c) waiver authority for Home and Community-Based Services (HCBS).

Iowa implemented Iowa Health Link in 2016. IA Health Link is a statewide, fully integrated, mandatory managed care program for all services and all populations including people with I/DD. The program operates under a 1915(b)/(c) waiver and contracts with multi-state national for-profit MCOs. The stated goals of Health Link included improved quality and access, accountability for outcomes and predictable and sustainable Medicaid budgets. The state pursued aggressive savings targets, projecting $53.1 million in savings in the first six months of operation. The state also sought to rebalance the LTSS system from institutional to community-based services.

HMA reported that the focus on costs savings and lack of stakeholder engagement in system design have halted, if not eroded, progress and harmed the I/DD service system. HMA reported that MCOs, providers and beneficiaries all reported that the transition to managed care, “has been rough”. The three participating MCOs all reported significant losses in 2017 with medical loss ratios above 100% in most quarters. In October 2017, the plan with the largest enrollment, AmeriHealth Caritas, exited largely due to the losses they incurred. Subsequently, a replacement contract was awarded to Centene’s Iowa Total Care Plan. As of July 2019, Amerigroup Iowa and Iowa Total Care Plan are the MCOs remaining, according to the state’s website.[24]

Providers have reported significant issues with billing and payment. Providers reported concerns with low reimbursement rates, reductions in services, and statements from families fearful of long-time providers going out of business. HMA reported that interviewees emphasized that Iowa has lost ground on its efforts to improve community integrated services, including employment.

[24] https://dhs.iowa.gov/iahealthlink.

Iowa's managed care program is so new that outcome data is limited. HMA reports that, after a brief decline, waiver waiting lists have risen above previous levels and rebalancing targets have not materialized.

In April 2019, the HHS Office of Inspector General (OIG) announced that it would be initiating a review to determine whether Medicaid Managed Care Organizations were in compliance with federal requirements when denying access to treatment that required prior authorization[25]. The OIG announcement came after a request from Senator Bob Casey[26], the ranking member of the U.S. Senate Special Committee on Aging. Senator Casey's letter cited examples from media reports from Texas and Iowa of denials of care by large managed care organizations. The organization referenced in the Texas examples is a subsidiary of Centene, whose Iowa subsidiary was recently awarded a contract in that state.

In addition to reviewing the actions of managed care organizations, Senator Casey's letter requests the OIG determine if CMS has conducted sufficient oversight to ensure that Medicaid MCOs are meeting their obligations to provide access to care for people enrolled. The HHS OIG's work plan indicates this review will be completed in FFY 2020.

IMPLICATIONS FOR FLORIDA?

It is difficult to draw clear conclusions from the experience of other states. In many of the available descriptions, the primary focus of managed care programs has been on the elderly and physically disabled and the outcomes of these people mask the impact of the programs on people with intellectual and developmental disabilities.

Of the goals pursued in other states, the goals most relevant to Florida are controlling costs without adversely affecting service quality and potentially using cost reduction to reduce the waiting list. The experience of Kansas and Iowa shows that these goals are difficult to achieve, particularly in the initial years of implementation.

Where states have made progress in reducing costs and rebalancing Medicaid spending, this has largely been accomplished through shifting from institutional care (such as nursing homes) to community-based settings. This is not particularly relevant to the situation in Florida for people with developmental disabilities.

It should be noted that much of the information outlined above related to Kansas and Iowa is based on interviews and input from stakeholders including providers of service. Information from the agency websites emphasize more positive aspects of implementation. For example, the press release from The Governor's Office in Kansas announcing the award of contracts to three managed care companies stated, "KanCare has proven an effective and efficient delivery model for Medicaid in Kansas…We have

[25] HHS Office of Inspector General Work Plan, April 2019, Report Number W-00-19-31535.
[26] Letter from Senator Casey to HHS Inspector General of April 4, 2019

achieved cost savings, but more importantly, we've seen greater preventative care access to improve health outcomes for Kansans."[27]

The challenge of mapping the best way to proceed with considering managed care for people with intellectual and developmental disabilities was the subject of recent work by the Council on Quality and Leadership (CQL), the Institute on Public Policy for People with Disabilities and Mosaic. These organizations organized a symposium with thought leaders in the industry and stakeholders in October 2018 followed by a second session in March 2019. The report of these sessions noted that there is little research about quality standards for people with intellectual and developmental disabilities and that the majority of research about managed care for persons with disabilities is about health care services and controlling costs, not about quality[28]. The report notes that not only is the provision of quality managed care understudied, but it may also be implemented without an appropriate evidence-base as a result. Further, the report cautions that it is important to recognize that I/DD services are different from supports for all other populations. For other health conditions or disabilities, services and supports are often time limited. However, what may be adequate for other populations, may not be adequate for people with I/DD. Although service needs may ebb and flow during their lifespan, services and supports are often lifelong.[29]

This observation highlights the difficulty in applying findings from managed care experiences related to the elderly and people with physical disabilities to the likely experience of people with intellectual and developmental disabilities.

Conclusions

From the review of experience in other states, there are some lessons learned that should be considered:

1. **Adequate Planning Time.** The most effective system transformations are the result of a thoughtful and deliberative planning process.
2. **Consumer, Family, and Stakeholder Engagement**. The experiences of states that have encountered difficulties in implementing managed care show the importance of involving consumers, families and stakeholders. This should include person-centered planning and recognition that self-determination is an essential component of quality.
3. **Experience with People with Intellectual and Developmental Disabilities.** Involvement of organizations and providers with extensive experience in meeting the unique service needs of people with intellectual and developmental disabilities is of critical importance.

[27] Office of Governor Jeff Colyer, M.D. June 22, 2018.
[28] Williamson, et al. (2017) cited in Friedman, C. (2019).
[29] Friedman, C. (2019).

Beyond these considerations, the processes of data analysis, program design, procurement, contract development and development of capitation rates are complex. The experience of Florida in establishing the existing managed care program for the elderly and physically disabled may provide very useful information. However, the service needs of people with developmental disabilities are unique.

To date, there is little evidence that managed care for people with intellectual and developmental disabilities results in reduced cost or increased quality of care. It would be prudent to closely monitor the experience of other states that have implemented managed care and to use their lessons-learned to inform strategies for the future.

Submitted by:

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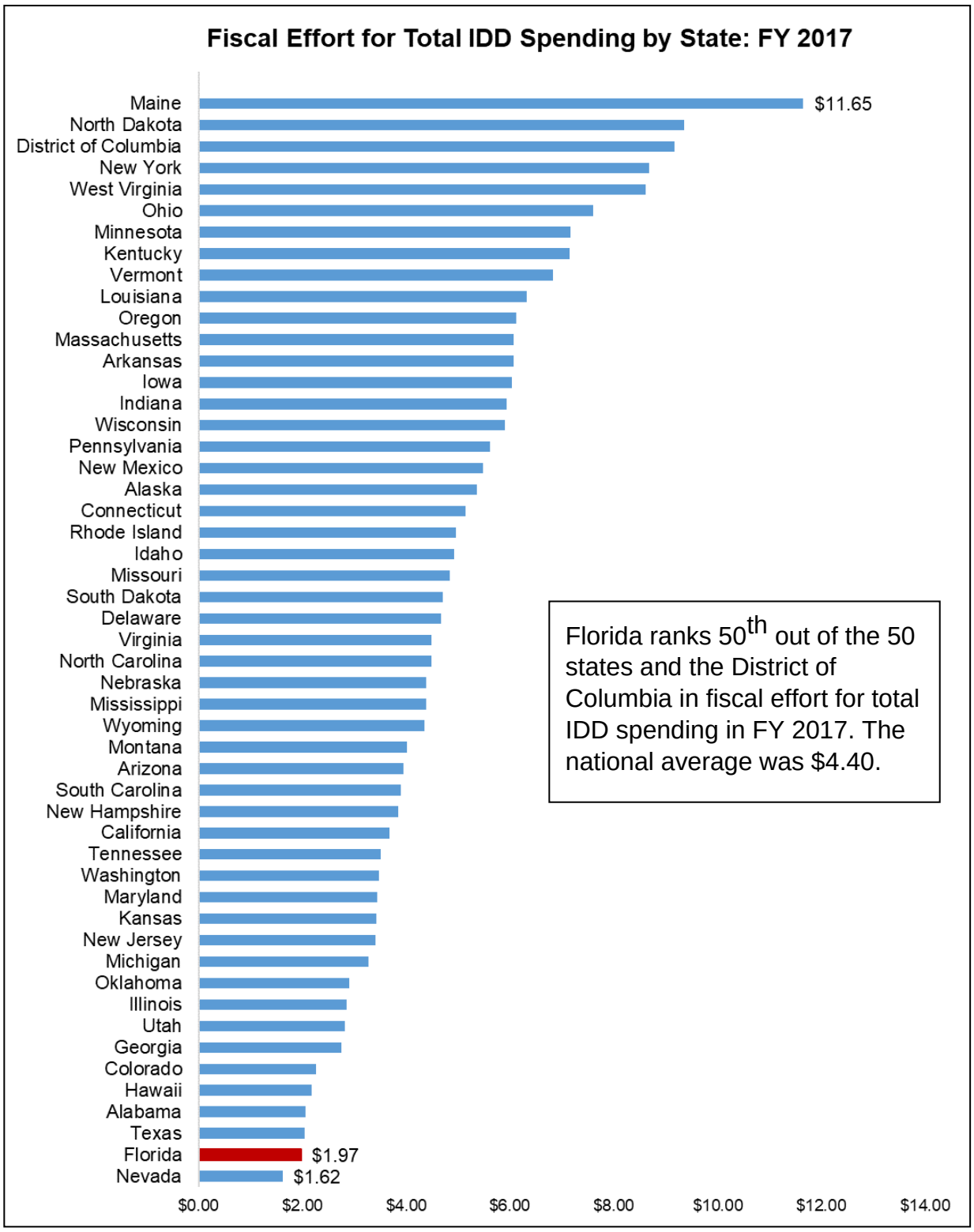
Appendix I

Data Analysis

Florida Disability Rankings
As of 2015[30]

- 1st – Family caregivers over age 60 caring for individuals with developmental disabilities (DD).
    - Caregivers no longer able to provide care is one of the main reasons for waiver clients to require increased services to meet their needs either in their home or in a group home.
    - Caregivers no longer able to provide care is one of the main reasons for individuals with DD not on the waiver to go into crisis requiring either waiver services or institutional care to address their needs.
- 46th – Annual Cost of Care in a Group Home
- 44th – Annual Cost of Care for Supported Living
- 34th – Individual and Family Support Spending per Capita

[30] The State of the States in Intellectual and Developmental Disabilities: 2017, 11th Edition
http://www.stateofthestates.org/

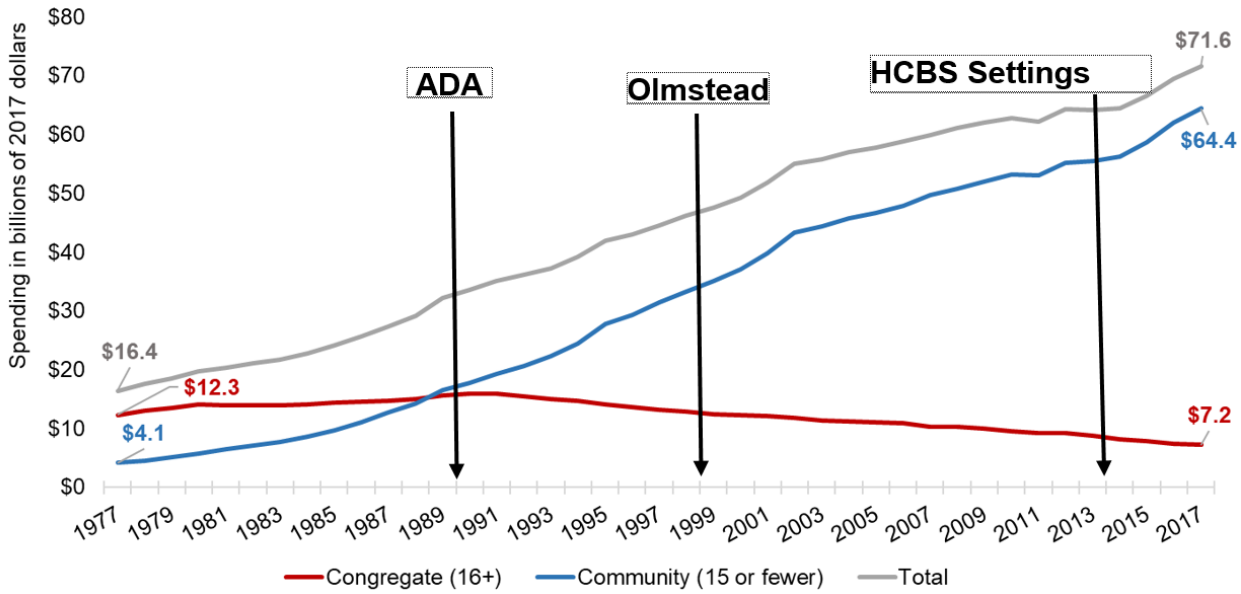

Fiscal Effort for Total IDD Spending by State: FY 2017
Maine $11.65
North Dakota
District of Columbia
New York
West Virginia
Ohio
Minnesota
Kentucky
Vermont
Louisiana
Oregon
Massachusetts
Arkansas
Iowa
Indiana
Wisconsin
Pennsylvania
New Mexico
Alaska
Connecticut
Rhode Island
Idaho
Missouri
South Dakota
Delaware
Virginia
North Carolina
Nebraska
Mississippi
Wyoming
Montana
Arizona
South Carolina
New Hampshire
California
Tennessee
Washington
Maryland
Kansas
New Jersey
Michigan
Oklahoma
Illinois
Utah
Georgia
Colorado
Hawaii
Alabama
Texas
Florida $1.97
Nevada $1.62
$0.00
$2.00
$4.00
$6.00
$8.00
$10.00
$12.00
$14.00
Florida ranks 50th out of the 50 states and the District of Columbia in fiscal effort for total IDD spending in FY 2017. The national average was $4.40.

State of the States Data Highlight

Public Expenditures on I/DD Community-Based Supports Continue to Outpace Institutional Expenditures

Total public spending on supports and services for individuals with intellectual and developmental disabilities in the United States rose by over four-fold in inflation-adjusted dollars between FYs 1977 and 2017, averaging a 4% increase each year. Spending on community settings (for 15 or fewer individuals) **increased** by nearly 16-fold, while spending on institutional settings (for 16+ individuals) **decreased** by 41% during the same period. Closer examination of institutional expenditures reveal a 54% decrease since the passage of the Americans with Disabilities Act (ADA) in 1990, 42% decrease since the Supreme Court's *Olmstead* decision in 1999, and a 12% decrease since the HCBS Settings Rule was introduced in 2014. [31]

Public Expenditures on I/DD Supports and Services in the US: 1977-2014



Source: Tanis, E.S., Lulinski, A., Wu, J., Braddock, D.L., & Hemp, R. (in preparation). *State of the States in Intellectual and Developmental Disabilities: FY 2017*. University of Colorado.

[31] National Association of State Directors of Developmental Disabilities Services (NASDDDS) VOLUME 26, NUMBER 7 JULY 2019, page 9

HCBS Waiver Service Utilization - Fiscal Years 2013-14 through 2018-19

Service Groupings	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
CDC+Allowance	$ 60,127,933	$ 70,022,989	$ 73,855,533	$ 91,188,155	$ 104,077,140	$ 119,996,974
Behavior Analysis	$ 17,407,695	$ 17,566,946	$ 18,164,545	$ 19,206,897	$ 18,469,225	$ 18,912,326
Behavior Assistance	$ 6,520,669	$ 5,604,951	$ 4,849,156	$ 3,921,033	$ 3,260,384	$ 3,019,699
Diet & Dental Care	$ 2,832,771	$ 4,473,398	$ 5,482,776	$ 5,918,820	$ 6,339,799	$ 4,515,923
Employment	$ 4,997,647	$ 5,214,817	$ 5,355,648	$ 5,328,625	$ 5,268,850	$ 5,231,315
Home & Environ Access	$ 291,904	$ 698,170	$ 1,003,858	$ 1,023,666	$ 1,265,449	$ 1,600,105
In-Home Svs/Companion	$ 194,431,296	$ 212,202,363	*$ 240,362,765*	*$ 285,061,074*	*$ 298,378,305*	$ 323,667,703
Live-In Home Staff	$ 225,983	$ -	$ -	$ -	$ -	$ -
Med/Personal Equip	$ 468,466	$ 813,564	$ 818,518	$ 995,584	$ 1,166,970	$ 894,054
Medical Supplies	$ 10,803,972	$ 13,486,089	$ 13,594,154	$ 13,416,901	$ 13,977,898	$ 14,640,850
Nursing/Spcl Med Care	$ 25,433,045	$ 31,149,136	$ 34,397,595	$ 36,465,073	$ 41,102,727	$ 44,272,847
Personal Care	$ 1,109,382	$ 324	$ -	$ -	$ -	$ -
Residential Habilitation - Behavior Focus	$ 3,124,556	$ 1,396,235	$ 1,728,745	*$ 1,933,480*	*$ 1,880,307*	$ 2,140,892
Residential Habilitation - Intensive Behavior	$ 62,193,444	$ 63,380,469	$ 64,889,343	*$ 70,690,840*	*$ 73,111,244*	$ 78,896,311
Residential Habilitation - Standard or ALF	$ 299,254,141	$ 320,673,959	$ 331,552,691	*$ 351,186,593*	*$ 362,566,856*	$ 385,586,696
Respite	$ 10,929,706	$ 14,008,877	$ 15,148,962	*$ 17,348,457*	*$ 15,950,818*	$ 14,986,089
Support Coach	$ 23,849,936	$ 24,582,151	$ 25,273,296	$ 25,625,334	$ 24,734,003	$ 24,815,319
Support Coordination	$ 39,812,514	$ 41,711,633	*$ 49,966,714*	$ 53,972,968	$ 54,287,625	$ 55,251,330
Therapeutic Svs	$ 8,577,464	$ 9,035,605	$ 9,842,243	$ 10,575,400	$ 10,762,084	$ 10,488,599
Training - Facility	$ 65,168,816	*$ 70,724,217*	$ 74,326,400	*$ 82,896,178*	*$ 85,282,238*	$ 91,295,225
Training Off Site	$ 568,191	*$ 795,598*	$ 953,580	*$ 1,171,456*	*$ 1,231,009*	$ 1,309,653
Transportation	$ 22,379,096	$ 25,503,245	$ 28,559,423	$ 30,779,097	$ 31,338,518	$ 34,496,640
Grand Total	**860,508,629**	**933,044,734**	**1,000,125,946**	**1,108,705,629**	**1,154,451,450**	**1,236,018,550**

% Change in service expenditure from previous Fiscal Year

FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
16.46%	5.47%	23.47%	14.13%	15.30%
0.91%	3.40%	5.74%	-3.84%	2.40%
-14.04%	-13.48%	-19.14%	-16.85%	-7.38%
57.92%	22.56%	7.95%	7.11%	-28.77%
4.35%	2.70%	-0.50%	-1.12%	-0.71%
139.18%	43.78%	1.97%	23.62%	26.45%
9.14%	*13.27%*	*18.60%*	*4.67%*	8.48%
73.67%	0.61%	21.63%	17.21%	-23.39%
24.83%	0.80%	-1.30%	4.18%	4.74%
22.48%	10.43%	6.01%	*12.72%*	7.71%
-55.31%	23.81%	*11.84%*	*-2.75%*	13.86%
1.91%	2.38%	*8.94%*	*3.42%*	7.91%
7.16%	3.39%	*5.92%*	*3.24%*	6.35%
28.17%	8.14%	*14.52%*	-8.06%	-6.05%
3.07%	2.81%	1.39%	-3.48%	0.33%
4.77%	*19.79%*	8.02%	0.58%	1.78%
5.34%	8.93%	7.45%	1.77%	-2.54%
8.52%	5.09%	*11.53%*	*2.88%*	7.05%
40.02%	19.86%	*22.85%*	*5.08%*	6.39%
13.96%	11.98%	7.77%	1.82%	10.08%

Source: APD's Allocation, Budget and Contract Control (ABC) System.

Provider rate increases contribute to increase in expenditures
effective 7/1/2014
effective 7/1/2015
effective 4/1/2016
effective 7/1/2016
effective 7/1/2017

FY 16-17 TOTAL NUMBER OF SANS STATEWIDE TO DATE

SAN system data as of 10/10/17

	July	August	Sept.	October	Nov.	Dec.	January	February	March	April	May	June	Total	%	WSC Requested Increase Amount	Final Budget Change Amount
Approved	6	33	7	83	114	150	183	369	641	685	597	542	3,410	**59.87%**	23,541,789	21,306,716
Partially Approved		14	3	55	91	98	121	231	299	329	371	350	1,962	**34.45%**	37,064,618	18,391,273
Denied	2	21	22	13	21	20	28	27	30	51	41	48	324	**5.69%**	4,226,654	-
Total	**8**	**68**	**32**	**151**	**226**	**268**	**332**	**627**	**970**	**1,065**	**1,009**	**940**	**5,696**	**100.00%**	**64,833,061**	**39,697,989**

Electronic SAN submissions began July 1, 2016. Paper submissions prior to July 1, 2016 not captured in this data.

A total of 10,864 SANs were submitted through the electronic SANs submission process identified as FY2016-2017. Not all SANs result in a decision as some are cancelled, withdrawn or re-submitted.

SAN volume increases occurred starting in October as a result of iBudget algorithm implementation.

New algorithms were calculated for consumers with annual Support Plans due January 2017 and forward.

From October 2016 through June 2017, a total of 3,488 SANs were submitted for consumers receiving a new algorithm.

In order to maintain currently approved medically necessary services, a SAN must be submitted when the consumers new algorithm amount is less than the consumers existing iBudget amount.

New algorithms were calculated for consumers with a SAN request whose annual Support Plan was not yet due relative to the algorithm implementation schedule.

From July 2016 through June 2017, a total of 2,208 SANs were submitted for consumers with significant additional needs.

** Unduplicated Consumer Count* *5,513*

FY 17-18 TOTAL NUMBER OF SANS STATEWIDE TO DATE

SAN system data as of 8/13/2018

	July	August	Sept.	October	November	December	January	February	March	April	May	June	Total	%	WSC Requested Increase Amount	Final Budget Change Amount
Approved	342	380	302	376	330	341	394	338	416	348	319	222	4,108	**54.47%**	87,292,057	38,904,394
Partially Approved	240	290	246	274	267	260	261	274	307	262	309	267	3,257	**43.18%**	290,697,134	33,143,438
Denied	39	19	10	18	18	16	19	10	6	6	10	6	177	**2.35%**	2,848,569	1,200,296
Total	**621**	**689**	**558**	**668**	**615**	**617**	**674**	**622**	**729**	**616**	**638**	**495**	**7,542**	**100.00%**	**380,837,761**	**73,248,128**

Electronic SAN submissions began July 1, 2016.

A total of 6,906 SANs were submitted through the electronic SANs submission process identified as FY2017-2018. Not all SANs result in a decision as some are cancelled, withdrawn or re-submitted.

SAN volume increases occurred starting in October 2016 as a result of iBudget algorithm implementation.

New algorithms were calculated for consumers with annual Support Plans due January 2017 and forward.

From July 2017 through June 30, 2018, a total of 4,353 SANs notices were issued for consumers whose Waiver Support Coordinator indicated the SAN was the result of an Algorithm Implementation Meeting (AIM).

In order to maintain currently approved medically necessary services, a SAN must be submitted when the consumers new algorithm amount is less than the consumers existing iBudget amount.

New algorithms were calculated for consumers with a SAN request whose annual Support Plan was not yet due relative to the algorithm implementation schedule.

From July 2017 through June 30, 2018, a total of 3,189 SANs notices were issued for consumers with significant additional needs and whose Waiver Support Coordinator indicated the SAN was not the result of an Algorithm Implementation Meeting (AIM).

FY 18-19 TOTAL NUMBER OF SANS STATEWIDE TO DATE

SAN system data as of 8/1/2019

	July	August	Sept.	October	November	December	January	February	March	April	May	June	Total	%	WSC Requested Increase Amount	Final Budget Change Amount
Approved	322	372	484	380	261	200	264	219	194	253	265	215	3,429	**49.66%**	45,315,793	39,690,138
Partially Approved	247	311	245	268	266	216	268	299	291	355	362	257	3,385	**49.02%**	109,327,166	47,326,896
Denied	8	14	11	4	4	5	8	8	5	8	7	9	91	**1.32%**	1,327,570	(700,756)
Total	**577**	**697**	**740**	**652**	**531**	**421**	**540**	**526**	**490**	**616**	**634**	**481**	**6,905**	**100.00%**	**155,970,529**	**86,316,278**

Electronic SAN submissions began July 1, 2016.

A total of 8,002 SANs were submitted through the electronic SANs submission process identified as FY2018-2019. Not all SANs result in a decision as some are cancelled, withdrawn or re-submitted.

SAN volume increases occurred starting in October 2016 as a result of iBudget algorithm implementation.

New algorithms were calculated for consumers with annual Support Plans due January 2017 and forward.

From July 2018 through June 30, 2019, a total of 3,152 SANs notices were issued for consumers whose Waiver Support Coordinator indicated the SAN was the result of an Algorithm Implementation Meeting (AIM).

In order to maintain currently approved medically necessary services, a SAN must be submitted when the consumers new algorithm amount is less than the consumers existing iBudget amount.

New algorithms were calculated for consumers with a SAN request whose annual Support Plan was not yet due relative to the algorithm implementation schedule.

From July 2018 through June 30, 2019, a total of 3,753 SANs notices were issued for consumers with significant additional needs and whose Waiver Support Coordinator indicated the SAN was not the result of an Algorithm Implementation Meeting (AIM).

Waiver Population by Age Groups
Fiscal Year 2015-16 to 2018-19

Age Group	ALL Waiver FY1516 EOY		ALL Waiver FY1617 EOY		ALL Waiver FY1718 EOY		ALL Waiver FY1819 EOY		Net Change FY1516 vs FY1819	
	Count	%	Count	%	Count	%	Count	%	Count	%
AGE: 2 TO 10	473	1.44%	567	1.66%	592	1.73%	601	1.73%	128	6.73%
AGE: 11 TO 20	4,110	12.52%	3,872	11.37%	3,584	10.45%	3,337	9.61%	(773)	-40.64%
AGE: 21 TO 30	8,985	27.37%	9,495	27.88%	9,764	28.48%	9,887	28.47%	902	47.42%
AGE: 31 TO 40	7,084	21.58%	7,526	22.10%	7,557	22.04%	7,699	22.17%	615	32.33%
AGE: 41 TO 50	5,351	16.30%	5,404	15.87%	5,539	16.16%	5,729	16.49%	378	19.87%
AGE: 50 TO 60	4,423	13.47%	4,576	13.44%	4,523	13.19%	4,558	13.12%	135	7.10%
AGE: 60 TO 70	1,905	5.80%	2,074	6.09%	2,141	6.24%	2,262	6.51%	357	18.77%
AGE: 70 TO 80	447	1.36%	484	1.42%	525	1.53%	594	1.71%	147	7.73%
AGE: 81 OR OLDER	52	0.16%	57	0.17%	60	0.18%	65	0.19%	13	0.68%
Grand Total	32,830	100.00%	34,055	100.00%	34,285	100.00%	34,732	100.00%	1,902	100.00%

Data includes clients in waiver active status and their age as of the end of each fiscal year period

Analysis of Top 100 Clients by Expenditure for Fiscal Year 2017-18

- Top 100 Expenditure Average $220,358, Lowest $183,055, Highest $315,909
- 82% are between the ages of 22 and 32

Age Group	Top 100		ALL Waiver	
	Count	%	Count	%
03-10	-	0.00%	591	1.71%
11-20	-	0.00%	3,375	9.79%
21-30	75	75.00%	9,832	28.51%
31-40	19	19.00%	7,618	22.09%
41-50	3	3.00%	5,676	16.46%
51-60	3	3.00%	4,534	13.15%
61-70	-	0.00%	2,222	6.44%
71+	-	0.00%	633	1.84%
Total	100	100.00%	34,481	100.00%

- By Living Setting
  - 61% live in the family home
  - 38% live in a group home
  - 1% live in independent/supported living
- By Disability
  - 68% have Intellectual Disabilities
  - 28% have Cerebral Palsy
  - 3% have Autism
  - 1% have Spina Bifida
- By Region

Region	Top 100	%	All Waiver	%
Central	25	25.00%	6,459	18.73%
Northeast	9	9.00%	5,149	14.93%
Northwest	-	0.00%	2,987	8.66%
Southeast	21	21.00%	6,932	20.10%
Southern	24	24.00%	5,014	14.54%
Suncoast	21	21.00%	7,940	23.03%

- By Service - 6 costliest services
  - Private Duty Nursing – LPN/RN $12,180,293
  - Residential Nursing – LPN/RN $ 5,168,237
  - Residential Habilitation – CTEP $ 1,243,272
  - Personal Supports $ 869,839
  - Residential Habilitation – Standard/ALF $ 845,507
  - Consumable Medical Supplies $ 514,947

Analysis of Top 100 Clients by Expenditure for Fiscal Year 2018-19

- Top 100 Expenditure Average $238,936, Lowest $206,841, Highest $322,041
- 76% are between the ages of 22 and 32

Age Group	Top 100		ALL Waiver	
	Count	%	Count	%
03-10	-	0.00%	598	1.73%
11-20	1	1.00%	3,335	9.64%
21-30	71	71.00%	9,872	28.52%
31-40	21	21.00%	7,685	22.20%
41-50	4	4.00%	5,716	16.51%
51-60	2	2.00%	4,528	13.08%
61-70	1	1.00%	2,234	6.45%
71+	-	0.00%	643	1.86%
Total	100	100.00%	34,611	100.00%

- By Living Setting
  - 55% live in the family home
  - 44% live in a group home
  - 1% live in independent/supported living
- By Disability
  - 68% have Intellectual Disabilities
  - 27% have Cerebral Palsy
  - 5% have Autism
- By Region

Region	Top 100	%	All Waiver	%
Central	19	19.00%	6,484	18.73%
Northeast	10	10.00%	5,125	14.81%
Northwest	-	0.00%	2,950	8.52%
Southeast	28	28.00%	7,006	20.24%
Southern	22	22.00%	5,044	14.57%
Suncoast	21	21.00%	8,002	23.12%

- By Service - 6 costliest services
  - Private Duty Nursing – LPN/RN $ 8,838,097
  - Residential/Skilled Nursing $ 6,371,889
  - Residential Habilitation – Standard/ALF $ 3,094,058
  - Residential Habilitation – CTEP $ 453,802
  - Consumable Medical Supplies $ 416,134
  - Personal Supports $ 349,000

Appendix J

APD/AHCA Meeting Dates and Agendas

The Agency for Persons with Disabilities (APD) and the Agency for Health Care Administration (AHCA) met over the course of several months to discuss topics related to the Waiver redesign plan. Below is a list of the meeting dates and agendas when available.

March 15, 2019

April 4, 2019

May 14, 2019

May 30, 2019

Topic
1. Introductions
2. Review: Other States Research Comparison of the DD Waiver
3. Discuss: Status of Redesign Options
4. Discuss: Next Steps

June 19, 2019

Topic
1. Introductions & Review of Action Items
2. Review: Comprehensive List of Redesign Options
3. Discuss: Governor's Office Check-in Reminder and What will be Provided
4. Discuss: Scheduling the Next Check-in Meeting with Director Palmer and Secretary Mayhew
5. Discuss: Status of Report
6. Review: APD Budget by Setting for SFY1819
7. Review: Implementation Process and Timeframe on the Focused Topics: • Reduce Service Rates • Limit Crisis Enrollment • Individual Caps
8. Review: Project Schedule and Report Timeline
9. Discuss: Next Steps

June 25, 2019

Topic
1. Introductions & Review of Action Items
2. Discuss: Building Out Waiver Redesign Options
3. Discuss: Next Steps

July 11, 2019

Topic
1. Introductions & Review of Previous Action Items
2. Prep for APD / AHCA Leadership Meeting on 7/12 • Final Report Routing Procedure Options • Status Report Framework • Finalization of Cost Containment Options
3. Review: Cost Containment Options and Managed Care Approaches
4. Review of Project Schedule

July 12, 2019

July 23, 2019

Topic
1. Introductions & Review of Previous Action Items
2. Update on APD / AHCA Leadership Meeting on 7/12
3. Discuss: Research of Waiver Services in Other States
4. Discuss: Managed Care Options
5. Discuss: Public Meeting Outcomes
6. Update on First Status Report Submission
7. Next Steps
8. Review of Project Schedule

September 3, 2019

September 11, 2019

Appendix K

Research Options

The Agency for Persons with Disabilities has been directed, in conjunction with the Agency for Health Care Administration, to develop a plan to redesign the waiver program and submit such plan to the Legislature for consideration. See Chapter 2019-116, Laws of Florida. The agencies do not necessarily endorse any of these options at this time. Some options, if implemented, will require notifying the affected waiver clients of the change and possible fair hearing rights.

									Implementation Requirements		
Option Type	**Service**	**Change to Consider**	**Maximum Service Limits**	**Total Number of Clients**	**Total Clients Affected**	**Overall Financial Impact (Savings)**	**Cost Shift**	**Being Done in Other State(s)**	**Federal**	**State**	**Other**
Rate Reduction	Provider Service Rates Reduction	Reduction of 1% Reduction of 2% Reduction of 3%	N/A	34,500	34,500	$11,717,837 $23,435,674 $35,153,511	No	N/A	Yes	Yes	No
		Client/Agency Impact and/or Risks •Some private sector service providers may be unwilling or unable to continue doing business in Florida which could create challenges regarding the ability of APD clients to access services within their local communities. •Rate reductions may cause a cost shift to AHCA if community-based providers are no longer willing or able to serve APD clients and those clients subsequently choose to live in ICFs or skilled nursing facilities in order to obtain medically necessary services and supports. •For some providers and services, rate reductions may not support compliance with the United States Department of Labor (USDOL) minimum wage requirements. •A rate reduction would be contrary to rates set through previous rate studies and legislative mandates (which identified and established appropriate costs of care for APD clients). This could result in litigation if the state of Florida knowingly pays inadequate rates for services.									
	Residential Habilitation	Expand the number of agency group homes that qualify for the AHCA Medicaid Assistive Care Services (ACS) to reduce waiver program residential costs	N/A	9,000	No client impact	$40,000,000	Cost shift to AHCA	N/A	Yes	Yes	No
		Client/Agency Impact and/or Risks None.									
Service Limitation/Service Change	ADT	•Reduction in number of levels, client shift to next higher ratio •Implement a redesign to promote employment •Introduce a lower rate for "adult day care"		13,502 11,405		$15,000,000 $19,000,000	No	N/A	Yes	Yes	No
		Client/Agency Impact and/or Risks •Less intensive staffing ratios could adversely impact client health and safety and decrease community participation (since less staff would be available to accompany clients on outings). •Providers may not be willing to serve client at lower ratio.									
	Behavior Services	Limit service to individuals ages 21 and over as Behavior services are available for those under age 21 through Medicaid State Plan	0	76	76	$284,349	Yes	N/A	Yes	Yes	No
		Client/Agency Impact and/or Risks •None.									

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Service Limitation/Service Change	Life Skills Development	Combination of companion, supported employment, and adult day training services not to exceed 1,440 hours annually	1,440 hours annually	18,593	1,557	$2,570,210	No	N/A	Yes	Yes	No
		Client/Agency Impact and/or Risks •Some clients will experience a reduction in services. •Some individuals may increase other waiver services to make up for the loss in Life Skills Development services. For example, if an individual living in the family home or supported living setting requires a set number of hours to ensure their health and safety, some clients may request increases in Personal Supports or other waiver services. •Behavioral issues are often exacerbated by lack of engagement in meaningful day activities and may result in the need for additional services, including more costly behavioral analysis and assistant services.									
	Occupational Therapy	Limit of 2 hours per week if only therapy service If the individual has other therapies (OT, ST, PT) limit is 1 hour per week per therapy Limited to 1 hour per week if the individual receives nursing services	416 QH Annually 208 QH Annually 208 QH Annually	870	> 416 QH =17 > 208 QH=475 >208 QH = 47	Service Plans = $1,831,109 Expenditures = $864,677	Potential	N/A	Yes	Yes	No
		Client/Agency Impact and/or Risks •Significantly limiting therapy hours may result in functional and physical declines for individuals who already have limited capabilities. •Decreasing therapeutic services such as occupational therapy may increase the need for paid staff to perform daily living skills and functions that the clients are learning and maintaining through occupational therapy. This may include daily living skills such as eating, brushing teeth, grasping objects, toileting, etc. •When medically necessary therapies are decreased, some clients may lose job opportunities and the potential for independent living. •Reductions may cause a cost shift to AHCA if community-based providers are no longer willing or able to serve APD clients and those clients subsequently choose to live in ICFs or skilled nursing facilities in order to obtain medically necessary services and supports. •This change increases the likelihood that some clients will choose institutional care to have their needs met if comparable services are not available in the community, which could result in litigation (see Olmstead v. L.C.).									

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Service Limitation/Service Change	Personal Supports	Revise definition to exclude "supervision" Require hours beyond 12 hours to be at higher ratios (1:2, 1:3, etc.) the basic areas identified due to physical, medical, or adaptive limitations. Additional hours a month over the 180-hour limit may be requested for intensive physical, medical, or adaptive needs when the hours are essential to maintain the recipient's health and medical status. Any recipient who requires Personal Supports during sleep hours shall provide documentation from a physician stating that services are medically necessary during this time. The support plan shall also explain the duties that the Personal Supports provider will perform.	6 hours per day = 2,190 H / 8,760 QH Annually 8 hours per day Annually 12 hours per day = 4,380H / 17,520QH Annually 14 hours per day = 5,110H / 20,440QH Annually 16 hours per day = 5,840H / 23,360QH Annually 18 hours per day = 6,570H / 26,280QH Annually	13,395	2,909 650 351 214 119 77	$44,043,512 $12,260,352 $7,142,561 $4,362,000 $2,611,256 $1,518,580	Potential	N/A	Yes	Yes	No
		Client/Agency Impact and/or Risks •Some individuals require up to 24 hours per day of Personal Supports because they are unable to complete any activity of daily living without the assistance of someone else. Personal Supports is a life-sustaining service for many APD clients and reducing the amount of personal supports will impact health and safety. •The majority of APD clients live in the family home. The family home is the most cost effective and least restrictive setting for iBudget Waiver clients. The provision of Personal Supports is often the service that allows families to keep APD clients in their homes long term. It includes hands-on care, supervision, community access, and respite for adults who do not access personal care through the Medicaid program. Some APD clients may not be able to remain in their current living setting with reduction of paid support hours. For individuals who live in the family home, parents may not be able to work and meet the housing needs of APD clients. This removes caregivers for individuals who live in supported living settings in their own homes. •This limitation also imposes a health and safety risk for individuals who live in supported living. Individuals require this service so that they can get out of bed, evacuate, eat, and live safely in their homes. •This limitation may result in some clients choosing more costly living settings, including residential care. •Some clients may to choose institutional care to have their needs met if they cannot access Personal Supports which poses a federal litigation risk (see Olmstead v. L.C.)								

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Service Limitation/Service Change	Physical Therapy	Limit of 2 hours per week if only therapy service If the individual has other therapies (OT, ST, PT) limit is 1 hour per week per therapy Limited to 1 hour per week if the individual receives nursing services	416 QH Annually 208 QH Annually 208 QH Annually	1,367	> 416 QH =83 > 208 QH=456 >208 QH = 62	Service Plans = $1,947,849 Expenditures = $1,074,622	Potential	N/A	No	Yes	No
		Client/Agency Impact and/or Risks •Some APD clients have severe physical limitations and require extensive amounts of therapies to prevent contractures, spasticity and to maintain their level of functioning. Significantly limiting therapy hours may result in functional and physical declines for individuals who already have limited capabilities. •Decreasing therapeutic services may increase the need for paid staff to perform daily living skills and functions that the clients are learning and maintaining through therapy. •When medically necessary therapies are decreased, some clients may lose job opportunities and the potential for independent living.										
	Residential Habilitation	• Reduce number of levels • Revise the annual medical necessity determination process to include a third party for recommendations • Res Hab at Moderate/Minimal rate if individual is receiving high levels of nursing through waiver or Medicaid State Plan or personal care through Medicaid State Plan	Where client has Residential Nursing in the Group Home: • 0-12 hours of Nursing (17,520 QH max), Res Hab level remains the same • 13-16 hours of Nursing (23,360 QH max), Res Hab at the moderate level • 17-24 hours of Nursing (35,040 QH max), Res Hab at the minimal level	134	22	$600,000	Potential	N/A	Yes	Yes	No
		Client/Agency Impact and/or Risks •Reducing the number of rate levels may require a formal rate study to determine the appropriate cost of care based on client needs. •If payment amounts change, some individuals may have to move out of current stable living arrangement and locate alternate placements. •Rate changes impact private sector providers who may not be able to continue to serve APD clients, thereby creating access-to-care issues.									

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Service Limitation	Respiratory Therapy	Limit of 3 hours per week	624 QH Annually	87	> 624 QH =43	Service Plans = $261,142 Expenditures = $120,376	Potential	N/A	No	Yes	No
		Client/Agency Impact and/or Risks •Respiratory therapy services ensure that individuals with compromised airways get oxygen needed to sustain life. Respiratory therapy is critical for addressing impairments of respiratory function and other deficiencies of the cardiopulmonary system. If there is a reduction in this service, there must be an assurance that a nurses or other caregivers can perform the tasks no longer covered by the respiratory therapist.									
Service Limitation	[illegible]	Ÿ Limited to 720 Hours / 2880 Quarter Hours for children ages 3-14 Ÿ [illegible]	• Limited to 720 Hours / 2880 Quarter	703	210	$1,000,000	Potential	N/A	Yes	Yes	No
		Client/Agency Impact and/or Risks [illegible]									
Service Limitation	Skilled Nursing	service as it is available for all ages through Medicaid State Plan	0	40	40	$478,985	Yes	N/A	Yes	Yes	No
		Client/Agency Impact and/or Risks •AHCA will need to ensure that adequate provider capacity exists to meet APD client needs.									
Service Limitation	Specialized Mental Health	Limit of 2 hours per month	96 QH Annually	294	> 96 QH =241	Service Plans = $511,301 Expenditures = $247,113	Yes	N/A	No	Yes	No
		Client/Agency Impact and/or Risks •APD has numerous clients who are dually diagnosed with co-occurring mental illness and developmental disabilities. Limiting the availability of mental health services can result in an increase in Baker Acts, extended hospitalizations, and encounters with law enforcement. •Many APD clients are not able to benefit from traditional community mental health services (which are typically geared towards individuals without cognitive impairments).									

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Service Limitation/Service Change	Speech Therapy	Limit of 2 hours per week if only therapy service If the individual has other therapies (OT, ST, PT) limit is 1 hour per week per therapy Limited to 1 hour per week if the individual receives nursing services	416 QH Annually 208 QH Annually 208 QH Annually	816	> 416 QH =36 > 208 QH=252 >208 QH = 13	Service Plans = $999,584 Expenditures = $296,906	Potential	N/A	No	Yes	No
		Client/Agency Impact and/or Risks •Behavioral issues are often exacerbated by the inability of non-verbal clients to sufficiently communicate their needs in an appropriate manner. Speech therapy assists such clients and restricting access to this service and may result in the need for additional supports, including more costly behavioral analysis and behavior assistant services. •When medically necessary therapies are decreased, some clients may lose job opportunities and the potential for independent living. •Reductions may cause a cost shift to AHCA if community-based providers are no longer willing or able to serve APD clients and those clients subsequently choose to live in ICFs or skilled nursing facilities in order to obtain medically necessary services and supports. •This change increases the likelihood that some clients will choose institutional care to have their needs met if comparable services are not available in the community which could result in litigation (see Olmstead v. L.C.).									
	Supported Living Coaching	Limit of 20 hours per month	960 QH Annually	4,321	> 960 QH=771	Service Plans = $2,449,377 Expenditures = $2,052,941	Potential	N/A	No	Yes	No
		Client/Agency Impact and/or Risks •Supported Living Coaching services provide training and support to vulnerable adults who live in their own homes. An analysis of incident and abuse/neglect/exploitation data indicates an increasing prevalence in the number of issues adversely impacting the health and safety of APD clients who live in supported living settings. In addition to their own victimization, a number of APD clients in supported living settings (without proper supervision and supports) are increasingly identified as the perpetrators of crimes committed against other community members.									
	Support Coordination	Improve performance and increase accountability for Waiver Support Coordinators	N/A	34,500	34,500	N/A	N/A	N/A	No	Yes	No
		Client/Agency Impact and/or Risks •None									

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Waiver Change	Child Waiver	Waiver for children under age 18 with a cap. Doesn't provide res hab to children	N/A	225	225	TBD	Potential	Yes	Yes	Yes	No
		Client/Agency Impact and/or Risks •APD currently has approximately 2,000 children enrolled on the iBudget waiver who reside in APD-licensed facilities. These children would be required to move or locate other funding for their placement. Requiring unnecessary moves can cause numerous issues, including transfer trauma and adjustment concerns. • Impacts children in foster care. • Provider capacity for non-residential providers would need occur to meet the needs of children who require care 24 hours per day. •Some families may to choose institutional care to have needs met if they cannot access adequate amounts of Respite. There is federal case law regarding institutionalization of individuals with disabilities (see Olmstead v. L.C.).									
	Crisis Enrollment	Zero crisis enrollment Limit monthly crisis enrollment to 30	0 crisis enrollees per month 30 crisis enrollees per month	• FY 17/18 average was 106 p/m, total of 1,272 • FY 18/19 average is 97 p/m, total as of 5/31/19 was 1,067	At zero enrollees per month, estimated average of 1,100 annually At 30 enrollees per month, estimated average of 740 annually	**Zero enrollees** Year 1: $12,182,025 Year 2: $44,565,319 Year 3: $82,871,338 Year 4: $125,540,846 Year 5: $171,689,035 **30 pm / 360 py** • Year 1: $8,195,180 • Year 2: $29,980,305 • Year 3: $55,749,809 • Year 4: $84,454,750 • Year 5: $115,499,896	Potential	N/A	No	Yes	No
		Client/Agency Impact and/or Risks •The agency currently enrolls individuals onto the waiver continuously who are in crisis situations. This includes vulnerable individuals who are homeless, a danger to self/others, and their caregiver is unable to provide care who have no other resources to meet these needs. •If crisis enrollment is limited, some individuals will choose institutional care to have needs met if they cannot access community-based services (which could create capacity issues for AHCA) •This change will increase the growth of individuals on the waiting list for services. •APD may spend additional non-waiver/IFS dollars to address crisis situations month-to-month.									
	Host Home Model	• Host home model (similar to foster care model) instead of a group home	TBD	TBD	TBD	TBD	N/A	Yes	Yes	Yes	Yes
		Client/Agency Impact and/or Risks •TBD - Needs further exploration.									

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Waiver Change	Waiver Cap at Individual Level	Implement an annual cap at the individual level for all living settings	Individual CAP at % of ICF Rate: 100% = $133,000 125% = $166,250 150% = $199,500 OR At $150,000 **Behavioral ICF Rate = $205,130**	34,500	 460 178 94 272 **85**	 $16,675,995 $7,046,812 $2,930,764 $10,521,746 **$2,434,320**	Potential	Yes	Yes	Yes	Yes
		Client/Agency Impact and/or Risks •The waiver was created to serve people in the community in the most appropriate living setting possible. •At times an individual's service needs and costs may reach a level that their current living setting may not be the most appropriate setting for them to receive services. •For individuals impacted a waiver cap, APD will work with the waiver client to either arrange services within the limits necessary for them to remain in their current settings; or assist them in identifying an alternative living setting better suited to meet their service needs.									
	Managed Care	•Hybrid managed care model through AHCA for medical services. APD maintains companion, res hab and ADT, etc.	N/A	34,500	14,166	$66,604,816	Cost shift to AHCA	Yes	Yes	Yes	Yes
		Client/Agency Impact and/or Risks •This will cause disruption in continuity of care as it will require that clients find new providers who are within a managed care provider's network. •This will cause disruption with existing private sector providers who are currently Medicaid providers but not part of a managed care network. •AHCA and the managed care plans will need to ensure that adequate provider networks exist to meet APD client needs. •AHCA and APD may need to expand the complaint hub processes for mitigating access issues between clients and managed care plans. •This will require new managed care contracts as this changes the scope of existing managed care contracts.									

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Waiver Change	Managed Care	Long Term Managed Care model plan for all services. APD contract or AHCA administered?	N/A	34,500	34,500	TBD	Potential	Yes	Yes	Yes	No
		Client/Agency Impact and/or Risks •This will cause disruption in continuity of care as it will require that clients find new providers who are within a managed care provider's network. •This will cause disruption with existing private sector providers who are currently Medicaid providers but not part of a managed care network. •AHCA and the managed care plans will need to ensure that adequate provider networks exist to meet APD client needs. •AHCA and APD may need to expand the complaint hub processes for mitigating access issues between clients and managed care plans. •This will require new managed care contracts as this changes the scope of existing managed care contracts.									
	Medicaid State Plan (MSP) Services Budget Transfer for Aging Out	Allow budgetary transfer from AHCA to APD for waiver clients aging out of MSP services upon turning 21	N/A	Approx. 800 Annually	Approx. 800 Annually	Approx. $4-5 Million Each Year	Fund transfer from AHCA to APD	N/A	No	Yes	No
		Client/Agency Impact and/or Risks •Would result in immediate cost savings upon implementation. When APD clients turn 21, many of their services are no longer available through the Medicaid State Plan Early Periodic Screening and Diagnostic Treatment (EPSDT) coverage. APD has identified this as a major cost driver related to program growth.									
	Medical Necessity Determination/ Significant Additional Needs (SAN)	Centralize the process of SAN determination of medically necessary services to ensure consistency in application of criteria	N/A	34,500	34,500	N/A	N/A	N/A	No	No	No
		Client/Agency Impact and/or Risks •Implement inter-rater reliability and peer review process by Jan 2020									
	Social Services Estimating Conference (SSEC)	Include the waiver program in SSEC to provide the Legislature with projections for the program	N/A	N/A	N/A	N/A	N/A	N/A	No	No	No
		Client/Agency Impact and/or Risks None.									

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Waiver Change	TeleCare	Independent living technology involves the use of remote monitoring services and/or equipment in conjunction with additional technological support and services				In Ohio - Reduction in support costs for over-night staffing of $15,000 per person	No	Yes - (19 states) Ohio Washington Montana New Mexico South Dakota Minnesota Missouri Arkansas Tennessee Indiana Maine Vermont Connecticut Pennsylvania West Virginia Virginia North Carolina Maryland Washington D.C.	No	Yes	No
		Client/Agency Impact and/or Risks •May be beneficial and appropriate for some higher functioning clients for certain waiver services but not conducive for individuals with significant functional, physical, or behavioral limitations who always require staff to be physically present with them. •Power outages or equipment failures could put clients at risk. •May result in increased access to services and supports (particularly for those individuals in rural parts of the state).									
	Waiver Support Coordination	APD contract with limited number of Waiver Support Coordination agency(ies) regionally/statewide Make Waiver Support Coordination the role of an FTE or contract employee	N/A	TBD	TBD	TBD	TBD	N/A	Yes	Yes	No
		Client/Agency Impact and/or Risks •TBD - Needs further exploration.									
	Florida Assertive Community Treatment (FACT) and Community Action Team (CAT) Pilot	Increase the resources available to the DCF FACT and CAT teams in order to serve individuals with comorbid mental health and developmental disabilities to address issues early and avoid more costly services in the future	N/A	34,500	34,500	N/A	N/A	N/A	No	Yes	No
		Client/Agency Impact and/or Risks •Waiver clients will receive mental health services in a more timely manner which may result in a reduced need for more intensive and costly waiver services. •Implementation can occur once the FACT and CAT teams have the training and/or resources to serve individuals with comorbid mental health and developmental disabilities									

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Option Type	**Redesign Key Components**	**Change to Consider**	**Maximum Service Limits**	**Total Number of Clients**	**Total Clients Affected**	**LBR Issue**	**Cost Shift**		**Federal**	**State**	**Other**
Non-Waiver Change	Next Generation-Questionnaire for Situational Information (NG-QSI)	Eliminate iBudget algorithm and allocation process. Implement the NG-QSI assessment tool capable of determining client needs and funding based on assessment results	N/A	34,500	34,500	$120,000 APD FY 2020-21 LBR Non-Recurring	N/A		Yes	Yes	No
		Implementation Timeline • Waiver amendment: Approximately 6 months • Rule amendment: Approximately 6 months ▪ Amend Florida Statue: FY 2020-21 ▪ Fully implement by FY 2023-24									
	Specialized ICF Rate	Implement an ICF service and rate in the Medicaid program to serve individuals with intensive maladaptive behaviors	$562 per person per day	187	187	$38,363,421 AHCA FY 2020-21 LBR Recurring	Potential		No	Yes	No
		Implementation Timeline FY 2020-21									

APD-AHCA

WAIVER redesign

1. Include the waiver program in the Social Services Estimating Conference which is the group that projects costs for Medicaid.
2. The main change in the approach of the waiver is moving from an algorithm that determines funding to an assessment tool that shows which services each client needs, and funding can be allocated based on need.
3. All Significant Additional Needs requests will be centralized at the APD State Office instead of the regions to ensure continuity.
4. Ramp up training and accountability for WSCs to make sure they are using APD as the true payor of last resort.
5. Work with the few clients who have more than $205,000 in their cost plans to address their needs in a more cost-effective way.
6. Provide Life Skills Development services that will provide essential daily services while reducing duplication of services

1. Help more group homes qualify for the AHCA Medicaid Assistive Care Services funding.
2. Make it so that the funding follows the individual when they turn 21 from AHCA's Medicaid State Plan to APD.
3. Start allowing for and paying ICFs to serve people with intensive maladaptive behaviors who have needs beyond the limits of the waiver program.
4. Increase funding for the Department of Children and Families Florida Assertive Community Treatment and Community Action Team (or FACT and CAT) programs to help better serve people who have both mental health and developmental disabilities.
5. Increase overall funding so that our agencies can give Florida's most vulnerable population the medically necessary services in the best setting for them.