I. EXECUTIVE SUMMARY

The Agency for Persons with Disabilities (APD) serves nearly 35,000 Floridians with developmental disabilities through the Home and Community-Based Services iBudget Florida Medicaid waiver. The waiver appropriation for Fiscal Year (FY) 2018-19 is $1.1 billion. Due to the changing service needs of waiver clients, APD projects waiver expenditures to be $1.2 billion for the fiscal year. In addition, the waiver expenditures for the previous fiscal year exceeded appropriations by $54 million. The shortfall was paid from FY 2018-19 appropriations. These figures are consistent with APD's projections performed in Fall 2017 which were used to develop the APD's legislative budget request and the Governor's Recommended Budget for FY 2018-19 iBudget waiver funding. The request was not included in the 2018 General Appropriations Act (GAA).

Section 393.0661, F.S., and proviso language in the 2019 GAA require APD to work with the Agency for Health Care Administration (AHCA) to develop a plan to redesign the waiver program and submit that plan to the President of the Senate and the Speaker of the House of Representatives by September 30, 2019.

The submittal of this plan constitutes APD's waiver redesign and cost containment initiatives, as required by the FY 2019-20 GAA. This plan has been developed to result in sufficient fiscal and operational controls to allow budget predictability. The plan shall include specific steps to monitor and control spending; identify core services that are essential to provide for client health and safety and recommend elimination of coverage for other services that are not affordable based on available resources; be responsive to individual needs and to the extent possible encourage client control over allocated resources for their needs; and modify the manner of providing support coordination services to improve management of service utilization and increase accountability and responsiveness to agency priorities.

This plan also contains options to bring spending in line with appropriations, including advantages and disadvantages for each approach. Each of these options may associate impact to certain areas such as legal implications, fairness and equity for both clients and providers, and quality-of-life issues that all must be thoroughly and properly evaluated.

The following are four types of options to bring spending in line with appropriations:

1. Legislatively mandated cost-containment initiatives
2. Near-term initiatives, which may be implemented this fiscal year and for which savings may also be primarily realized this fiscal year if approved
3. Initiatives requiring law changes and/or federal approval, which will impact next fiscal year spending if approved
4. Strategic initiatives, which take more time for the agency to implement but which will ensure the agency will operate within legislative appropriations in the following

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fiscal year (Some of these initiatives require further study and development before implementation)

Ultimately, the future of services to individuals with developmental disabilities is at stake. The Legislature authorized iBudget Florida as a key element of that future — a system that is simpler, prioritizes individual choice, and seeks greater equity while living within its means. However, iBudget Florida alone has been insufficient to address the projected deficit. Therefore, the agency is proposing other initiatives that will create efficiencies and evaluate the costs of individual services.

We look forward to working together to help serve one of Florida's most vulnerable populations.

II. BACKGROUND

A. Evolution of the iBudget Waiver

The Florida waiver was established in 1982 allowing up to 2,631 individuals to receive home and community-based services. Waiver services help individuals with developmental disabilities live everyday lives in the community rather than in institutions. Most individuals live with their families or in their own homes; many others live in community homes licensed by the agency.

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, to provide full funding for medically necessary services requested and due process rights for individuals.

During the 2000s, the waiver underwent several changes. The Consumer-Directed Care program was implemented. A standard rate structure was implemented, and thousands of individuals were enrolled onto the waiver. The waiver began running a deficit and service rates were reduced, services were eliminated or reduced, and the tier waiver system was implemented as a cost containment measure.

During the 2010s, funds were provided to address past deficits and the iBudget waiver system was implemented as a cost containment measure. The 2013 Moreland ruling required the cost allocations of 6,000 individuals be restored to pre-iBudget levels. The 2013 Wheaton settlement 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.

Over a five-year period beginning in Fiscal Year 2013-14, $140 million was appropriated to offer waiver enrollment to over 6,500 waiting list individuals. Statutory changes were made to automatically enroll individuals diagnosed with Phelan-McDermid syndrome,

individuals entering extended foster care and dependents of military individuals transferring from another state where they were receiving waiver services.

B. Evolution of the Current Waiver and Rule Authority

Effective in 2010, 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).

Home and community-based services (HCBS) waivers are authorized under section 1915(c) of the Social Security Act and governed by Title 42, Code of Federal Regulations (CFR), Parts 440 and 441.

Section 409.906, Florida Statutes (F.S.), and Rule 59G-13.070, Florida Administrative Code (F.A.C.), authorize the application for the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver. The iBudget Waiver is referenced in Chapter 393, F.S., and the Agency for Person's with Disabilities' Rule 65G-4.0210, F.A.C.

C. Roles and Responsibilities

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D. Explanation of Algorithm Process

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APD has operated the iBudget according to the requirements of section 393.0662, F.S. All individuals were transitioned to the iBudget waiver by July 1, 2013, with an algorithm and methodology that determined their final iBudget amount.

APD contracted with a statistician to update the algorithm in 2015. To run the algorithm, APD determined a set -aside amount for Significant Additional Needs (SANs) based upon an actuarial study, then used the algorithm to allocate the remainder of the waiver funds to each enrollee.

As the new algorithm is applied to individuals on the waiver, those whose current iBudget amount is more than the new algorithm amount may elect to submit a SANs request if they have a continued need for services that exceeds the new algorithm amount.

In developing each client's iBudget amount, APD uses the allocation methodology as defined in s. 393.063(4). The allocation methodology includes the following steps to determine the amount of funds allocated to a client's iBudget:

1. Certified and trained APD staff assess the individual using the Questionnaire for Situational Information (QSI), if assessment has not previously been conducted or is not current (less than 3 years old)
2. APD calculates the individuals Allocation Algorithm Amount using the mathematical formula based upon statistically validated relationships between individual characteristics (variables) and the individual's level of need for services provided through the Waiver which has been apportioned according to available funding. The allocation algorithm is set forth in Rule 65G-4.0214, F.A.C., and as provided in Section 393.0662(1)(a), F.S.
3. Waiver Support Coordinator (WSC) conducts the Amount Implementation Meeting (AIM) with the individual, their representative and, if applicable, the client advocate, in order to determine if the individual has any Significant Additional Needs (SAN) and documents the needs using the AIM Worksheet and provides supplemental documentation as needed to demonstrate medical necessity.
4. If the individual requests services that exceed the algorithm amount due to significant additional needs, the WSC submits the AIM Worksheet and documentation to APD on the iBudget SAN system.
5. If the individual does not request services that exceed the algorithm amount, the WSC submits the AIM Worksheet to APD.
6. APD conducts an Individual Review to determine whether services requested meet health and safety needs and waiver coverage and limitations.
7. APD issues a decision of the iBudget Amount within 30 days of receipt of the AIM Worksheet form. The individual or their representative will be advised of APD's decision for the amount of the individual's final iBudget Amount within 30 days.
8. If additional documentation is requested, the deadline for APD's response is extended to 60 days following the receipt of the original request.

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9. APD must approve an increase to the iBudget Amount if additional funding is required to meet the Significant Additional Needs subject to the provisions of the iBudget rules.
10. APD, upon completion of the review, notifies in writing the individual, the WSC and the client advocate, if any, of the decision.
11. The WSC reviews the notice with the individual and individual representative.
12. APD updates the budget in the iBudget system.

Typically, the algorithm is not rerun every year for individuals because doing so would require reevaluation of each individual's services that were previously determined to be medically necessary. Revising the set aside amount and recalculating an algorithm amount every year when there are increased service needs is not feasible and extremely disruptive to the individuals we serve and their families. In addition, the added workload is beyond the current capacity of APD.

APD re-runs the algorithm under one or more of the following circumstances:

- Age change that impacts the algorithm
- Living setting change that impacts the algorithm
- QSI changes that impact the algorithm

E. Explanation of Significant Additional Needs (SAN) Process

Significant Additional Needs (SAN) is defined as the need for additional funding that if not provided would place the health and safety of the individual, the individual's caregiver, or public in serious jeopardy which are authorized under Section 393.0662(1)(b), F.S., and categorized as extraordinary need, significant need for one time or temporary support or services, or significant increase in the need for services after the beginning of the service plan year. In addition, the term includes a significant need for transportation services as provided in paragraph 65G-4.2018(1)(d), F.A.C. Examples of SANs that may require long-term support include, but are not limited to, any of the following:

- A documented history of significant, potentially life-threatening behaviors, such as recent attempts at suicide, arson, nonconsensual sexual behavior, or self-injurious behavior requiring medical attention
- A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a non-licensed person
- A chronic comorbid condition. As used in this subparagraph, the term "comorbid condition" means a diagnosed medical or mental health condition existing simultaneously but independently with another medical or mental health condition in a patient
- A need for total physical assistance with activities of daily living such as eating, bathing, toileting, grooming, dressing, personal hygiene, lifting, transferring or ambulation

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- Permanent or long-term loss or incapacity of a caregiver
- Loss of services authorized under the state Medicaid plan or through the school system due to a change in age
- Significant change in medical, behavioral or functional status
- Lack of a meaningful day activity needed to foster mental health, prevent regression or engage in meaningful community life and activities
- One or more of the situations described in Rule 65G-1.047, F.A.C., Crisis Status Criteria
- Risk of abuse, neglect, exploitation or abandonment

In order for an individual to receive iBudget Waiver services in an amount greater than their algorithm amount, the individual must meet SAN Criteria.

The agency receives SAN requests under the following circumstances when a client's total cost for services will exceed the algorithm amount:

- Upon implementation of the algorithm for the first time
- If the individual experiences a change that impacts their health and safety and requires waiver services to address the need
- If the client has a change in their age, living setting, or needs assessment that requires the algorithm to be recalculated

SAN requests include a prior authorization review to ensure that services are medically necessary and authorized in accordance with waiver coverage and limitations.

Considerations for all SAN requests include the following:

- Can the need be met by moving funds from unused services?
- Can the need be met by using unallocated funds from the budget?
- Does the request meet criteria for SAN funding as identified in Rule 65G-4.0218, FAC?
- Are services medically necessary in accordance with Rule 59G?
- Are services requested within handbook coverage and limitations in accordance with Rule 59G-13.070?
- Can the need be met by other funding sources, natural supports, or community supports?

F. Litigation Background

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.

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Garrido v. Dudek, (US 11th Circuit 9/20/2013), 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.

Federal case law, such as Alvarez v. Betlach, WL10861543 (US District Court, D. Arizona 5/21/2012), ruled that 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. Additionally, Moore ex rel. Moore v. Reese 637 F.3d 1220, 1259 (11th Cir.2011) 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.

G. Comparison to other States

Seventy-two percent of all individuals enrolled in the iBudget waiver live with their families or in their own homes; and 28 percent live in group homes within communities licensed by the agency.

The average cost of an individual being served on the waiver is approximately $33,600 per year, as compared to approximately $120,000 in an institutional setting.

According to 2017 State of the States in Intellectual and Developmental Disabilities report, Florida ranks in the bottom two in the nation in Total Fiscal Effort, spending less than $2.00 per $1,000 of statewide personal income for Intellectual/Developmental Disability (IDD) services.

III. APPLICABLE STATE LAWS

Section 393.0661(8), Florida Statutes, grants the Agency for Health Care Administration (AHCA), in consultation with APD, the authority to: adjust fees, reimbursement rates, lengths of stay, number of visits, and number of services; limit enrollment; and make any other adjustment necessary to comply with the availability of funds and any limitations or directions provided for in the General Appropriations Act.

Further, subsection (9) states that, if at any time an analysis by the agency, in consultation with AHCA, indicates that the cost of waiver services is expected to exceed the amount appropriated, the agency shall submit a plan to the Executive Office of the Governor, the chair of the Senate Ways and Means Committee or its successor, and the chair of the House Fiscal Council or its successor for remaining within the amount appropriated. APD is directed to work with AHCA to implement a plan to track actual expenditures and project future spending to remain within the legislative appropriation for waiver services. APD submitted an initial plan under sections 393.0661(8) and (9), F.S., on February 27, 2019.

In addition to this statutory authority, proviso language in the Fiscal Year 2019-20 GAA requires APD to work with AHCA to develop a plan to redesign the waiver program by September 30, 2019. This plan has been developed to provide options to consider, which, depending upon the option(s) selected for implementation, would result in sufficient fiscal and operational controls to allow APD to manage Medicaid waiver spending within the legislative appropriation.

In accordance with Rule 59G-1.010, F.A.C., “Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

“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.”

IV. BUDGET PREDICTABILITY

A. Overview of Budget

APD HCBS Waiver History			
Fiscal Year	Appropriations ALL FUNDS	Expenditures ALL FUNDS	Surplus-Deficit ALL FUNDS
FY 2013-14	$ 917,331,689	$ 858,259,944	$ 59,071,745
FY 2014-15	$ 941,032,259	$ 916,701,686	$ 24,330,573
FY 2015-16	$ 1,004,356,204	$ 986,597,092	$ 17,759,112
FY 2016-17	$ 1,097,206,747	$ 1,097,462,366	$ (255,619)
FY 2017-18	$ 1,111,283,220	$ 1,168,178,357	$ (56,895,137)
FY 2018-19	$ 1,181,467,119	$ 1,283,301,700	$ (101,834,581)

FY 2015-16 and FY 2016-17 expenditures were realigned to reflect expenditures during the respective fiscal year incurred and not the year of payment.

B. Comparison of Current Budget vs. Actual Spend

FY 2018-19 - Projected deficit based on actual expenditures through March 2019 using AHCA projection model. Appropriations amount reflects the inclusion of $56,895,137 (All Funds) supplemental appropriations from Section 30, Conference Report on SB 2500 and $7,881,106 (General Revenue) from Section 32, Conference Report on SB 2500 for use in FY 2018-19.

C. Overview of Highest Cost Drivers Based on Data Analysis

1. AHCA analysis of iBudget services from State Fiscal Year 2015-16 through 2017-18
   - The population served by the iBudget waiver appears to be aging and the average cost per individual increases with age
   - When reviewing the change in age bands across the years, the number of recipients in the younger age bands is decreasing, while the number of recipients in the older age bands is increasing. Additionally, the average cost per recipient in each age band generally increased each year.
   - For example, between SFY 2016-17 and SFY 2017-18, there was a decrease of 390 recipients in the 21-24 age band and an increase of 475 in the 25-29 age band. This shift in age bands also increases costs, as the average annual cost per recipient increased from $30,041 for 21-24 to $38,358 for the 25-29 age band.
   - It appears that this shift in age bands is primarily due to a stable population that is aging, rather than new entrants into the program.

- For each of the three years examined, Residential Habilitation, Personal Supports, and Life Skills Development accounted for approximately 72% of the total cost.
  - From SFY 2015-16 to 2017-18, the average cost per recipient increased for all three of these services
    - Residential Habilitation (5.9%)
    - Personal Supports (14.8%)
    - Life Skills Development (14.9%)
- When examining drivers of the cost increases, all three services experienced an increase in the number of members receiving each of these services. Additionally, for Personal Supports and Life Skills Development, there was an increase in the number of units per person from 2015-16 to 2017-18. The number of units per recipient for Residential Habilitation remained stable
- Living Setting also affects the average cost per recipient
  - The two settings with the largest number of recipients were Family Home and Licensed Facility. The average cost per recipient in Family Home was $21,923 while it was $61,480 for a Licensed Facility.
    - Licensed Home accounted for 47% of 2017-18 total dollars and 26% of recipients
    - Family Home accounted for 36% of total dollars and 55% of recipients
-

2. APD analysis of the top 100 individuals with highest expenditures in FY2017-18:
- 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
  - 37% live in a group home
- By Disability
  - 68% have Intellectual Disabilities

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  - 28% have Cerebral Palsy
- 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 $12,016,785
  - Residential Nursing – LPN $ 5,327,040
  - Private Duty Nursing – RN $ 898,818
  - Personal Supports $ 658,574
  - Enhanced Intensive Behavioral Residential Habilitation – Medical $450,552
  - Personal Care Items $ 424,980
- 60 consumers with 24/7 of Nursing Services (Private Duty and Residential)
- 8 consumers have 24/7 or more of Nursing Services (Private Duty and Residential) and Personal Supports combined
- 8 were previous residents at Carlton Palms

3. APD Analysis of SAN Increases
   - By Reason – top 5 reasons for SAN requests
     - Behaviors 27%
     - Multifactor 22%
     - Other WSC 21%
     - Loss of Caregiver Support 10%
     - Total Physical Assistance 9%
   - By Service - 5 costliest services
     - Residential Habilitation $97,119,158
     - Personal Supports $85,716,364
     - Life Skills Dev 1 – Companion $20,299,464
     - Life Skills Dev 3 – ADT $20,246,910
     - Private Duty Nursing–LPN $16,003,490

D. Options to Control Cost in Current Design Including:

1. Institute Individual Cost Limit
2. Enforce iBudget Algorithm

V. SERVICES

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A. Overview of Covered Services

The iBudget Waiver enhances each recipient's opportunity for participant direction by providing greater choice among services within the limits of an individual budget.

APD offers a wide range of social, medical, residential, and behavioral services. Services provided are based on need and coverage criteria, so not all individuals receive all services. Services offered include:

- Behavior Analysis Services
- Behavior Assistant Services
- Consumable Medical Supplies
- Dental Services
- Dietitian Services
- Durable Medical Equipment and Supplies
- Environmental Accessibility Adaptations
- Life Skills Development Level 1 – Companion
- Life Skills Development Level 2 – Supported Employment
- Life Skills Development Level 3 – Adult Day Training
- Occupational Therapy
- Personal Emergency Response Systems
- Personal Supports
- Physical Therapy
- Private Duty Nursing
- Residential Habilitation
- Residential Nursing Services
- Respiratory Therapy
- Respite Care
- Skilled Nursing
- Special Medical Home Care
- Specialized Mental Health Counseling
- Speech Therapy
- Supported Coordination
- Supported Living Coaching
- Transportation Services

B. Overview of Highest Service and Service Setting Cost Drivers Based on Data Analysis

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C. Options for Elimination of Coverage for Services that are not Affordable Based on Available Resources in Current Design

Table : Near-Term Cost-Containment Initiatives

Type	Initiative	Estimated Annual Savings	Status
Rate adjustment	Residential Habilitation levels for individuals with high levels of Nursing	To Be Determined	Under consideration, needs further study
Rate adjustment	Pay behavior analysts with higher qualifications at the same rate	To Be Determined	Under consideration, needs further study

Service limit reductions	Reductions in service limits	To Be Determined	Under consideration, needs further study
Utilization management	Voluntary reductions by individuals and families	To Be Determined	
Utilization management	Comprehensive utilization reviews	To Be Determined	

Table : Cost-Containment Initiatives Requiring State and Federal Approval

Type	Initiative	Estimated Annual Savings	Status
Service eliminations	Limiting the waiver to core services to ensure health and safety	To Be Determined	Under consideration, needs further study
Service eliminations	Transfer Specialized Mental Health Counseling and Assessment from the waiver to the Medicaid State Plan	To Be Determined	Under consideration, needs further study
Service eliminations	Transfer Skilled Nursing from the waiver to the Medicaid State Plan	To Be Determined	Under consideration, needs further study
Service eliminations	Transfer Dietician services from the waiver to the Medicaid State Plan	To Be Determined	Under consideration, needs further study
Service eliminations	Transfer Respiratory Supplies from the waiver to the Medicaid State Plan	To Be Determined	Under consideration, needs further study
Cap individual cost plans	Limit individual cost plans to a maximum of $150,000 with no exceptions	To Be Determined	Under consideration, needs further study

VI. APPROACH

There are four types of options to bring spending in line with appropriations:

1. Legislatively mandated cost-containment initiatives
2. Near-term initiatives, which may be implemented this fiscal year and for which savings may also be primarily realized this fiscal year if approved
3. Initiatives requiring law changes and/or federal approval, which will impact next fiscal year spending if approved
4. Strategic initiatives, which take more time for the agency to implement but which will ensure the agency will operate within legislative appropriations in the following fiscal year (Some of these initiatives require further study and development before implementation)

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APD has implemented legislatively mandated cost-containment initiatives in the past, such as provider rate reductions and individual cost plan freezes, as required by law. In addition, the agency has pursued other types of options to reduce waiver costs because the waiver system is very complex. The agency must use a multifaceted approach to reduce expenditures. Experience shows that cost-containment efforts focused on only one factor do not realize sufficient savings.

There are five different approaches to cost-containment. Each has general advantages and disadvantages. For example, some approaches have nearly immediate savings, while others take more time. Some affect all of a given group of people in the state, such as all individuals using a particular service or providers offering a given service, while other approaches are more targeted. Some will take significant agency resources to implement, while others require fewer agency resources.

The options in this plan also vary in regard to APD's ability to implement them without meeting additional requirements or gaining additional approvals. As described above, under s. 393.0661(8), F.S., APD and AHCA have wide authority under state law to put cost-containment initiatives in place without delay; for example, changes which would otherwise require formal rulemaking may be made without it. Once the final set of initiatives is chosen, APD and AHCA intend to use that authority to begin implementing those initiatives immediately. APD and AHCA would then pursue rulemaking. However, APD could not immediately put in place initiatives requiring federal approval. AHCA would still need to obtain federal approval first.

The five approaches are:

1. **Rate adjustments:** This affects all providers of the services for which rates are adjusted. While this is one of the easier options for the agency to implement and one that does not reduce the quantity of services authorized for individuals, it affects all providers.
2. **Service eliminations or service limitations:** This involves the agency ceasing to offer a specific level of waiver service to individuals, the elimination of a specific service under the waiver, or lowering the maximum amount of a specific service that individuals may receive. It reduces or ends some of the services that individuals receive; it also affects the providers offering it. Additionally, individuals will have hearing rights. The elimination of services requires federal approval through an amendment to the Home and Community Based Services waiver.
3. **Utilization management:** This features routine specific review and agency approval of an individual's use of services based on expected results from the delivery of specific services. It considers an individual's unique circumstances and requires more significant agency resources as well as time to implement, due to the thorough nature of the reviews conducted.

4. **Service restructuring:** This requires a review and update of the description, requirements, ratios, limitations, and rates for a service to find ways to meet individuals' needs at lower costs. This takes agency and provider time and resources to implement but is intended to lead to longer-term efficiencies with less impact on individuals.
5. **Capping an individual's cost plan and/or expenditures:** This involves the agency limiting or capping the total amount an individual can spend on a per-person basis. An example is limiting each individual's expenditures to no more than 1.5 times the average cost of institutional care. This option requires federal approval through an amendment to the Home and Community-Based Services waiver, as the current limit is based upon the aggregate cost of all individuals.

VII. PRESENTATION OF OPTIONS

A. Legislatively Mandated Cost-Containment Initiatives

B. Near-Term Cost Containment Initiatives

1. Initiative: Rate Adjustments

Advantages: This would reduce costs while not reducing services to individuals.

Disadvantages: Some individuals may have difficulty securing providers at the lower rates.

a) Residential Habilitation levels for individuals with high levels of Nursing
b) Behavior Analysis – Match Medicaid State Plan rate and eliminate stepped rates (1, 2, and 3) to use a singular rate regardless of education/years of experience level

2. Initiative: Limitation of Services (to be considered)

Advantages: This would reduce costs while ensuring services are appropriate for an individual's level of need.

Disadvantages: By law, APD must give an individual a chance to request a hearing if services are reduced. In these cases, services continue at current levels until the hearing is resolved.

a) Personal Supports with high levels of Nursing – cannot exceed 24/7 for combination of services
b) Life Skills Development 1, 2, and 3 – combination cannot exceed 1440 H/5760 QH (20 days per month) annually

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c) Supported Living Coaching – limit service to 15 H per month/180 H annually
d) Respite –
   i. Ages 3-14 limit service to 30 days/720 H/2880 QH annually
   ii. Ages 15-20 limit service to???
e) Behavior Services
   i. Behavior Assistant not allowable in a Behavior Focus Group Home
   ii.
f) Therapies (OT, PT, ST) – limit weekly service hours if Nursing or other therapies are being delivered

C. Initiatives Requiring Federal Approval

1. Initiative: Elimination of Services (to be considered)

Advantages*:* It would be administratively easier for the agency to implement than some other options. It would redirect individuals to services which are available from other sources.

Disadvantages: This would have a major impact on both individuals who had used the eliminated services and the providers who had offered them. This would require a waiver amendment and thus federal approval; the process of submitting and receiving approval for a waiver amendment can be lengthy, which would delay the agency's realizing savings from this option. Individuals would have the opportunity to file for administrative hearings, but given that the services are no longer available, they do not have to be continued at agency cost and the hearings can be processed quickly. Some consumers may have difficulty replacing eliminated services due to lack of availability in their community from other sources.

a) Skilled Nursing – available through Medicaid State Plan
b) Specialized Mental Health Counseling – available through community resources, Medicare, and Medicaid
c) Dietician Services – available through community resources, Medicare, and Medicaid
d) Respiratory Supplies – available through Medicaid State Plan
e) Residential Habilitation Live In – convert to a lower monthly Residential Habilitation service
f) Shift of all medical services to Medicaid State Plan Managed Care
g) Overall Capped waiver amount limited to x% of ICF rate

Service Name	Estimated Annual Savings
Skilled Nursing	$662,751
Specialized Mental Health Counseling	$877,981
Specialized Mental Health Counseling - Assessment	$10,004

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Dietician Services	$109,430
Residential Habilitation Live In	

2. Initiative: Service Restructuring
   a) CDC+ - all cost plan rates must be reduced to the solo rate
   b) Increased rates for ICF/DD behavioral clients

VIII. FLEXIBILITY

The iBudget waiver uses an individual budgeting approach to enhance opportunities for self-determination. To promote independence, the waiver offers an array of services and providers that are chosen by the client. The iBudget waiver enhances each client's opportunity for participant direction by providing choice among services within the limits of an individual budget. Per 65G-4.015 F.A.C., after the individual's cost plan and budget are approved, they may change the services in their approved cost plan provided that such change does not jeopardize the health and safety of the individual and meets medical necessity criteria. When changing the services within the cost plan, the individual and their WSC shall ensure that sufficient funding remains allocated for unpaid services that were authorized and rendered prior to the effective date of the change.

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

- Life Skills Development 1
- Life Skills Development 2
- Life Skills Development 3, within the approved ratio
- Durable Medical Equipment
- Adult Dental
- Personal Emergency Response Systems
- Environmental accessibility adaptations
- Consumable Medical Supplies
- Transportation
- Personal Supports up to $16,000
- Respite up to $10,000

IX. SUPPORT COORDINATION SERVICES

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Options for changes to Waiver Support Coordination (WSC) services to improve management of service utilization and increase accountability and responsiveness to agency priorities:

- Eliminate WSC service by Solo Providers
- Contract with a singlular WSC Agency Provider (or one in each region) to manage all WSC providers
- Make all WSCs contract employees of APD
- Make all WSCs employees of APD as FTEs

X. REDESIGN OPTIONS WITH RECOMMENDATION AND IMPLEMENTATION PLAN

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