Tab 1	**SB 1116** by **Joyner (CO-INTRODUCERS) Grimsley**; (Identical to H 0947) Long-acting Reversible Contraception Pilot Program					
611498	A	S	RCS	AHS, Abruzzo	Delete L.91 - 98:	02/15 12:21 PM

Tab 2	**CS/SB 1170** by **BI, Detert**; (Compare to CS/H 0951) Health Plan Regulatory Administration					
180490	A	S	RCS	AHS, Richter	Delete L.275 - 779:	02/15 03:01 PM

Tab 3	**SB 1144** by **Gaetz**; Certificates of Need for Health Care-related Projects					
223842	D	S		AHS, Richter	Delete everything after	02/10 11:05 AM
492782	AA	S		AHS, Richter	Delete L.15 - 16:	02/10 05:58 PM

Tab 4	**CS/SB 212** by **HP, Gaetz**; (Compare to H 0085) Ambulatory Surgical Centers

Tab 5	**CS/SB 818** by **HP, Latvala (CO-INTRODUCERS) Sobel, Abruzzo, Soto**; (Compare to H 0469) Instruction on Human Trafficking

Tab 6	**SB 1336** by **Latvala**; (Compare to CS/H 0979) Behavioral Health Care Services

Tab 7	**CS/SB 998** by **HP, Ring**; Adolescent and Child Treatment Programs

Tab 8	**CS/SB 204** by **HP, Clemens**; (Identical to CS/H 0571) Music Therapists

Tab 9	**CS/SB 1686** by **HP, Bean, Joyner**; (Similar to H 1353) Telehealth

Tab 10	**SB 7054** by **CF**; (Similar to CS/H 1083) Agency for Persons with Disabilities					
220012	D	S	RCS	AHS, Sobel	Delete everything after	02/15 03:01 PM

Tab 11	**SB 7056** by **HP**; (Similar to CS/H 1335) Long-term Care Managed Care Prioritization					
395530	A	S	RCS	AHS, Bean	Delete L.106 - 175:	02/15 03:01 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

Senator Garcia, Chair
Senator Smith, Vice Chair

MEETING DATE: Thursday, February 11, 2016
TIME: 10:00 a.m.—12:00 noon
PLACE: *James E. "Jim" King, Jr. Committee Room,* 401 Senate Office Building

MEMBERS: Senator Garcia, Chair; Senator Smith, Vice Chair; Senators Abruzzo, Bean, Benacquisto, Grimsley, Richter, and Sobel

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 1116** Joyner (Identical H 947)	Long-acting Reversible Contraception Pilot Program; Requiring the Department of Health to establish a long-acting reversible contraception (LARC) pilot program in Hillsborough, Palm Beach, and Pinellas Counties; requiring the department to contract with family planning providers to implement the pilot program; requiring the department to apply for grants for additional funding; providing an appropriation subject to certain requirements, etc. HP 01/26/2016 Favorable AHS 02/11/2016 Fav/CS FP	Fav/CS Yeas 8 Nays 0
2	**CS/SB 1170** Banking and Insurance / Detert (Compare CS/H 951)	Health Plan Regulatory Administration; Deleting a provision authorizing group insurance plans to impose a certain preexisting condition exclusion; revising a provision specifying that certain sections of the Florida Insurance Code do not apply to a group health insurance policy as that policy relates to specified benefits, under certain circumstances; redefining the term “creditable coverage”, etc. BI 01/26/2016 Fav/CS AHS 02/11/2016 Fav/CS AP	Fav/CS Yeas 8 Nays 0
3	**SB 1144** Gaetz	Certificates of Need for Health Care-related Projects; Providing an exemption from certificate of need review for certain health care-related projects; specifying conditions and requirements for the exemption; requiring a certain agreement between the project applicant and the Agency for Health Care Administration; providing penalties for failure to comply with certain requirements for an exemption to a certificate of need review, etc. HP 02/01/2016 Favorable AHS 02/11/2016 Temporarily Postponed AP	Temporarily Postponed

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**CS/SB 212** Health Policy / Gaetz (Compare H 85)	Ambulatory Surgical Centers; Revising the definition of the term “ambulatory surgical center” or “mobile surgical facility”; requiring, as a condition of licensure and license renewal, that ambulatory surgical centers provide services to specified patients, etc. HP 01/19/2016 Fav/CS AHS 02/11/2016 Favorable AP	Favorable Yeas 7 Nays 1
5	**CS/SB 818** Health Policy / Latvala (Compare H 469)	Instruction on Human Trafficking; Providing that certain licensing boards must require specified licensees to complete a specified continuing education course that includes a section on human trafficking as a condition of relicensure or recertification, etc. HP 01/26/2016 Fav/CS AHS 02/11/2016 Favorable FP	Favorable Yeas 8 Nays 0
6	**SB 1336** Latvala (Compare CS/H 979, CS/H 7097, S 12)	Behavioral Health Care Services; Authorizing the Department of Children and Families to monitor and enforce compliance with ch. 394, F.S., relating to mental health; creating the "Jennifer Act"; requiring service providers to give patients information relating to mental health or substance abuse treatment advance directives; requiring the Department of Children and Families to provide information and forms on its website relating to mental health or substance abuse treatment advance directives, etc. CF 01/27/2016 Favorable AHS 02/11/2016 Favorable AP	Favorable Yeas 8 Nays 0
7	**CS/SB 998** Health Policy / Ring	Adolescent and Child Treatment Programs; Providing purpose of adolescent and child residential treatment programs; requiring the Department of Children and Families to adopt rules for the licensure, administration, and operation of programs and program facilities; providing purpose of adolescent and child outdoor programs, etc. HP 01/19/2016 Fav/CS AHS 02/11/2016 Favorable AP	Favorable Yeas 8 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
8	**CS/SB 204** Health Policy / Clemens (Identical CS/H 571)	Music Therapists; Establishing requirements for registration as a music therapist; prohibiting the practice of music therapy unless the therapist is registered; authorizing the Department of Health to adopt rules and take disciplinary action against an applicant or registrant who violates the act, etc. HP 01/19/2016 Fav/CS AHS 02/11/2016 Favorable FP	Favorable Yeas 8 Nays 0
9	**CS/SB 1686** Health Policy / Bean / Joyner (Similar H 1353, Compare CS/H 7087)	Telehealth; Creating the Telehealth Task Force within the Agency for Health Care Administration; requiring the agency to use existing and available resources to administer and support the task force; excluding telehealth products from the definition of “discount medical plan”, etc. HP 01/26/2016 Fav/CS AHS 02/11/2016 Favorable AP	Favorable Yeas 8 Nays 0
10	**SB 7054** Children, Families, and Elder Affairs (Compare CS/CS/CS/H 919, H 1083, H 4037, CS/H 7003, CS/S 7010)	Agency for Persons with Disabilities; Repealing provisions relating to a program for the prevention and treatment of severe self-injurious behavior; adding client needs that qualify as extraordinary needs, which may result in the approval of an increase in a client’s allocated funds; requiring the Agency for Persons with Disabilities to conduct a certain utilization review; providing for annual reviews for persons involuntarily committed to residential services, etc. AHS 02/11/2016 Fav/CS AP	Fav/CS Yeas 8 Nays 0
11	**SB 7056** Health Policy (Compare H 1335)	Long-term Care Managed Care Prioritization; Requiring the Department of Elderly Affairs to maintain a statewide wait list for enrollment for home and community-based services through the Medicaid long-term care managed care program; requiring the department to prioritize individuals for potential enrollment using a frailty-based screening tool that provides a priority score; providing for determinations regarding offers of enrollment, etc. AHS 02/11/2016 Fav/CS AP	Fav/CS Yeas 8 Nays 0

Other Related Meeting Documents

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR ARTHENIA L. JOYNER
Democratic Leader
19th District

COMMITTEES:
Appropriations Subcommittee on Criminal and Civil Justice, *Vice Chair*
Appropriations
Health Policy
Higher Education
Judiciary
Rules

JOINT COMMITTEE:
Joint Legislative Budget Commission

January 26, 2016

Senator Rene Garcia, Chair
Senate Appropriations Subcommittee on
Health and Human Services
201 The Capitol
404 S. Monroe Street
Tallahassee, FL 32399-1100

Dear Chairman Garcia:

This is to request that Senate Bill 1116, Long-acting Reversible Contraception Pilot Program, be placed on the agenda for the Appropriations Subcommittee on Health and Human Services. Your consideration of this request is greatly appreciated.

Sincerely,

Arthenia L. Joyner
State Senator, District 19

REPLY TO:
❐ 508 W. Dr. Martin Luther King, Jr. Blvd., Suite C, Tampa, Florida 33603-3415 (813) 233-4277
❐ 200 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5019 FAX: (813) 233-4280

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: PCS/SB 1116 (684148)

INTRODUCER: Appropriations Subcommittee on Health and Human Services; Senators Joyner and Grimsley

SUBJECT: Long-acting Reversible Contraception Pilot Program

DATE: February 15, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Favorable**
2.	Brown	Pigott	AHS	**Recommend: Fav/CS**
3.			FP	

I. Summary:

PCS/SB 1116 directs the Department of Health (DOH) to establish a long-acting reversible contraception (LARC) pilot program in Hillsborough, Palm Beach, and Pinellas counties. The DOH must contract with eligible family planning providers to deliver the services. A report on the effectiveness of the pilot program is due to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2018.

The bill directs the DOH to implement a LARC pilot program under the bill if specific funding is provided in the General Appropriations Act. The DOH estimates that implementing the bill would require one full-time-equivalent position and an appropriation of $207,897 general revenue, $4,146 of which would be nonrecurring, in the 2016-2017 fiscal year.

The bill has an effective date of July 1, 2016.

II. Present Situation:

The LARC methods are the most effective forms of reversible birth control available, with fewer than 1 in 100 women using a LARC method becoming pregnant, the same range as for sterilization.[1] LARC methods include an intrauterine device (IUD) and a birth control implant. Both methods last for several years, are reversible, and can be removed at any time.

[1] American College of Obstetricians and Gynecologists, *Frequently Asked Questions - Contraception (LARC)*, http://www.acog.org/Patients/FAQs/Long-Acting-Reversible-Contraception-LARC-IUD-and-Implant (last visited: Jan. 12, 2016).

An IUD is a small, T-shaped, plastic device that is inserted and left inside the uterus. There are two types of IUDs. The hormonal IUD releases progestin and is approved for up to five years. The copper IUD does not contain hormones and is approved for up to 10 years.[2]

The birth control implant is a single flexible rod about the size of a matchstick that is inserted in the upper arm under the skin and releases progestin. The implant lasts for three years.

Both the IUD and the implant may be placed or removed by a health care provider. There are few side effects to either method, and almost all women are eligible for an IUD or implant.[3]

In the United States, approximately 3 million pregnancies per year, or 50 percent of all pregnancies, are unintended.[4] Of those unintended pregnancies, half are from contraceptive failure and the other half are due to non-use of contraception.[5] Adolescents especially use contraceptive methods with relatively higher failure rates, such as condoms, withdrawal, or oral contraceptive pills.[6]

In Florida, the unintended pregnancy rate was 58 per 1,000 women in 2010 for females aged 15-44, and the teen pregnancy rate was 50 per 1,000 women.[7] The federal and state governments spent $1.3 billion on unintended pregnancies in 2010, of which $892.8 million (57%) was paid by the federal government and $427.1 million was paid by the state.[8]

While being cost-effective over the long-term, the high up-front costs of the LARC methods may be a barrier to widespread use, as the wholesale cost of an IUD or implant can be as high as $850, plus the cost of insertion.[9] In February 2015, the federal Food and Drug Administration approved a new IUD, Liletta, which was developed by a non-profit organization and is made available by that organization to public clinics for just $50.[10]

While most insurance plans under the Affordable Care Act and Medicaid cover contraception and the associated services with no out-of-pocket costs, those without insurance coverage may face a financial hurdle. The American College of Obstetricians and Gynecologists also recognized the high cost as a barrier to wide use of LARCs by adolescents in its *Committee on*

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[2] *Id.*

[3] Brooke Winner, et al., *Effectiveness of Long-Acting Reversible Contraception,* N ENGL J MED 366; 21, nejm.org, May 24, 2012.

[4] *Id.*

[5] *Id.*

[6] American College of Obstetricians and Gynecologists, *Committee Opinion: Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices*, (October 2012), http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Adolescents-and-Long-Acting-Reversible-Contraception, (last visited: Jan. 12, 2016).

[7] Guttmacher Institute, *State Facts About Unintended Pregnancy: Florida (2014)*, http://www.guttmacher.org/statecenter/unintended-pregnancy/pdf/FL.pdf (last visited: Jan. 12, 2016.)

[8] *Id.*

[9] Heather D. Boonstra, *Leveling the Playing Field: The Promise of Long-Acting Reversible Contraceptives for Adolescents*, Guttmacher Policy Review, Vol. 16, p. 16, https://www.guttmacher.org/pubs/gpr/16/4/gpr160413.html (last visited: Jan. 12, 2016).

[10] Karen Weise, *Warren Buffet's Family Secretly Funded a Birth Control Revolution,* Bloomberg Business (July 30, 2015), http://www.bloomberg.com/news/articles/2015-07-30/warren-buffett-s-family-secretly-funded-a-birth-control-revolution (last visited: Jan. 12, 2016).

Adolescent Health Care Long-Acting Reversible Contraception Working Group Committee Opinion document in 2014, along with lack of familiarity with or misconceptions about the methods, the lack of access, and health care providers' concerns about the safety of LARC use in adolescents (ages 9-11).[11]

Overall, the Committee found LARC methods to be "top-tier contraceptives based on effectiveness, with pregnancy rates of less than 1 percent per year for perfect use and typical use. Adolescents are at high risk of unintended pregnancy and may benefit from increased access to LARC methods."[12]

Current Family Planning Services

County Health Departments

The DOH currently provides comprehensive family planning services, including LARC services, in all 67 Florida counties. Funding for these services is provided through a Title X federal grant, part of a Title V federal grant, and state general revenue. Funds are distributed to each county health department (CHD) by the DOH.

According to the DOH, more than 152,000 individuals received family planning services in 2014 with 71.3 percent of the clients having incomes at or below 150 percent of the federal poverty level.[13] For a family of two, 150 percent of the federal poverty level is $23,895.[14] Of those served by the DOH for family planning services, 44.1 percent were covered by public insurance and 27.4 percent were uninsured.

Men and women served under this program have access to FDA-approved birth control methods and supplies, abstinence counseling, pregnancy testing, physical examinations, screenings, and HIV counseling and testing.[15] Services are provided on a sliding scale, based on family size and income, resulting in persons under 100 percent of the federal poverty level paying no fees.

The majority of family planning services are delivered at CHD clinic sites. A small number of CHDs contract with outside providers for family planning services, including the three below.[16]

	Numbers of Clinic Sites, including Contracted Sites
Hillsborough CHD	11
Palm Beach CHD	10
Pinellas CHD	5

[11] *Supra,* Note 6 at 2.
[12] *Supra,* Note 6 at 1.
[13] Florida Department of Health, *Family Planning Fact Sheet,* *http://www.floridahealth.gov/programs-and-services/womens-health/family-planning/fp-facts.html* (last visited: Jan. 12, 2016).
[14] 2015 Federal Poverty Guidelines, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf (last visited: Jan. 12, 2016).
[15] Florida Department of Health, *Family Planning,* *http://www.floridahealth.gov/programs-and-services/womens-health/family-planning/index.html* (last visited: Jan. 12, 2016).
[16] Florida Department of Health, *2016 Agency Bill Analysis - SB 1116*, Dec. 16, 2015. (on file with Senate Health Policy Committee).

In State Fiscal Year 2014-15, the CHDs provided services to 10,806 clients who were using a LARC method.[17] Of those 10,806 clients seen by the CHDs, 5,451 of these clients were new users and received the LARC during the 2014-15 fiscal year.[18] The table below illustrates the total number of services in the proposed pilot counties and statewide.

Long Acting Reversible Contraceptives (LARCs) Use by County, Florida Fiscal Year 2014-2015[19]

	Age <15-19			Age 20-45+			Total		
County	# of Clients with LARCs	# of Clients	%	# of Clients with LARCs	# of Clients	%	Total # of Clients with LARCs	Total Clients	%
Hillsborough	52	493	10.55%	726	4,748	15.29%	778	5,241	14.84%
Palm Beach	38	1,529	2.49%	842	8,139	10.35%	880	9,668	9.10%
Pinellas	15	1,714	0.88%	242	7,749	3.12%	257	9,463	2.72%
Statewide	963	24,027	4.01%	9,843	118,205	8.33%	10,806	142,232	7.60%

The DOH's Family Planning Program (FPP) has received consistent funding of approximately $4.7 million in general revenue for contraceptives over the last five years.[20] These funds are allocated to the DOH's Bureau of Statewide Pharmacy. Ordering higher-cost contraceptives such as LARCs is done through the FPP and paid for through funds that are separate and distinct from the general revenue funds.

The Legislature designated an appropriation of $300,000 in Fiscal Year 2014-15 for the purchase of LARCs.[21] The DOH reports that this allocation was quickly spent by the 67 CHDs and no appropriation was made in the subsequent fiscal year. The Maternal and Child Health Program at the DOH allocated Title V funds to the CHDs, allowing them to choose from three Title V priorities, one being "well woman," which would allow the CHDs to provide LARCs.[22] The three proposed pilot programs did not request their Title V funding to be used for this purpose.

Florida Medicaid Program

Family planning services are also covered under Medicaid for recipients of child-bearing age and include reimbursement for:

- New and established patient visits;
- Required laboratory tests;
- Selection of contraceptive method, provision of supplies;
- Post examination review;
- Counseling visits;
- Supply visits;

[17] Email from Bryan P. Wendel, Government Analyst II, Department of Health, to Jennifer Lloyd, Senate Health Policy Committee, Jan. 13, 2016, on file with Senate Health Policy Committee.
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] See Specific Appropriation 525 in ch. 2014-51, Laws of Fla. (an appropriation of $300,000 for the purchase of long-acting reversible contraceptives with non-recurring general revenue funds, effective July 1, 2014).
[22] *Supra,* Note 17.

- HIV Counseling;
- Coverage for insertion and removal of IUD;
- Services associated with decision to use long-acting injectable or implantable contraceptives; and
- Pregnancy testing.[23]

Family planning services for Medicaid recipients are funded through Title XIX federal funds and state general revenue.

Family planning services are also provided through a family planning waiver (FPW) for females aged 14 through 55 who lose Medicaid coverage at the end of their 60 days postpartum coverage and who have family income at or below 185 percent of the federal poverty level at the time of their annual redetermination, or for females who have lost their Medicaid coverage. Enrollees must also not be otherwise eligible for Medicaid, Children's Health Insurance Program (CHIP), or other health insurance coverage with family planning services. Eligibility is limited to two years after losing Medicaid coverage and must be re-determined every 12 months.

The FPW was first implemented in 1998 and has been through several extension periods. The state received its most recent extension in December 2014, and was approved through December 31, 2017.[24]

Covered services under the FPW are limited to those services and supplies whose primary purpose is family planning. Those services under the FPW include:
- Approved methods of contraception;
- Sexually transmitted infection (STI) testing;
- Sexually transmitted disease (STD) testing;
- Pap smears and pelvic exams;
- Approved sterilizations;
- Drugs, supplies, or devices related to women's health services; and
- Contraceptive management, patient education, and counseling.[25]

The FPW does not cover emergency room visits, inpatient services, or any other non-family planning related services.

Family planning services and supplies are funded with a 90-percent federal matching rate while costs relating to the processing of claims is matched at 50 percent.[26] In 2010, the total public

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[23] Agency for Health Care Administration, *Practitioner Services Coverage and Limitations Handbook*, pp.51-55, http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Practitioner%20Services%20Handbook_Adoption.pdf (last visited: Jan. 12, 2016).
[24] Letter from Department of Health and Human Services, Center for Medicare and Medicaid Services to Justin Senior from Cindy Mann, http://ahca.myflorida.com/medicaid/Family_Planning/pdf/FL_FPW_Extension_CMS_Approval_Ltr_12-29-14.pdf (Dec, 29, 2014) (last visited: Jan. 12, 2016).
[25] Agency for Health Care Administration, *Extension of the Florida Medicaid Family Planning Waiver*, *(June 27, 2014)* p.23, *http://ahca.myflorida.com/Medicaid/Family_Planning/pdf/FPW_Extension_Request_6-27-14_final.pdf* (last visited: Jan. 12, 2016).
[26] *Id.* at 32.

expenditures for family planning client services was $103.1 million, which included $66 million through Medicaid and $11.5 million through Title X.[27]

III. Effect of Proposed Changes:

The bill creates s. 381.00515, F.S., and the LARC pilot program within the DOH. The pilot program is established in Hillsborough, Palm Beach, and Pinellas counties with the purpose of improving the provision of LARC services in those counties. Under the pilot program, the DOH is directed to contract with eligible family planning providers to implement the program. A contract for LARC services must include:

- Provision of intrauterine devices and implants;
- Training for providers and staff regarding LARC devices, counseling strategies, and the management of side effects;
- Technical assistance regarding issues such as coding, billing, pharmacy rules, and clinic management due to increased use of LARC services;
- General support to expand the capacity of family planning clinics; and
- Other services the DOH considers necessary to ensure the health and safety of LARC participants.

The bill also directs the DOH to seek federal grants and funds from other sources to supplement state funds.

By January 1, 2018, the DOH must submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the effectiveness of the pilot program. The report must also be published on the DOH's website. The report must include:

- An assessment of the pilot program, including any progress made in the reduction of unintended pregnancies and subsequent births, especially among teenagers;
- An assessment on the effectiveness of the pilot program in increasing the availability of LARC services;
- The number and location of family planning providers who participated in the pilot program;
- The number of clients served by family planning providers;
- The number of times LARC services were provided by participating family planning providers;
- The average cost per client served;
- The demographics of clients served;
- The sources and amounts of funding used;
- A description of federal grants the DOH applied for, including the outcomes;
- An analysis of the return on investment for the provision of LARC services, including tax dollars saved on health and social services;
- A description and analysis of marketing and outreach activities conducted to promote the availability of LARC services; and
- Recommendation for improving the pilot program.

[27] *Supra,* Note 7.

The bill directs the DOH to implement the LARC pilot project under the bill if specific funding is provided in the General Appropriations Act.

The bill is effective July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Under PCS/SB 1116, a reduction in unintended pregnancies in the pilot counties may have a fiscal and operational impact on the private sector by reducing costs and business interruptions related to unplanned pregnancies on private employers and taxpayers. The average birth covered by Medicaid cost $14,930 in 2014.[28]

The bill also anticipates marketing and outreach efforts to promote the availability of LARC services, and private business may benefit from funds or other resources spent on such a campaign.

C. Government Sector Impact:

In order to implement the pilot project, the DOH estimates the need for one full-time-equivalent position and $207,897 in general revenue for the 2016-2017 fiscal year, $4,146 of which would be nonrecurring. This estimate includes the cost of a marketing plan and campaign.[29] However, the bill directs the DOH to implement the pilot project if specific funding is provided in the General Appropriations Act. The Senate's General

[28] Agency for Health Care Administration, MED 145 Deliverable 2.3 Interim Report (Family Planning Waiver) (July 29, 2015), p.17, http://ahca.myflorida.com/medicaid/Family_Planning/pdf/Final_Inteim_Report_July_29_2015.pdf (last visited: Jan. 12, 2016).

[29] The Department of Health, *2016 Agency Legislative Bill Analysis, SB 1116,* Dec. 16, 2015, revised Feb. 4, 2016. On file with the Senate Appropriations Subcommittee on Health and Human Services.

Appropriations Bill for Fiscal Year 2016-2017, SB 2500, does not include such an appropriation.

Under the bill, the state could benefit in costs if the pilot program results in fewer unintended pregnancies. Each birth covered by Medicaid costs the state $14,930 while the highest priced LARC may be $800 to $1,000.[30] The extent of this potential effect is indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 381.00515 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

Recommended CS by Appropriations Subcommittee on Health and Human Services on February 11, 2016:
The proposed committee substitute removes from the bill an appropriation of $75,000 of nonrecurring general revenue to the DOH for the purpose of implementing the pilot program. These funds were to be distributed equally among the three counties participating in the pilot. Instead, the proposed CS directs the DOH to implement the pilot program if specific funding is provided in the General Appropriations Act.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

[30] *Supra,* Note 28.

611498

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/15/2016	.	
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	.	

Appropriations Subcommittee on Health and Human Services (Abruzzo) recommended the following:

1 **Senate Amendment (with title amendment)**

2

3 Delete lines 91 - 98

4 and insert:

5 Section 2. The Department of Health shall implement a long-

6 acting reversible contraception (LARC) pilot program pursuant to

7 this act if specific funding is provided in the General

8 Appropriations Act.

9

10 ================= T I T L E A M E N D M E N T ================

611498

11 And the title is amended as follows:
12 Delete lines 16 - 17
13 and insert:
14 such report; directing the department to implement the
15 LARC pilot program if specific funding is provided in
16 the General Appropriations Act; providing legislative
17 findings;

By Senator Joyner

19-00563B-16 20161116__

1
2 A bill to be entitled
3 An act relating to a long-acting reversible
4 contraception pilot program; creating s. 381.00515,
5 F.S.; requiring the Department of Health to establish
6 a long-acting reversible contraception (LARC) pilot
7 program in Hillsborough, Palm Beach, and Pinellas
8 Counties; requiring the department to contract with
9 family planning providers to implement the pilot
10 program; requiring that such contracts include
11 specified provisions; requiring the department to
12 apply for grants for additional funding; requiring the
13 department to submit a report to the Governor and the
14 Legislature; requiring the department to publish the
15 report on its website; specifying requirements for
16 such report; providing an appropriation subject to
17 certain requirements; providing legislative findings;
18 providing an effective date.
19
20 WHEREAS, the Legislature finds that unintended pregnancies,
21 especially among young women, carry health risks for mother and
22 baby, and
23 WHEREAS, the Legislature further finds that programs that
24 provide long-acting reversible contraceptive (LARC) methods,
25 along with other contraceptive methods, contribute to declines
26 in the number of unintended pregnancies and abortions, NOW,
27 THEREFORE,
28
29 Be It Enacted by the Legislature of the State of Florida:
30
31 Section 1. Section 381.00515, Florida Statutes, is created
32 to read:

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

19-00563B-16 20161116__

33 381.00515 Long-acting reversible contraception pilot
34 program.—
35 (1) The Department of Health shall establish a long-acting
36 reversible contraception (LARC) pilot program in Hillsborough,
37 Palm Beach, and Pinellas Counties. The purpose of the pilot
38 program is to improve the provision of LARC services in those
39 counties. The department shall contract with eligible family
40 planning providers to implement the pilot program. A contract to
41 provide LARC services must include all of the following:
42 (a) Provision of intrauterine devices and implants to
43 participants.
44 (b) Training for providers and staff regarding the
45 provision of LARC devices, counseling strategies, and the
46 management of side effects.
47 (c) Technical assistance regarding issues such as coding,
48 billing, pharmacy rules, and clinic management necessitated by
49 the increased use of LARC devices.
50 (d) General support to expand the capacity of family
51 planning clinics.
52 (e) Marketing and outreach regarding the availability of
53 LARC services among other currently available contraceptive
54 services.
55 (f) Other services the department considers necessary to
56 ensure the health and safety of participants who receive LARC
57 devices.
58 (2) The department shall seek grants from federal agencies
59 and other sources to supplement state funds provided for the
60 pilot program.
61 (3) By January 1, 2018, the department shall submit a

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

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62 report to the Governor, the President of the Senate, and the
63 Speaker of the House of Representatives on the effectiveness of
64 the pilot program. The department shall publish the report on
65 its website. The report must include, but is not limited to:
66 (a) An assessment of the operation of the pilot program,
67 including any progress made in reducing the number of unintended
68 pregnancies and subsequent births, especially among teenagers.
69 (b) An assessment of the effectiveness of the pilot program
70 in increasing the availability of LARC services.
71 (c) The number and location of family planning providers
72 that participated in the pilot program.
73 (d) The number of clients served by participating family
74 planning providers.
75 (e) The number of times LARC services were provided by
76 participating family planning providers.
77 (f) The average cost per client served.
78 (g) The demographic characteristics of clients served.
79 (h) The sources and amounts of funding used for the pilot
80 program.
81 (i) A description of federal grants the department applied
82 for in order to provide LARC services, including the outcomes of
83 the grant applications.
84 (j) An analysis of the return on investment for the
85 provision of LARC services with regard to tax dollars saved on
86 health and social services.
87 (k) A description and analysis of marketing and outreach
88 activities conducted to promote the availability of LARC
89 services.
90 (l) Recommendations for improving the pilot program.

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91 Section 2. For the 2016-2017 fiscal year, the sum of
92 $75,000 in nonrecurring funds is appropriated from the General
93 Revenue Fund to the Department of Health for the purpose of
94 implementing this act. The department shall distribute the funds
95 equally among the three counties participating in the pilot
96 program. These funds do not supplant or reduce any other
97 appropriation of state funds to family planning providers or to
98 the department for family planning services.
99 Section 3. The Legislature finds that this act is necessary
100 to protect the public health, safety, and welfare.
101 Section 4. This act shall take effect July 1, 2016.

The Florida Senate

Committee Agenda Request

To: Senator Rene Garcia, Chair
Appropriations Subcommittee on Health and Human Services

Subject: Committee Agenda Request

Date: January 27, 2016

I respectfully request that **Senate Bill #1170**, relating to Health Plan Regulatory Administration, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Nancy C. Detert
Florida Senate, District 28

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: PCS/SB 1170 (899852)

INTRODUCER: Appropriations Subcommittee on Health and Human Services; Banking and Insurance Committee and Senator Detert

SUBJECT: Health Plan Regulatory Administration

DATE: February 15, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Brown	Pigott	AHS	**Recommend: Fav/CS**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/SB 1170 revises provisions in the Insurance Code and other Florida Statutes that conflict with the federal Patient Protection and Affordable Care Act (PPACA) and provides other changes. These changes include:

- Eliminates provisions relating to preexisting condition exclusions since the federal act requires guaranteed issue of coverage and prohibits preexisting condition exclusions;
- Removes the requirement that insurers provide an outline of coverage for individual or family accident and health insurance policies;
- Requires insurers to provide an outline of coverage for a large group policy or policy offering excepted benefits;
- Eliminates provisions relating to medical loss ratios since the federal act prescribes such standards and requires rebates if certain conditions are met;
- Eliminates the requirement for insurers to issue certificates of creditable coverage; and
- Provides technical and conforming changes.

The bill has no fiscal impact.

The effective date of the bill is July 1, 2016.

II. Present Situation:

Federal Patient Protection and Affordable Care Act (PPACA)

The federal Patient Protection and Affordable Care Act was signed into law on March 23, 2010.[1] The federal law made significant changes to the U.S. health care system such as providing requirements for health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. The PPACA imposes many insurance requirements, including required benefits, rating and underwriting standards, required review of rate increases, establishing and reporting of medical loss ratios and payment of rebates, covering adult dependents, internal and external appeals of adverse benefit determinations, and other requirements on individual and group coverage.[2] All health insurance coverage sold in the individual and group market must include the benefits in the essential health benefits benchmark with some exceptions. Excepted benefits are not subject to these requirements.[3]

Generally, health insurance is divided into two types of coverage: major medical coverage and excepted benefits. The PPACA regulates major medical, also known as comprehensive health insurance. Health insurance that provides benefits on a limited or ancillary basis have been referred to as excepted benefits. The Florida Insurance Code delineates the excepted benefits in s. 627.6561(5)(b), F.S. Excepted benefits include coverage such as limited scope dental, hospital indemnity, and specified disease coverage.

Guaranteed Availability and Renewability of Coverage

Individual major medical health maintenance organization (HMO) coverage is guaranteed issue and renewable. That is, the PPACA requires health insurers to accept every individual and every employer that applies for coverage, commonly referred to as offering coverage on a guaranteed-issue basis. The PPACA also requires health insurers to renew or continue in force the coverage with exceptions.[4] In Florida, this requirement is found in s. 627.6425(1), F.S., and applies to coverage defined in s. 627.6561(5)(a)2., F.S., which includes insurer policies and HMO contracts.

Grandfathered Health Plans

The PPACA exempts "grandfathered health plan coverage" from many of its insurance requirements (as specified in the summary of the key insurance provisions, below). For an insured plan, grandfathered health plan coverage is group or individual coverage in which an individual was enrolled on March 23, 2010, subject to conditions for maintaining grandfathered status as specified by law and rule.[5] Grandfathered health plan coverage is tied to the individual

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1 On March 23, 2010, President Obama signed into law Public Law No. 111-148, the Patient Protection and Affordable Care Act (PPACA), and on March 30, 2010, President Obama signed into law Public Law No. 111-152, the Health Care and Education Affordability Reconciliation Act of 2010, amending PPACA.

2 Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act (PHSA), (42 U.S.C. 300gg et seq.).

3 42 U.S.C. s. 300gg-91.

4 45 C.F.R. s. 147.104 and 45 C.F.R. s. 147.106.

5 PPACA s. 1251; 42 U.S.C. s. 18011 and 45 C.F.R. s. 147.140.

or employer who obtained the coverage, not to the policy or contract form itself. An insurer may have both policyholders with grandfathered coverage and policyholders with non-grandfathered coverage insured under the same policy form, depending on whether the coverage was effective before or after March 23, 2010. The conditions for maintaining grandfathered status are specified in the rule.

Medical Loss Ratio and Payment of Rebates

Effective for plan years beginning January 1, 2011, the PPACA requires health insurers to report to the federal Department of Health and Human Services (HHS) information concerning the percent of premium revenue spent on claims for clinical services and activities. This percentage is also known as the medical loss ratio, or MLR. Insurers must provide a rebate to consumers if the MLR is less than 85 percent in the large group market and 80 percent in the small group and individual markets. [6] Grandfathered health plans are not exempt from this requirement. Florida law requires as a condition of prior approval of rates by the Office of Insurance Regulation[7] (OIR) that the projected minimum loss ratio for small group and individual policies is 65 percent,[8] and rebates are not required if the MLR is not met. The calculation of Florida's MLR is not consistent with federal regulations.

Summary of Benefits and Coverage

The PPACA directs the HHS and the U.S. Department of the Treasury to develop standards for insurers and HMOs to use in compiling and providing a summary of benefits and coverage (SBC) that ''accurately describes the benefits and coverage under the applicable plan or coverage." On June 16, 2015, the HHS issued final rules relating to the summary of benefits and coverage disclosures that insurers and HMOs are required to provide for individual and group coverage. Section 627.6482, F.S., requires insurers to provide an outline of coverage for individuals and family accident and health policies.

Preexisting Conditions and Certificates of Coverage

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)[9] was enacted to provide guaranteed availability of coverage for certain employees and individuals, and to increase portability through the limitation of preexisting condition exclusions. Generally, group plans were allowed to impose a preexisting condition exclusion for up to 18 months after the enrollment date. The exclusion period could be reduced by the aggregate periods of creditable coverage applicable to the individual as of the enrollment date. Creditable coverage included group health plan and other specified coverage. Creditable coverage did not include excepted benefits. In 1997,[10] Florida adopted many of the requirements of HIPAA, which, in part, is codified in s. 627.6561, F.S.

Insurers were required to issue certificates of creditable coverage to individuals switching from

[6] 45 C.F.R. part 158.
7 Florida's Office of Insurance Regulation licenses and regulates the activities of insurers, health maintenance organizations, and other risk-bearing entities.
[8] Section 627.411(3)(a), F.S.
[9] Pub.L. 104–191.
[10] Ch. 97-179, Laws of Fla.

one health insurance plan to another that would allow the individual to mitigate or avoid preexisting condition exclusions. Effective December 31, 2014, certificates of creditable coverage are no longer required to be provided. After December 31, 2014, most health insurance plans will no longer contain preexisting condition exclusions because of the PPACA.[11]

Florida Kidcare Program

The Florida Kidcare Program[12] (Kidcare) was created in 1998 by the Florida Legislature in response to the federal enactment of the Children's Health Insurance Program (CHIP) in 1997. The Florida Kidcare program was created to provide a defined set of health benefits to uninsured, low-income children through the establishment of a variety of affordable health benefits coverage options from which families may select coverage and through which families may contribute financially to the health care of their children.[13]

III. Effect of Proposed Changes:

Section 1 amends s. 408.909, F.S., to revise a cross-references to excepted benefits and limited benefits, which are amended in the bill.

Section 2 amends s. 409.817, F.S., relating to Kidcare, to eliminate an exception to the prohibition on preexisting condition exclusions, since PPACA prohibits such exclusions.

Sections 3 and 4 amends ss. 624.123 and 627.402, F.S., to revise cross-references to sections amended by the bill.

Section 5 repeals subsection (3) of s. 627.411, F.S. The bill removes a ground for disapproval of a major medical health insurance policy for failure to meet a 65 percent medical loss ratio and removes the definition of incurred claims. The PPACA requires major medical health insurance to have an 80 percent loss ratio.

Sections 6 and 7 amend ss. 627.6011 and 627.602, F.S. to update cross-references to sections amended by the bill.

Section 8 amends s. 627.642, F.S., to eliminate the requirement that insurers provide an outline of coverage for individual or family accident and health insurance policies. Instead, insurers are required to provide an outline of coverage for a large group policy or policy offering excepted benefits. The PPACA requires a summary of benefits be included in individual and small group major medical policies.

Section 9 amends s. 627.6425, F.S., to remove the guaranteed renewable requirements for individual HMO major medical policies. Currently, s. 627.6425(1), F.S., applies to health insurance coverage as defined in s. 627.6561(5)(a)2., F.S., which includes HMO contracts. Additionally, the only guaranteed renewable statute in the HMO chapter is s. 641.31074, F.S.,

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[11] 45 C.F.R. 148.124.
[12] See http://floridakidcare.org/#eligible (last visited Jan. 23, 2016).
[13] Section 409.812, F.S.

but it only applies to group health insurance. The bill deletes the reference to s. 627.6561(5)(a)2., F.S., and refers to s. 624.603, F.S., which includes the definition of health insurance.

Section 10 amends s. 627.6487, F.S., to update cross-references to sections amended by the bill.

Section 11 repeals s. 627.64871, F.S., which relates to creditable coverage and the issuance of certifications of coverage by insurers, since PPACA prohibits preexisting condition exclusions and such certificates are no longer needed.

Section 12 amends s. 627.6512, F.S., relating to the exemption of certain policies from regulations imposed on health insurance policies, to update cross-references to sections amended by the bill.

Section 13 amends s. 627.6513, F.S., to delineate excepted benefits and provide that excepted benefits do not apply to group policies.

Section 14 amends s. 627.6561, F.S., to delete provisions relating to creditable coverage and to update cross-references to sections amended by the bill.

Section 15 amends s. 627.6562, F.S., relating to dependent coverage, to provide a definition of creditable coverage, which delineates what type of coverage qualifies as "creditable coverage" and what coverage does not qualify as creditable. These provisions are currently delineated in s. 627.6561, F.S., which is being repealed by the bill.

Section 16 amends s. 727.65626, F.S., to update a cross-reference to sections amended by the bill.

Section 17 amends s. 627.6699, F.S., to revise a cross-reference to excepted benefits, which is amended by the bill. The section also provide a definition of "late enrollee" and eliminates provisions relating to creditable coverage.

Section 18 amends s. 627.6741, F.S., to update cross-references to sections amended by the bill.

Section 19 amends s. 641.31, F.S. to delete a provision that exempts individual or large group HMO contracts from any law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments. Federal law establishes deductibles and annual and lifetime limits and provides that copayments are not allowed for certain essential health benefits.

Section 20 amends s. 641.31071, F.S., to delete provisions relating to creditable coverage and to update cross-references to sections amended by the bill.

Section 21 amends s. 641.31074, F.S., to revise provisions relating to the guaranteed renewability of health maintenance organization coverage to conform to changes made under the bill.

Section 22 amends s. 641.312, F.S., to update a cross-reference to a section amended by the bill.

Section 23 provides an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

Section 5 of PCS/SB 1170 deletes s. 627.411(3)(a)-(b), F.S. According to the OIR, only paragraph (3)(a) needs to be deleted. The elimination of paragraph (3)(b) removes the definition of incurred claims, which is needed by OIR to review a company's request for rating action (increase or decrease), and therefore paragraph (3)(b) needs to be retained.[14]

VII. Related Issues:

The effective date of the bill is July 1, 2016. According to the Office of Insurance Regulation, implementing the bill in the middle of a plan year may create policyholder confusion and market disruption. Making these provisions effective at the beginning of the calendar year could avoid these negative outcomes.[15]

[14] Office of Insurance Regulation, 2016 Agency Legislative Bill Analysis, Jan. 13, 2016. (on file with Banking and Insurance Committee).
[15] *Id*.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 408.909, 409.817, 624.123, 627.402, 627.411, 627.6011, 627.602, 627.642, 627.6425, 627.6487, 627.6512, 627.6513, 627.6561, 627.6562, 627.65626, 627.6699, 627.6741, 641.31, 641.31071, 641.31074, and 641.312.

This bill repeals the following section of the Florida Statutes: 627.64871.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

Recommended CS by Appropriations Subcommittee on Health and Human Services on February 11, 2016:
The proposed CS makes numerous technical corrections throughout the bill relating to preexisting conditions and creditable coverage. The PCS also provides for additional conforming changes to s. 641.31074, F.S., relating to the guaranteed renewability of health maintenance organization coverage.

CS by Banking and Insurance on January 26, 2016:
The CS reinstates provisions relating to HMO conversions and provides technical and conforming changes.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/15/2016	.	
	.	
	.	
	.	

Appropriations Subcommittee on Health and Human Services
(Richter) recommended the following:

1 **Senate Amendment (with title amendment)**

2

3 Delete lines 275 - 779

4 and insert:

5 policies.—Sections 627.6561, 627.65615, 627.65625, and 627.6571

6 do not apply to~~:~~

7 ~~(1)~~ any group insurance policy in relation to its provision

8 of ~~excepted~~ benefits described in s. 627.6513(1)-(14)

9 ~~627.6561(5)(b)~~.

10 ~~(2) Any group health insurance policy in relation to its~~

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11 ~~provision of excepted benefits described in s. 627.6561(5)(c),~~
12 ~~if the benefits:~~
13 ~~(a) Are provided under a separate policy, certificate, or~~
14 ~~contract of insurance; or~~
15 ~~(b) Are otherwise not an integral part of the policy.~~
16 ~~(3) Any group health insurance policy in relation to its~~
17 ~~provision of excepted benefits described in s. 627.6561(5)(d),~~
18 ~~if all of the following conditions are met:~~
19 ~~(a) The benefits are provided under a separate policy,~~
20 ~~certificate, or contract of insurance;~~
21 ~~(b) There is no coordination between the provision of such~~
22 ~~benefits and any exclusion of benefits under any group policy~~
23 ~~maintained by the same policyholder; and~~
24 ~~(c) Such benefits are paid with respect to an event without~~
25 ~~regard to whether benefits are provided with respect to such an~~
26 ~~event under any group health policy maintained by the same~~
27 ~~policyholder.~~
28 ~~(4) Any group health policy in relation to its provision of~~
29 ~~excepted benefits described in s. 627.6561(5)(e), if the~~
30 ~~benefits are provided under a separate policy, certificate, or~~
31 ~~contract of insurance.~~
32 Section 13. Section 627.6513, Florida Statutes, is amended
33 to read:
34 627.6513 Scope.—Section 641.312 and the provisions of the
35 Employee Retirement Income Security Act of 1974, as implemented
36 by 29 C.F.R. s. 2560.503-1, relating to internal grievances,
37 apply to all group health insurance policies issued under this
38 part. This section does not apply to a group health insurance
39 policy that is subject to the Subscriber Assistance Program in

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40 s. 408.7056 or to: ~~the types of benefits or coverages provided~~
41 ~~under s. 627.6561(5)(b)-(e) issued in any market.~~
42 (1) Coverage only for accident insurance, or disability
43 income insurance, or any combination thereof.
44 (2) Coverage issued as a supplement to liability insurance.
45 (3) Liability insurance, including general liability
46 insurance and automobile liability insurance.
47 (4) Workers' compensation or similar insurance.
48 (5) Automobile medical payment insurance.
49 (6) Credit-only insurance.
50 (7) Coverage for onsite medical clinics, including prepaid
51 health clinics under part II of chapter 641.
52 (8) Other similar insurance coverage, specified in rules
53 adopted by the commission, under which benefits for medical care
54 are secondary or incidental to other insurance benefits. To the
55 extent possible, such rules must be consistent with regulations
56 adopted by the United States Department of Health and Human
57 Services.
58 (9) Limited scope dental or vision benefits, if offered
59 separately.
60 (10) Benefits for long-term care, nursing home care, home
61 health care, or community-based care, or any combination
62 thereof, if offered separately.
63 (11) Other similar, limited benefits, if offered
64 separately, as specified in rules adopted by the commission.
65 (12) Coverage only for a specified disease or illness, if
66 offered as independent, noncoordinated benefits.
67 (13) Hospital indemnity or other fixed indemnity insurance,
68 if offered as independent, noncoordinated benefits.

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69 (14) Benefits provided through a Medicare supplemental
70 health insurance policy, as defined under s. 1882(g)(1) of the
71 Social Security Act, coverage supplemental to the coverage
72 provided under 10 U.S.C. chapter 55, and similar supplemental
73 coverage provided to coverage under a group health plan, which
74 are offered as a separate insurance policy and as independent,
75 noncoordinated benefits.
76 Section 14. Section 627.6561, Florida Statutes, is amended
77 to read:
78 627.6561 Preexisting conditions.—
79 (1) As used in this section, the term:
80 (a) “Enrollment date” means, with respect to an individual
81 covered under a group health policy, the date of enrollment of
82 the individual in the plan or coverage or, if earlier, the first
83 day of the waiting period of such enrollment.
84 (b) “Late enrollee” means, with respect to coverage under a
85 group health policy, a participant or beneficiary who enrolls
86 under the policy other than during:
87 1. The first period in which the individual is eligible to
88 enroll under the policy.
89 2. A special enrollment period, as provided under s.
90 627.65615.
91 (c) “Waiting period” means, with respect to a group health
92 policy and an individual who is a potential participant or
93 beneficiary of the policy, the period that must pass with
94 respect to the individual before the individual is eligible to
95 be covered for benefits under the terms of the policy.
96 (2) Subject to the exceptions specified in subsection (4),
97 an insurer that offers group health insurance coverage may, with

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98 respect to a participant or beneficiary, impose a preexisting
99 condition exclusion only if:
100 (a) Such exclusion relates to a physical or mental
101 condition, regardless of the cause of the condition, for which
102 medical advice, diagnosis, care, or treatment was recommended or
103 received within the 6-month period ending on the enrollment
104 date;
105 (b) Such exclusion extends for a period of not more than 12
106 months, or 18 months in the case of a late enrollee, after the
107 enrollment date; and
108 (c) The period of any such preexisting condition exclusion
109 is reduced by the aggregate of the periods of creditable
110 coverage, as defined in s. 627.6562(3) ~~subsection (5)~~,
111 applicable to the participant or beneficiary as of the
112 enrollment date.
113 (3) Genetic information may not be treated as a condition
114 described in paragraph (2)(a) in the absence of a diagnosis of
115 the condition related to such information.
116 (4)(a) Subject to paragraph (b), an insurer that offers
117 group health insurance coverage may not impose any preexisting
118 condition exclusion in the case of:
119 1. An individual who, as of the last day of the 30-day
120 period beginning with the date of birth, is covered under
121 creditable coverage.
122 2. A child who is adopted or placed for adoption before
123 attaining 18 years of age and who, as of the last day of the 30-
124 day period beginning on the date of the adoption or placement
125 for adoption, is covered under creditable coverage. This
126 provision does not apply to coverage before the date of such

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127 adoption or placement for adoption.
128 3. Pregnancy.
129 (b) Subparagraphs 1. and 2. do not apply to an individual
130 after the end of the first 63-day period during all of which the
131 individual was not covered under any creditable coverage.
132 ~~(5)(a) The term, "creditable coverage," means, with respect~~
133 ~~to an individual, coverage of the individual under any of the~~
134 ~~following:~~
135 ~~1. A group health plan, as defined in s. 2791 of the Public~~
136 ~~Health Service Act.~~
137 ~~2. Health insurance coverage consisting of medical care,~~
138 ~~provided directly, through insurance or reimbursement, or~~
139 ~~otherwise and including terms and services paid for as medical~~
140 ~~care, under any hospital or medical service policy or~~
141 ~~certificate, hospital or medical service plan contract, or~~
142 ~~health maintenance contract offered by a health insurance~~
143 ~~issuer.~~
144 ~~3. Part A or part B of Title XVIII of the Social Security~~
145 ~~Act.~~
146 ~~4. Title XIX of the Social Security Act, other than~~
147 ~~coverage consisting solely of benefits under s. 1928.~~
148 ~~5. Chapter 55 of Title 10, United States Code.~~
149 ~~6. A medical care program of the Indian Health Service or~~
150 ~~of a tribal organization.~~
151 ~~7. The Florida Comprehensive Health Association or another~~
152 ~~state health benefit risk pool.~~
153 ~~8. A health plan offered under chapter 89 of Title 5,~~
154 ~~United States Code.~~
155 ~~9. A public health plan as defined by rules adopted by the~~

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156 ~~commission. To the greatest extent possible, such rules must be~~
157 ~~consistent with regulations adopted by the United States~~
158 ~~Department of Health and Human Services.~~
159 ~~10. A health benefit plan under s. 5(e) of the Peace Corps~~
160 ~~Act (22 U.S.C. s. 2504(e)).~~
161 ~~(b) Creditable coverage does not include coverage that~~
162 ~~consists solely of one or more or any combination thereof of the~~
163 ~~following excepted benefits:~~
164 ~~1. Coverage only for accident, or disability income~~
165 ~~insurance, or any combination thereof.~~
166 ~~2. Coverage issued as a supplement to liability insurance.~~
167 ~~3. Liability insurance, including general liability~~
168 ~~insurance and automobile liability insurance.~~
169 ~~4. Workers’ compensation or similar insurance.~~
170 ~~5. Automobile medical payment insurance.~~
171 ~~6. Credit-only insurance.~~
172 ~~7. Coverage for onsite medical clinics, including prepaid~~
173 ~~health clinics under part II of chapter 641.~~
174 ~~8. Other similar insurance coverage, specified in rules~~
175 ~~adopted by the commission, under which benefits for medical care~~
176 ~~are secondary or incidental to other insurance benefits. To the~~
177 ~~extent possible, such rules must be consistent with regulations~~
178 ~~adopted by the United States Department of Health and Human~~
179 ~~Services.~~
180 ~~(c) The following benefits are not subject to the~~
181 ~~creditable coverage requirements, if offered separately:~~
182 ~~1. Limited scope dental or vision benefits.~~
183 ~~2. Benefits for long-term care, nursing home care, home~~
184 ~~health care, community-based care, or any combination thereof.~~

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185 ~~3. Such other similar, limited benefits as are specified in~~
186 ~~rules adopted by the commission.~~
187 ~~(d) The following benefits are not subject to creditable~~
188 ~~coverage requirements if offered as independent, noncoordinated~~
189 ~~benefits:~~
190 ~~1. Coverage only for a specified disease or illness.~~
191 ~~2. Hospital indemnity or other fixed indemnity insurance.~~
192 ~~(e) Benefits provided through a Medicare supplemental~~
193 ~~health insurance, as defined under s. 1882(g)(1) of the Social~~
194 ~~Security Act, coverage supplemental to the coverage provided~~
195 ~~under chapter 55 of Title 10, United States Code, and similar~~
196 ~~supplemental coverage provided to coverage under a group health~~
197 ~~plan are not considered creditable coverage if offered as a~~
198 ~~separate insurance policy.~~
199 ~~(6)(a) A period of creditable coverage may not be counted,~~
200 ~~with respect to enrollment of an individual under a group health~~
201 ~~plan, if, after such period and before the enrollment date,~~
202 ~~there was a 63-day period during all of which the individual was~~
203 ~~not covered under any creditable coverage.~~
204 ~~(b) Any period during which an individual is in a waiting~~
205 ~~period for any coverage under a group health plan or for group~~
206 ~~health insurance coverage may not be taken into account in~~
207 ~~determining the 63-day period under paragraph (a) or paragraph~~
208 ~~(4)(b).~~
209 ~~(7)(a) Except as otherwise provided under paragraph (b), an~~
210 ~~insurer shall count a period of creditable coverage without~~
211 ~~regard to the specific benefits covered under the period.~~
212 ~~(b) An insurer may elect to count, as creditable coverage,~~
213 ~~coverage of benefits within each of several classes or~~

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214 ~~categories of benefits specified in rules adopted by the~~
215 ~~commission rather than as provided under paragraph (a). To the~~
216 ~~extent possible, such rules must be consistent with regulations~~
217 ~~adopted by the United States Department of Health and Human~~
218 ~~Services. Such election shall be made on a uniform basis for all~~
219 ~~participants and beneficiaries. Under such election, an insurer~~
220 ~~shall count a period of creditable coverage with respect to any~~
221 ~~class or category of benefits if any level of benefits is~~
222 ~~covered within such class or category.~~
223 ~~(c) In the case of an election with respect to an insurer~~
224 ~~under paragraph (b), the insurer shall:~~
225 ~~1. Prominently state in 10-point type or larger in any~~
226 ~~disclosure statements concerning the policy, and state to each~~
227 ~~certificateholder at the time of enrollment under the policy,~~
228 ~~that the insurer has made such election; and~~
229 ~~2. Include in such statements a description of the effect~~
230 ~~of this election.~~
231 ~~(8)(a) Periods of creditable coverage with respect to an~~
232 ~~individual shall be established through presentation of~~
233 ~~certifications described in this subsection or in such other~~
234 ~~manner as is specified in rules adopted by the commission. To~~
235 ~~the extent possible, such rules must be consistent with~~
236 ~~regulations adopted by the United States Department of Health~~
237 ~~and Human Services.~~
238 ~~(b) An insurer that offers group health insurance coverage~~
239 ~~shall provide the certification described in paragraph (a):~~
240 ~~1. At the time an individual ceases to be covered under the~~
241 ~~plan or otherwise becomes covered under a COBRA continuation~~
242 ~~provision or continuation pursuant to s. 627.6692.~~

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243 ~~2. In the case of an individual becoming covered under a~~
244 ~~COBRA continuation provision or pursuant to s. 627.6692, at the~~
245 ~~time the individual ceases to be covered under such a provision.~~
246 ~~3. Upon the request on behalf of an individual made not~~
247 ~~later than 24 months after the date of cessation of the coverage~~
248 ~~described in this paragraph.~~
249
250 ~~The certification under subparagraph 1. may be provided, to the~~
251 ~~extent practicable, at a time consistent with notices required~~
252 ~~under any applicable COBRA continuation provision or~~
253 ~~continuation pursuant to s. 627.6692.~~
254 ~~(c) The certification described in this section is a~~
255 ~~written certification that must include:~~
256 ~~1. The period of creditable coverage of the individual~~
257 ~~under the policy and the coverage, if any, under such COBRA~~
258 ~~continuation provision or continuation pursuant to s. 627.6692;~~
259 ~~and~~
260 ~~2. The waiting period, if any, imposed with respect to the~~
261 ~~individual for any coverage under such policy.~~
262 ~~(d) In the case of an election described in subsection (7)~~
263 ~~by an insurer, if the insurer enrolls an individual for coverage~~
264 ~~under the plan and the individual provides a certification of~~
265 ~~coverage of the individual, as provided in this subsection:~~
266 ~~1. Upon request of such insurer, the insurer that issued~~
267 ~~the certification provided by the individual shall promptly~~
268 ~~disclose to such requesting plan or insurer information on~~
269 ~~coverage of classes and categories of health benefits available~~
270 ~~under such insurer's plan or coverage.~~
271 ~~2. Such insurer may charge the requesting insurer for the~~

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272 ~~reasonable cost of disclosing such information.~~
273 ~~(c) The commission shall adopt rules to prevent an~~
274 ~~insurer's failure to provide information under this subsection~~
275 ~~with respect to previous coverage of an individual from~~
276 ~~adversely affecting any subsequent coverage of the individual~~
277 ~~under another group health plan or health insurance coverage. To~~
278 ~~the greatest extent possible, such rules must be consistent with~~
279 ~~regulations adopted by the United States Department of Health~~
280 ~~and Human Services.~~
281 ~~(9)(a) Except as provided in paragraph (b), no period~~
282 ~~before July 1, 1996, shall be taken into account in determining~~
283 ~~creditable coverage.~~
284 ~~(b) The commission shall adopt rules that provide a process~~
285 ~~whereby individuals who need to establish creditable coverage~~
286 ~~for periods before July 1, 1996, and who would have such~~
287 ~~coverage credited but for paragraph (a), may be given credit for~~
288 ~~creditable coverage for such periods through the presentation of~~
289 ~~documents or other means. To the greatest extent possible, such~~
290 ~~rules must be consistent with regulations adopted by the United~~
291 ~~States Department of Health and Human Services.~~
292 ~~(10) Except as otherwise provided in this subsection,~~
293 ~~paragraph (8)(b) applies to events that occur on or after July~~
294 ~~1, 1996.~~
295 ~~(a) In no case is a certification required to be provided~~
296 ~~under paragraph (8)(b) prior to June 1, 1997.~~
297 ~~(b) In the case of an event that occurred on or after July~~
298 ~~1, 1996, and before October 1, 1996, a certification is not~~
299 ~~required to be provided under paragraph (8)(b), unless an~~
300 ~~individual, with respect to whom the certification is required~~

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301 ~~to be made, requests such certification in writing.~~
302 ~~(11) In the case of an individual who seeks to establish~~
303 ~~creditable coverage for any period for which certification is~~
304 ~~not required because it relates to an event that occurred before~~
305 ~~July 1, 1996:~~
306 ~~(a) The individual may present other creditable coverage in~~
307 ~~order to establish the period of creditable coverage.~~
308 ~~(b) An insurer is not subject to any penalty or enforcement~~
309 ~~action with respect to the insurer's crediting, or not~~
310 ~~crediting, such coverage if the insurer has sought to comply in~~
311 ~~good faith with applicable provisions of this section.~~
312 ~~(12) For purposes of subsection (9), any plan amendment~~
313 ~~made pursuant to a collective bargaining agreement relating to~~
314 ~~the plan which amends the plan solely to conform to any~~
315 ~~requirement of this section may not be treated as a termination~~
316 ~~of such collective bargaining agreement.~~
317 ~~(13) This section does not apply to any health insurance~~
318 ~~coverage in relation to its provision of excepted benefits~~
319 ~~described in paragraph (5)(b).~~
320 ~~(14) This section does not apply to any health insurance~~
321 ~~coverage in relation to its provision of excepted benefits~~
322 ~~described in paragraphs (5)(c), (d), or (e), if the benefits are~~
323 ~~provided under a separate policy, certificate, or contract of~~
324 ~~insurance.~~
325 ~~(15) This section applies to health insurance coverage~~
326 ~~offered, sold, issued, renewed, or in effect on or after July 1,~~
327 ~~1997.~~
328 Section 15. Subsection (3) of section 627.6562, Florida
329 Statutes, is amended to read:

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330 627.6562 Dependent coverage.—
331 (3) If, pursuant to subsection (2), a child is provided
332 coverage under the parent's policy after the end of the calendar
333 year in which the child reaches age 25 and coverage for the
334 child is subsequently terminated, the child is not eligible to
335 be covered under the parent's policy unless the child was
336 continuously covered by other creditable coverage without a gap
337 in coverage of more than 63 days.
338 (a) For the purposes of this subsection, the term
339 "creditable coverage" means, with respect to an individual,
340 coverage of the individual under any of the following: ~~has the~~
341 ~~same meaning as provided in s. 627.6561(5).~~
342 1. A group health plan, as defined in s. 2791 of the Public
343 Health Service Act.
344 2. Health insurance coverage consisting of medical care
345 provided directly through insurance or reimbursement or
346 otherwise, and including terms and services paid for as medical
347 care, under any hospital or medical service policy or
348 certificate, hospital or medical service plan contract, or
349 health maintenance contract offered by a health insurance
350 issuer.
351 3. Part A or part B of Title XVIII of the Social Security
352 Act.
353 4. Title XIX of the Social Security Act, other than
354 coverage consisting solely of benefits under s. 1928.
355 5. Title 10 U.S.C. chapter 55.
356 6. A medical care program of the Indian Health Service or
357 of a tribal organization.
358 7. The Florida Comprehensive Health Association or another

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359 state health benefit risk pool.
360 8. A health plan offered under 5 U.S.C. chapter 89.
361 9. A public health plan as defined by rules adopted by the
362 commission. To the greatest extent possible, such rules must be
363 consistent with regulations adopted by the United States
364 Department of Health and Human Services.
365 10. A health benefit plan under s. 5(e) of the Peace Corps
366 Act, 22 U.S.C. s. 2504(e).
367 (b) Creditable coverage does not include coverage that
368 consists of one or more, or any combination thereof, of the
369 following excepted benefits:
370 1. Coverage only for accident insurance, or disability
371 income insurance, or any combination thereof.
372 2. Coverage issued as a supplement to liability insurance.
373 3. Liability insurance, including general liability
374 insurance and automobile liability insurance.
375 4. Workers' compensation or similar insurance.
376 5. Automobile medical payment insurance.
377 6. Credit-only insurance.
378 7. Coverage for onsite medical clinics, including prepaid
379 health clinics under part II of chapter 641.
380 8. Other similar insurance coverage specified in rules
381 adopted by the commission under which benefits for medical care
382 are secondary or incidental to other insurance benefits. To the
383 extent possible, such rules must be consistent with regulations
384 adopted by the United States Department of Health and Human
385 Services.
386 (c) The following benefits are not subject to the
387 creditable coverage requirements, if offered separately:

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388 1. Limited scope dental or vision benefits.
389 2. Benefits for long-term care, nursing home care, home
390 health care, community-based care, or any combination thereof.
391 3. Other similar, limited benefits specified in rules
392 adopted by the commission.
393 (d) The following benefits are not subject to creditable
394 coverage requirements if offered as independent, noncoordinated
395 benefits:
396 1. Coverage only for a specified disease or illness.
397 2. Hospital indemnity or other fixed indemnity insurance.
398 (e) Benefits provided through a Medicare supplemental
399 health insurance policy, as defined under s. 1882(g)(1) of the
400 Social Security Act, coverage supplemental to the coverage
401 provided under 10 U.S.C. chapter 55, and similar supplemental
402 coverage provided to coverage under a group health plan are not
403 considered creditable coverage if offered as a separate
404 insurance policy.
405 Section 16. Subsection (1) of section 627.65626, Florida
406 Statutes, is amended to read:
407 627.65626 Insurance rebates for healthy lifestyles.—
408 (1) Any rate, rating schedule, or rating manual for a
409 health insurance policy that provides creditable coverage as
410 defined in s. 627.6562(3) ~~627.6561(5)~~ filed with the office
411 shall provide for an appropriate rebate of premiums paid in the
412 last policy year, contract year, or calendar year when the
413 majority of members of a health plan have enrolled and
414 maintained participation in any health wellness, maintenance, or
415 improvement program offered by the group policyholder and health
416 plan. The rebate may be based upon premiums paid in the last

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417 calendar year or policy year. The group must provide evidence of
418 demonstrative maintenance or improvement of the enrollees’
419 health status as determined by assessments of agreed-upon health
420 status indicators between the policyholder and the health
421 insurer, including, but not limited to, reduction in weight,
422 body mass index, and smoking cessation. The group or health
423 insurer may contract with a third-party administrator to
424 assemble and report the health status required in this
425 subsection between the policyholder and the health insurer. Any
426 rebate provided by the health insurer is presumed to be
427 appropriate unless credible data demonstrates otherwise, or
428 unless the rebate program requires the insured to incur costs to
429 qualify for the rebate which equal or exceed the value of the
430 rebate, but the rebate may not exceed 10 percent of paid
431 premiums.
432 Section 17. Paragraphs (e) and (l) of subsection (3) and
433 paragraph (d) of subsection (5) of section 627.6699, Florida
434 Statutes, are amended to read:
435 627.6699 Employee Health Care Access Act.—
436 (3) DEFINITIONS.—As used in this section, the term:
437 (e) “Creditable coverage” has the same meaning as provided
438 ~~ascribed~~ in s. 627.6562(3) ~~627.6561~~.
439 (l) “Late enrollee” means an eligible employee or dependent
440 who, with respect to coverage under a group health policy, is a
441 participant or beneficiary who enrolls under the policy other
442 than during:
443 1. The first period in which the individual is eligible to
444 enroll under the policy.
445 2. A special enrollment period, as provided under s.

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446 627.65615 ~~as defined under s. 627.6561(1)(b)~~.
447 (5) AVAILABILITY OF COVERAGE.—
448 (d) A health benefit plan covering small employers, issued
449 or renewed on or after January 1, 1994, must comply with the
450 following conditions:
451 1. All health benefit plans must be offered and issued on a
452 guaranteed-issue basis. Additional or increased benefits may
453 only be offered by riders.
454 ~~2. Paragraph (c) applies to health benefit plans issued to~~
455 ~~a small employer who has two or more eligible employees and to~~
456 ~~health benefit plans that are issued to a small employer who has~~
457 ~~fewer than two eligible employees and that cover an employee who~~
458 ~~has had creditable coverage continually to a date not more than~~
459 ~~63 days before the effective date of the new coverage.~~
460 2.~~3.~~ For health benefit plans that are issued to a small
461 employer who has fewer than two employees and that cover an
462 employee who has not been continually covered by creditable
463 coverage within 63 days before the effective date of the new
464 coverage, preexisting condition provisions must not exclude
465 coverage for a period beyond 24 months following the employee’s
466 effective date of coverage and may relate only to:
467 a. Conditions that, during the 24-month period immediately
468 preceding the effective date of coverage, had manifested
469 themselves in such a manner as would cause an ordinarily prudent
470 person to seek medical advice, diagnosis, care, or treatment or
471 for which medical advice, diagnosis, care, or treatment was
472 recommended or received; or
473 b. A pregnancy existing on the effective date of coverage.
474 Section 18. Subsection (1) and paragraph (c) of subsection

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475 (2) of section 627.6741, Florida Statutes, are amended to read:
476 627.6741 Issuance, cancellation, nonrenewal, and
477 replacement.—
478 (1)(a) An insurer issuing Medicare supplement policies in
479 this state shall offer the opportunity of enrolling in a
480 Medicare supplement policy, without conditioning the issuance or
481 effectiveness of the policy on, and without discriminating in
482 the price of the policy based on, the medical or health status
483 or receipt of health care by the individual:
484 1. To any individual who is 65 years of age or older, or
485 under 65 years of age and eligible for Medicare by reason of
486 disability or end-stage renal disease, and who resides in this
487 state, upon the request of the individual during the 6-month
488 period beginning with the first month in which the individual
489 has attained 65 years of age and is enrolled in Medicare Part B,
490 or is eligible for Medicare by reason of a disability or end-
491 stage renal disease, and is enrolled in Medicare Part B; or
492 2. To any individual who is 65 years of age or older, or
493 under 65 years of age and eligible for Medicare by reason of a
494 disability or end-stage renal disease, who is enrolled in
495 Medicare Part B, and who resides in this state, upon the request
496 of the individual during the 2-month period following
497 termination of coverage under a group health insurance policy.
498 (b) The 6-month period to enroll in a Medicare supplement
499 policy for an individual who is under 65 years of age and is
500 eligible for Medicare by reason of disability or end-stage renal
501 disease and otherwise eligible under subparagraph (a)1. or
502 subparagraph (a)2. and first enrolled in Medicare Part B before
503 October 1, 2009, begins on October 1, 2009.

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504 (c) A company that has offered Medicare supplement policies
505 to individuals under 65 years of age who are eligible for
506 Medicare by reason of disability or end-stage renal disease
507 before October 1, 2009, may, for one time only, effect a rate
508 schedule change that redefines the age bands of the premium
509 classes without activating the period of discontinuance required
510 by s. 627.410(6)(e)2.
511 (d) As a part of an insurer's rate filings, before and
512 including the insurer's first rate filing for a block of policy
513 forms in 2015, notwithstanding the provisions of s.
514 627.410(6)(e)3., an insurer shall consider the experience of the
515 policies or certificates for the premium classes including
516 individuals under 65 years of age and eligible for Medicare by
517 reason of disability or end-stage renal disease separately from
518 the balance of the block so as not to affect the other premium
519 classes. For filings in such time period only, credibility of
520 that experience shall be as follows: if a block of policy forms
521 has 1,250 or more policies or certificates in force in the age
522 band including ages under 65 years of age, full or 100-percent
523 credibility shall be given to the experience; and if fewer than
524 250 policies or certificates are in force, no or zero-percent
525 credibility shall be given. Linear interpolation shall be used
526 for in-force amounts between the low and high values. Florida-
527 only experience shall be used if it is 100-percent credible. If
528 Florida-only experience is not 100-percent credible, a
529 combination of Florida-only and nationwide experience shall be
530 used. If Florida-only experience is zero-percent credible,
531 nationwide experience shall be used. The insurer may file its
532 initial rates and any rate adjustment based upon the experience

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533 of these policies or certificates or based upon expected claim
534 experience using experience data of the same company, other
535 companies in the same or other states, or using data publicly
536 available from the Centers for Medicaid and Medicare Services if
537 the insurer’s combined Florida and nationwide experience is not
538 100-percent credible, separate from the balance of all other
539 Medicare supplement policies.
540
541 A Medicare supplement policy issued to an individual under
542 subparagraph (a)1. or subparagraph (a)2. may not exclude
543 benefits based on a preexisting condition if the individual has
544 a continuous period of creditable coverage, as defined in s.
545 627.6562(3) ~~627.6561(5)~~, of at least 6 months as of the date of
546 application for coverage.
547 (2) For both individual and group Medicare supplement
548 policies:
549 (c) If a Medicare supplement policy or certificate replaces
550 another Medicare supplement policy or certificate or creditable
551 coverage as defined in s. 627.6562(3) ~~627.6561(5)~~, the replacing
552 insurer shall waive any time periods applicable to preexisting
553 conditions, waiting periods, elimination periods, and
554 probationary periods in the new Medicare supplement policy for
555 similar benefits to the extent such time was spent under the
556 original policy~~, subject to the requirements of s. 627.6561(6)-~~
557 ~~(11)~~.
558 Section 19. Subsection (2) and paragraph (a) of subsection
559 (40) of section 641.31, Florida Statutes, are amended to read:
560 641.31 Health maintenance contracts.—
561 (2) The rates charged by any health maintenance

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562 organization to its subscribers shall not be excessive,
563 inadequate, or unfairly discriminatory or follow a rating
564 methodology that is inconsistent, indeterminate, or ambiguous or
565 encourages misrepresentation or misunderstanding. ~~A law~~
566 ~~restricting or limiting deductibles, coinsurance, copayments, or~~
567 ~~annual or lifetime maximum payments shall not apply to any~~
568 ~~health maintenance organization contract that provides coverage~~
569 ~~as described in s. 641.31071(5)(a)2., offered or delivered to an~~
570 ~~individual or a group of 51 or more persons.~~ The commission, in
571 accordance with generally accepted actuarial practice as applied
572 to health maintenance organizations, may define by rule what
573 constitutes excessive, inadequate, or unfairly discriminatory
574 rates and may require whatever information it deems necessary to
575 determine that a rate or proposed rate meets the requirements of
576 this subsection.
577 (40)(a) Any group rate, rating schedule, or rating manual
578 for a health maintenance organization policy, which provides
579 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,
580 filed with the office shall provide for an appropriate rebate of
581 premiums paid in the last policy year, contract year, or
582 calendar year when the majority of members of a health plan are
583 enrolled in and have maintained participation in any health
584 wellness, maintenance, or improvement program offered by the
585 group contract holder. The group must provide evidence of
586 demonstrative maintenance or improvement of his or her health
587 status as determined by assessments of agreed-upon health status
588 indicators between the group and the health insurer, including,
589 but not limited to, reduction in weight, body mass index, and
590 smoking cessation. Any rebate provided by the health maintenance

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591 organization is presumed to be appropriate unless credible data
592 demonstrates otherwise, or unless the rebate program requires
593 the insured to incur costs to qualify for the rebate which
594 equals or exceeds the value of the rebate but the rebate may not
595 exceed 10 percent of paid premiums.
596 Section 20. Section 641.31071, Florida Statutes, is amended
597 to read:
598 641.31071 Preexisting conditions.—
599 (1) As used in this section, the term:
600 (a) "Enrollment date" means, with respect to an individual
601 covered under a group health maintenance organization contract,
602 the date of enrollment of the individual in the plan or coverage
603 or, if earlier, the first day of the waiting period of such
604 enrollment.
605 (b) "Late enrollee" means, with respect to coverage under a
606 group health maintenance organization contract, a participant or
607 beneficiary who enrolls under the contract other than during:
608 1. The first period in which the individual is eligible to
609 enroll under the plan.
610 2. A special enrollment period, as provided under s.
611 641.31072.
612 (c) "Waiting period" means, with respect to a group health
613 maintenance organization contract and an individual who is a
614 potential participant or beneficiary under the contract, the
615 period that must pass with respect to the individual before the
616 individual is eligible to be covered for benefits under the
617 terms of the contract.
618 (2) Subject to the exceptions specified in subsection (4),
619 a health maintenance organization that offers group coverage,

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620 may, with respect to a participant or beneficiary, impose a
621 preexisting condition exclusion only if:
622 (a) Such exclusion relates to a physical or mental
623 condition, regardless of the cause of the condition, for which
624 medical advice, diagnosis, care, or treatment was recommended or
625 received within the 6-month period ending on the enrollment
626 date;
627 (b) Such exclusion extends for a period of not more than 12
628 months, or 18 months in the case of a late enrollee, after the
629 enrollment date; and
630 (c) The period of any such preexisting condition exclusion
631 is reduced by the aggregate of the periods of creditable
632 coverage, as defined in s. 627.6562(3) ~~subsection (5)~~,
633 applicable to the participant or beneficiary as of the
634 enrollment date.
635 (3) Genetic information shall not be treated as a condition
636 described in paragraph (2)(a) in the absence of a diagnosis of
637 the condition related to such information.
638 (4)(a) Subject to paragraph (b), a health maintenance
639 organization that offers group coverage may not impose any
640 preexisting condition exclusion in the case of:
641 1. An individual who, as of the last day of the 30-day
642 period beginning with the date of birth, is covered under
643 creditable coverage.
644 2. A child who is adopted or placed for adoption before
645 attaining 18 years of age and who, as of the last day of the 30-
646 day period beginning on the date of the adoption or placement
647 for adoption, is covered under creditable coverage. This
648 provision shall not apply to coverage before the date of such

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649 adoption or placement for adoption.
650 3. Pregnancy.
651 (b) Subparagraphs (a)1. and 2. do not apply to an
652 individual after the end of the first 63-day period during all
653 of which the individual was not covered under any creditable
654 coverage.
655 ~~(5)(a) The term “creditable coverage” means, with respect~~
656 ~~to an individual, coverage of the individual under any of the~~
657 ~~following:~~
658 ~~1. A group health plan, as defined in s. 2791 of the Public~~
659 ~~Health Service Act.~~
660 ~~2. Health insurance coverage consisting of medical care,~~
661 ~~provided directly, through insurance or reimbursement or~~
662 ~~otherwise, and including terms and services paid for as medical~~
663 ~~care, under any hospital or medical service policy or~~
664 ~~certificate, hospital or medical service plan contract, or~~
665 ~~health maintenance contract offered by a health insurance~~
666 ~~issuer.~~
667 ~~3. Part A or part B of Title XVIII of the Social Security~~
668 ~~Act.~~
669 ~~4. Title XIX of the Social Security Act, other than~~
670 ~~coverage consisting solely of benefits under s. 1928.~~
671 ~~5. Chapter 55 of Title 10, United States Code.~~
672 ~~6. A medical care program of the Indian Health Service or~~
673 ~~of a tribal organization.~~
674 ~~7. The Florida Comprehensive Health Association or another~~
675 ~~state health benefit risk pool.~~
676 ~~8. A health plan offered under chapter 89 of Title 5,~~
677 ~~United States Code.~~

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678 ~~9. A public health plan as defined by rule of the~~
679 ~~commission. To the greatest extent possible, such rules must be~~
680 ~~consistent with regulations adopted by the United States~~
681 ~~Department of Health and Human Services.~~
682 ~~10. A health benefit plan under s. 5(e) of the Peace Corps~~
683 ~~Act (22 U.S.C. s. 2504(e)).~~
684 ~~(b) Creditable coverage does not include coverage that~~
685 ~~consists solely of one or more or any combination thereof of the~~
686 ~~following excepted benefits:~~
687 ~~1. Coverage only for accident, or disability income~~
688 ~~insurance, or any combination thereof.~~
689 ~~2. Coverage issued as a supplement to liability insurance.~~
690 ~~3. Liability insurance, including general liability~~
691 ~~insurance and automobile liability insurance.~~
692 ~~4. Workers' compensation or similar insurance.~~
693 ~~5. Automobile medical payment insurance.~~
694 ~~6. Credit-only insurance.~~
695 ~~7. Coverage for onsite medical clinics.~~
696 ~~8. Other similar insurance coverage, specified in rules~~
697 ~~adopted by the commission, under which benefits for medical care~~
698 ~~are secondary or incidental to other insurance benefits. To the~~
699 ~~greatest extent possible, such rules must be consistent with~~
700 ~~regulations adopted by the United States Department of Health~~
701 ~~and Human Services.~~
702 ~~(c) The following benefits are not subject to the~~
703 ~~creditable coverage requirements, if offered separately:~~
704 ~~1. Limited scope dental or vision benefits.~~
705 ~~2. Benefits or long-term care, nursing home care, home~~
706 ~~health care, community-based care, or any combination of these.~~

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707 ~~3. Such other similar, limited benefits as are specified in~~
708 ~~rules adopted by the commission. To the greatest extent~~
709 ~~possible, such rules must be consistent with regulations adopted~~
710 ~~by the United States Department of Health and Human Services.~~
711 ~~(d) The following benefits are not subject to creditable~~
712 ~~coverage requirements if offered as independent, noncoordinated~~
713 ~~benefits:~~
714 ~~1. Coverage only for a specified disease or illness.~~
715 ~~2. Hospital indemnity or other fixed indemnity insurance.~~
716 ~~(e) Benefits provided through Medicare supplemental health~~
717 ~~insurance, as defined under s. 1882(g)(1) of the Social Security~~
718 ~~Act, coverage supplemental to the coverage provided under~~
719 ~~chapter 55 of Title 10, United States Code, and similar~~
720 ~~supplemental coverage provided to coverage under a group health~~
721 ~~plan are not considered creditable coverage if offered as a~~
722 ~~separate insurance policy.~~
723 ~~(6)(a) A period of creditable coverage may not be counted,~~
724 ~~with respect to enrollment of an individual under a group health~~
725 ~~maintenance organization contract, if, after such period and~~
726 ~~before the enrollment date, there was a 63-day period during all~~
727 ~~of which the individual was not covered under any creditable~~
728 ~~coverage.~~
729 ~~(b) Any period during which an individual is in a waiting~~
730 ~~period, or in an affiliation period as defined in subsection~~
731 ~~(9), for any coverage under a group health maintenance~~
732 ~~organization contract may not be taken into account in~~
733 ~~determining the 63-day period under paragraph (a) or paragraph~~
734 ~~(4)(b).~~
735 ~~(7)(a) Except as otherwise provided under paragraph (b), a~~

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736 ~~health maintenance organization shall count a period of~~
737 ~~creditable coverage without regard to the specific benefits~~
738 ~~covered under the period.~~
739 ~~(b) A health maintenance organization may elect to count as~~
740 ~~creditable coverage, coverage of benefits within each of several~~
741 ~~classes or categories of benefits specified in rules adopted by~~
742 ~~the commission rather than as provided under paragraph (a). Such~~
743 ~~election shall be made on a uniform basis for all participants~~
744 ~~and beneficiaries. Under such election, a health maintenance~~
745 ~~organization shall count a period of creditable coverage with~~
746 ~~respect to any class or category of benefits if any level of~~
747 ~~benefits is covered within such class or category.~~
748 ~~(c) In the case of an election with respect to a health~~
749 ~~maintenance organization under paragraph (b), the organization~~
750 ~~shall:~~
751 ~~1. Prominently state in 10-point type or larger in any~~
752 ~~disclosure statements concerning the contract, and state to each~~
753 ~~enrollee at the time of enrollment under the contract, that the~~
754 ~~organization has made such election; and~~
755 ~~2. Include in such statements a description of the effect~~
756 ~~of this election.~~
757 ~~(8)(a) Periods of creditable coverage with respect to an~~
758 ~~individual shall be established through presentation of~~
759 ~~certifications described in this subsection or in such other~~
760 ~~manner as may be specified in rules adopted by the commission.~~
761 ~~(b) A health maintenance organization that offers group~~
762 ~~coverage shall provide the certification described in paragraph~~
763 ~~(a):~~
764 ~~1. At the time an individual ceases to be covered under the~~

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765 ~~plan or otherwise becomes covered under a COBRA continuation~~
766 ~~provision or continuation pursuant to s. 627.6692.~~
767 ~~2. In the case of an individual becoming covered under a~~
768 ~~COBRA continuation provision or pursuant to s. 627.6692, at the~~
769 ~~time the individual ceases to be covered under such a provision.~~
770 ~~3. Upon the request on behalf of an individual made not~~
771 ~~later than 24 months after the date of cessation of the coverage~~
772 ~~described in this paragraph.~~
773
774 ~~The certification under subparagraph 1. may be provided, to the~~
775 ~~extent practicable, at a time consistent with notices required~~
776 ~~under any applicable COBRA continuation provision or~~
777 ~~continuation pursuant to s. 627.6692.~~
778 ~~(c) The certification is a written certification of:~~
779 ~~1. The period of creditable coverage of the individual~~
780 ~~under the contract and the coverage, if any, under such COBRA~~
781 ~~continuation provision or continuation pursuant to s. 627.6692;~~
782 ~~and~~
783 ~~2. The waiting period, if any, imposed with respect to the~~
784 ~~individual for any coverage under such contract.~~
785 ~~(d) In the case of an election described in subsection (7)~~
786 ~~by a health maintenance organization, if the organization~~
787 ~~enrolls an individual for coverage under the plan and the~~
788 ~~individual provides a certification of coverage of the~~
789 ~~individual, as provided by this subsection:~~
790 ~~1. Upon request of such health maintenance organization,~~
791 ~~the insurer or health maintenance organization that issued the~~
792 ~~certification provided by the individual shall promptly disclose~~
793 ~~to such requesting organization information on coverage of~~

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794 classes and categories of health benefits available under such
795 insurer's or health maintenance organization's plan or coverage.
796 2. Such insurer or health maintenance organization may
797 charge the requesting organization for the reasonable cost of
798 disclosing such information.
799 (c) The commission shall adopt rules to prevent an
800 insurer's or health maintenance organization's failure to
801 provide information under this subsection with respect to
802 previous coverage of an individual from adversely affecting any
803 subsequent coverage of the individual under another group health
804 plan or health maintenance organization coverage.
805 (9)(a) A health maintenance organization may provide for an
806 affiliation period with respect to coverage through the
807 organization only if:
808 1. No preexisting condition exclusion is imposed with
809 respect to coverage through the organization;
810 2. The period is applied uniformly without regard to any
811 health-status-related factors; and
812 3. Such period does not exceed 2 months or 3 months in the
813 case of a late enrollee.
814 (b) For the purposes of this section, the term "affiliation
815 period" means a period that, under the terms of the coverage
816 offered by the health maintenance organization, must expire
817 before the coverage becomes effective. The organization is not
818 required to provide health care services or benefits during such
819 period, and no premium may be charged to the participant or
820 beneficiary for any coverage during the period. Such period
821 begins on the enrollment date and runs concurrently with any
822 waiting period under the plan.

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823 ~~(c) As an alternative to the method authorized by paragraph~~
824 ~~(a), a health maintenance organization may address adverse~~
825 ~~selection in a method approved by the office.~~
826 ~~(10)(a) Except as provided in paragraph (b), no period~~
827 ~~before July 1, 1996, shall be taken into account in determining~~
828 ~~creditable coverage.~~
829 ~~(b) The commission shall adopt rules that provide a process~~
830 ~~whereby individuals who need to establish creditable coverage~~
831 ~~for periods before July 1, 1996, and who would have such~~
832 ~~coverage credited but for paragraph (a), may be given credit for~~
833 ~~creditable coverage for such periods through the presentation of~~
834 ~~documents or other means.~~
835 ~~(11) Except as otherwise provided in this subsection, the~~
836 ~~requirements of paragraph (8)(b) shall apply to events that~~
837 ~~occur on or after July 1, 1996.~~
838 ~~(a) In no case is a certification required to be provided~~
839 ~~under paragraph (8)(b) prior to June 1, 1997.~~
840 ~~(b) In the case of an event that occurs on or after July 1,~~
841 ~~1996, and before October 1, 1996, a certification is not~~
842 ~~required to be provided under paragraph (8)(b), unless an~~
843 ~~individual, with respect to whom the certification is required~~
844 ~~to be made, requests such certification in writing.~~
845 ~~(12) In the case of an individual who seeks to establish~~
846 ~~creditable coverage for any period for which certification is~~
847 ~~not required because it relates to an event occurring before~~
848 ~~July 1, 1996:~~
849 ~~(a) The individual may present other creditable coverage in~~
850 ~~order to establish the period of creditable coverage.~~
851 ~~(b) A health maintenance organization is not subject to any~~

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852 ~~penalty or enforcement action with respect to the organization’s~~
853 ~~crediting, or not crediting, such coverage if the organization~~
854 ~~has sought to comply in good faith with applicable provisions of~~
855 ~~this section.~~
856 ~~(13) For purposes of subsection (10), any plan amendment~~
857 ~~made pursuant to a collective bargaining agreement relating to~~
858 ~~the plan which amends the plan solely to conform to any~~
859 ~~requirement of this section may not be treated as a termination~~
860 ~~of such collective bargaining agreement.~~
861 Section 21. Subsections (1), (3), and (4) of section
862 641.31074, Florida Statutes, are amended to read:
863 641.31074 Guaranteed renewability of coverage.—
864 (1) Except as otherwise provided in this section, a health
865 maintenance organization that issues a ~~group~~ health insurance
866 contract must renew or continue in force such coverage at the
867 option of the contract holder.
868 (3)(a) A health maintenance organization may discontinue
869 offering a particular contract form ~~for group coverage offered~~
870 ~~in the small group market or large group market~~ only if:
871 1. The health maintenance organization provides notice to
872 each contract holder provided coverage of this form in such
873 market, and participants and beneficiaries covered under such
874 coverage, of such discontinuation at least 90 days prior to the
875 date of the nonrenewal of such coverage;
876 2. The health maintenance organization offers to each
877 contract holder provided coverage of this form in such market
878 the option to purchase all, or in the case of the large group
879 market, any other health insurance coverage currently being
880 offered by the health maintenance organization in such market;

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881 and
882 3. In exercising the option to discontinue coverage of this
883 form and in offering the option of coverage under subparagraph
884 2., the health maintenance organization acts uniformly without
885 regard to the claims experience of those contract holders or any
886 health-status-related factor that relates to any participants or
887 beneficiaries covered or new participants or beneficiaries who
888 may become eligible for such coverage.
889 (b)1. In any case in which a health maintenance
890 organization elects to discontinue offering all coverage in the
891 individual market, the small group market, ~~or~~ the large group
892 market, or any combination thereof ~~both,~~ in this state, coverage
893 may be discontinued by the insurer only if:
894 a. The health maintenance organization provides notice to
895 the office and to each contract holder, and participants and
896 beneficiaries covered under such coverage, of such
897 discontinuation at least 180 days prior to the date of the
898 nonrenewal of such coverage; and
899 b. All health insurance issued or delivered for issuance in
900 this state in such market is discontinued and coverage under
901 such health insurance coverage in such market is not renewed.
902 2. In the case of a discontinuation under subparagraph 1.
903 in a market, the health maintenance organization may not provide
904 for the issuance of any health maintenance organization contract
905 coverage in the market in this state during the 5-year period
906 beginning on the date of the discontinuation of the last
907 insurance contract not renewed.
908 (4) At the time of coverage renewal, a health maintenance
909 organization may modify the coverage for a product offered:

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910 (a) In the large group market; ~~or~~
911 (b) In the small group market if, for coverage that is
912 available in such market other than only through one or more
913 bona fide associations, as defined in s. 627.6571(5), such
914 modification is consistent with s. 627.6699 and effective on a
915 uniform basis among group health plans with that product; or
916 (c) In the individual market if the modification is
917 consistent with the laws of this state and effective on a
918 uniform basis among all individuals with that policy form.
919
920 ================= T I T L E A M E N D M E N T ================
921 And the title is amended as follows:
922 Delete lines 29 - 55
923 and insert:
924 types of benefits or coverages; amending s. 627.6561,
925 F.S.; conforming a cross-reference; revising
926 conditions under which an insurer may impose a
927 preexisting condition exclusion; deleting the
928 definition of the term "creditable coverage"; removing
929 certain requirements relating to creditable coverage
930 to conform to changes made by the act; amending s.
931 627.6562, F.S.; redefining the term "creditable
932 coverage"; providing exceptions and applicability;
933 amending s. 627.65626, F.S.; conforming a cross-
934 reference; amending s. 627.6699, F.S.; redefining
935 terms; deleting a provision that requires a certain
936 health benefit plan to comply with specified
937 preexisting condition provisions; amending s.
938 627.6741, F.S.; conforming cross-references;

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939 conforming a provision to changes made by the act;
940 amending s. 641.31, F.S.; deleting a provision
941 specifying that a law restricting or limiting
942 deductibles, coinsurance, copayments, or annual or
943 lifetime maximum payments may not apply to a certain
944 health maintenance organization contract; conforming a
945 cross-reference; amending s. 641.31071, F.S.;
946 conforming a cross-reference; deleting the definition
947 of the term “creditable coverage”; removing certain
948 requirements relating to creditable coverage to
949 conform to changes made by the act; amending s.
950 641.31074; requiring a health maintenance organization
951 that issues a health insurance contract, rather than a
952 group health insurance contract, to renew or continue
953 in force such coverage at the contract holder’s
954 option; revising conditions under which a health
955 maintenance organization may discontinue offering a
956 particular contract form; adding to the conditions
957 under which a health maintenance organization may, at
958 the time of coverage renewal, modify coverage for a
959 product offered; amending s.

By the Committee on Banking and Insurance; and Senator Detert

597-02615-16 20161170c1

1 A bill to be entitled
2 An act relating to health plan regulatory
3 administration; amending s. 408.909, F.S.; redefining
4 the term "health care coverage" or "health flex plan
5 coverage"; amending s. 409.817, F.S.; deleting a
6 provision authorizing group insurance plans to impose
7 a certain preexisting condition exclusion; amending s.
8 624.123, F.S.; conforming a cross-reference; amending
9 s. 627.402, F.S.; redefining the term
10 "nongrandfathered health plan"; amending s. 627.411,
11 F.S.; deleting a provision relating to a minimum loss
12 ratio standard for specified health insurance
13 coverage; deleting provisions specifying certain
14 incurred claims; amending s. 627.6011, F.S.,
15 conforming a cross-reference; amending s. 627.602,
16 F.S.; conforming a cross-reference; amending s.
17 627.642, F.S.; revising the policies to which certain
18 outline of coverage requirements apply; amending s.
19 627.6425, F.S.; redefining the term "individual health
20 insurance"; revising applicability; amending s.
21 627.6487, F.S.; redefining terms; repealing s.
22 627.64871, F.S., relating to certification of
23 coverage; amending s. 627.6512, F.S.; revising a
24 provision specifying that certain sections of the
25 Florida Insurance Code do not apply to a group health
26 insurance policy as that policy relates to specified
27 benefits, under certain circumstances; amending s.
28 627.6513, F.S.; excluding applicability as to certain
29 types of benefits or coverages; repealing s. 627.6561,
30 F.S., relating to preexisting conditions; amending s.
31 627.6562, F.S.; redefining the term "creditable
32 coverage"; providing exceptions and applicability;

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

33 amending s. 627.65626, F.S.; conforming a cross-
34 reference; amending s. 627.6699, F.S.; redefining
35 terms; deleting a provision that requires a certain
36 health benefit plan to comply with specified
37 preexisting condition provisions; conforming
38 provisions to changes made by the act; amending s.
39 627.6741, F.S.; conforming cross-references;
40 conforming a provision to changes made by the act;
41 amending s. 641.185, F.S.; revising certain standards
42 to remove requirements for a health maintenance
43 organization to provide specified coverage for
44 preexisting conditions; conforming provisions to
45 changes made by the act; amending s. 641.31, F.S.;
46 deleting a provision specifying that a law restricting
47 or limiting deductibles, coinsurance, copayments, or
48 annual or lifetime maximum payments may not apply to a
49 certain health maintenance organization contract;
50 conforming a cross-reference; repealing s. 641.31071,
51 F.S., relating to preexisting conditions; amending s.
52 641.3111, F.S.; deleting a provision specifying that a
53 subscriber is not entitled to an extension of benefits
54 under certain circumstances after termination of a
55 group health maintenance contract; amending s.
56 641.312, F.S.; conforming a cross-reference; providing
57 an effective date.
58
59 Be It Enacted by the Legislature of the State of Florida:
60
61 Section 1. Paragraph (d) of subsection (2) of section

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.—

(2) DEFINITIONS.—As used in this section, the term:

(d) “Health care coverage” or “health flex plan coverage” means health care services that are covered as benefits under an approved health flex plan or that are otherwise provided, either directly or through arrangements with other persons, via a health flex plan on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis. The terms may also include one or more of the excepted benefits under s. 627.6513(1)-(13) ~~s. 627.6561(5)(b), the benefits under s. 627.6561(5)(c), if offered separately, or the benefits under s. 627.6561(5)(d), if offered as independent, noncoordinated benefits~~.

Section 2. Section 409.817, Florida Statutes, is amended to read:

409.817 Approval of health benefits coverage; financial assistance.—In order for health insurance coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.821, the health benefits coverage must:

(1) Be certified by the Office of Insurance Regulation of the Financial Services Commission under s. 409.818 as meeting, exceeding, or being actuarially equivalent to the benchmark benefit plan;

(2) Be guarantee issued;

(3) Be community rated;

(4) Not impose any preexisting condition exclusion for covered benefits; ~~however, group health insurance plans may permit the imposition of a preexisting condition exclusion, but only insofar as it is permitted under s. 627.6561;~~

(5) Comply with the applicable limitations on premiums and cost sharing in s. 409.816;

(6) Comply with the quality assurance and access standards developed under s. 409.820; and

(7) Establish periodic open enrollment periods, which may not occur more frequently than quarterly.

Section 3. Paragraph (b) of subsection (1) of section 624.123, Florida Statutes, is amended to read:

624.123 Certain international health insurance policies; exemption from code.—

(1) International health insurance policies and applications may be solicited and sold in this state at any international airport to a resident of a foreign country. Such international health insurance policies shall be solicited and sold only by a licensed health insurance agent and underwritten only by an admitted insurer. For purposes of this subsection:

(b) “International health insurance policy” means health insurance, as provided ~~defined~~ in s. 627.6562(3)(a)2. ~~s. 627.6561(5)(a)2.~~, which is offered to an individual, covering only a resident of a foreign country on an annual basis.

Section 4. Subsection (2) of section 627.402, Florida Statutes, is amended to read:

627.402 Definitions.—As used in this part, the term:

(2) “Nongrandfathered health plan” is a health insurance policy or health maintenance organization contract that is not a grandfathered health plan and does not provide the benefits or coverages specified under s. 627.6513(1)-(14) ~~s. 627.6561(5)(b)-(e)~~.

Section 5. Subsection (3) of section 627.411, Florida

120 Statutes, is amended to read:
121 627.411 Grounds for disapproval.—
122 ~~(3)(a) For health insurance coverage as described in s.~~
123 ~~627.6561(5)(a)2., the minimum loss ratio standard of incurred~~
124 ~~claims to earned premium for the form shall be 65 percent.~~
125 ~~(b) Incurred claims are claims occurring within a fixed~~
126 ~~period, whether or not paid during the same period, under the~~
127 ~~terms of the policy period.~~
128 ~~1. Claims include scheduled benefit payments or services~~
129 ~~provided by a provider or through a provider network for dental,~~
130 ~~vision, disability, and similar health benefits.~~
131 ~~2. Claims do not include state assessments, taxes, company~~
132 ~~expenses, or any expense incurred by the company for the cost of~~
133 ~~adjusting and settling a claim, including the review,~~
134 ~~qualification, oversight, management, or monitoring of a claim~~
135 ~~or incentives or compensation to providers for other than the~~
136 ~~provisions of health care services.~~
137 ~~3. A company may at its discretion include costs that are~~
138 ~~demonstrated to reduce claims, such as fraud intervention~~
139 ~~programs or case management costs, which are identified in each~~
140 ~~filing, are demonstrated to reduce claims costs, and do not~~
141 ~~result in increasing the experience period loss ratio by more~~
142 ~~than 5 percent.~~
143 ~~4. For scheduled claim payments, such as disability income~~
144 ~~or long-term care, the incurred claims shall be the present~~
145 ~~value of the benefit payments discounted for continuance and~~
146 ~~interest.~~
147 Section 6. Section 627.6011, Florida Statutes, is amended
148 to read:

149 627.6011 Mandated coverages.—Mandatory health benefits
150 regulated under this chapter are not intended to apply to the
151 types of health benefit plans listed in s. 627.6513(1)-(14) ~~s.~~
152 ~~627.6561(5)(b)-(e)~~, issued in any market, unless specifically
153 designated otherwise. For purposes of this section, the term
154 “mandatory health benefits” means those benefits set forth in
155 ss. 627.6401-627.64193, and any other mandatory treatment or
156 health coverages or benefits enacted on or after July 1, 2012.
157 Section 7. Paragraph (h) of subsection (1) of section
158 627.602, Florida Statutes, is amended to read:
159 627.602 Scope, format of policy.—
160 (1) Each health insurance policy delivered or issued for
161 delivery to any person in this state must comply with all
162 applicable provisions of this code and all of the following
163 requirements:
164 (h) Section 641.312 and the provisions of the Employee
165 Retirement Income Security Act of 1974, as implemented by 29
166 C.F.R. s. 2560.503-1, relating to internal grievances. This
167 paragraph does not apply to a health insurance policy that is
168 subject to the Subscriber Assistance Program under s. 408.7056
169 or to the types of benefits or coverages provided under s.
170 627.6513(1)-(14) ~~s. 627.6561(5)(b)-(e)~~ issued in any market.
171 Section 8. Subsection (1) of section 627.642, Florida
172 Statutes, is amended to read:
173 627.642 Outline of coverage.—
174 (1) A policy offering benefits defined in s. 627.6513(1)-
175 (14) or a large group ~~no individual or family accident and~~
176 ~~health insurance~~ policy may not ~~shall~~ be delivered, or issued
177 for delivery, in this state unless:

178 (a) It is accompanied by an appropriate outline of
179 coverage; or
180 (b) An appropriate outline of coverage is completed and
181 delivered to the applicant at the time application is made, and
182 an acknowledgment of receipt or certificate of delivery of such
183 outline is provided to the insurer with the application.
184
185 In the case of a direct response, such as a written application
186 to the insurance company from an applicant, the outline of
187 coverage shall accompany the policy when issued.
188 Section 9. Subsections (1), (6), and (7) of section
189 627.6425, Florida Statutes, are amended, to read:
190 627.6425 Renewability of individual coverage.—
191 (1) Except as otherwise provided in this section, an
192 insurer that provides individual health insurance coverage to an
193 individual shall renew or continue in force such coverage at the
194 option of the individual. For the purpose of this section, the
195 term “individual health insurance” means health insurance
196 coverage, as described in s. 624.603 ~~s. 627.6561(5)(a)2.~~,
197 offered to an individual in this state, including certificates
198 of coverage offered to individuals in this state as part of a
199 group policy issued to an association outside this state, but
200 the term does not include short-term limited duration insurance
201 or excepted benefits specified in s. 627.6513(1)-(14) ~~subsection~~
202 ~~(6) or subsection (7)~~.
203 ~~(6) The requirements of this section do not apply to any~~
204 ~~health insurance coverage in relation to its provision of~~
205 ~~excepted benefits described in s. 627.6561(5)(b).~~
206 ~~(7) The requirements of this section do not apply to any~~

207 ~~health insurance coverage in relation to its provision of~~
208 ~~excepted benefits described in s. 627.6561(5)(c), (d), or (e),~~
209 ~~if the benefits are provided under a separate policy,~~
210 ~~certificate, or contract of insurance.~~
211 Section 10. Paragraph (b) of subsection (2) and subsection
212 (3) of section 627.6487, Florida Statutes, are amended to read:
213 627.6487 Guaranteed availability of individual health
214 insurance coverage to eligible individuals.—
215 (2) For the purposes of this section:
216 (b) “Individual health insurance” means health insurance,
217 as defined in s. 624.603 ~~s. 627.6561(5)(a)2.~~, which is offered
218 to an individual, including certificates of coverage offered to
219 individuals in this state as part of a group policy issued to an
220 association outside this state, but the term does not include
221 short-term limited duration insurance or excepted benefits
222 specified in s. 627.6513(1)-(14) ~~s. 627.6561(5)(b) or, if the~~
223 ~~benefits are provided under a separate policy, certificate, or~~
224 ~~contract, the term does not include excepted benefits specified~~
225 ~~in s. 627.6561(5)(c), (d), or (e)~~.
226 (3) For the purposes of this section, the term “eligible
227 individual” means an individual:
228 (a)1. For whom, as of the date on which the individual
229 seeks coverage under this section, the aggregate of the periods
230 of creditable coverage, as defined in s. 627.6562(3) ~~s.~~
231 ~~627.6561(5) and (6)~~, is 18 or more months; and
232 2.a. Whose most recent prior creditable coverage was under
233 a group health plan, governmental plan, or church plan, or
234 health insurance coverage offered in connection with any such
235 plan; or

236 b. Whose most recent prior creditable coverage was under an
237 individual plan issued in this state by a health insurer or
238 health maintenance organization, which coverage is terminated
239 due to the insurer or health maintenance organization becoming
240 insolvent or discontinuing the offering of all individual
241 coverage in the State of Florida, or due to the insured no
242 longer living in the service area in the State of Florida of the
243 insurer or health maintenance organization that provides
244 coverage through a network plan in the State of Florida;
245 (b) Who is not eligible for coverage under:
246 1. A group health plan, as defined in s. 2791 of the Public
247 Health Service Act;
248 2. A conversion policy or contract issued by an authorized
249 insurer or health maintenance organization under s. 627.6675 or
250 s. 641.3921, respectively, offered to an individual who is no
251 longer eligible for coverage under either an insured or self-
252 insured employer plan;
253 3. Part A or part B of Title XVIII of the Social Security
254 Act; or
255 4. A state plan under Title XIX of such act, or any
256 successor program, and does not have other health insurance
257 coverage;
258 (c) With respect to whom the most recent coverage within
259 the coverage period described in paragraph (a) was not
260 terminated based on a factor described in s. 627.6571(2)(a) or
261 (b), relating to nonpayment of premiums or fraud, unless such
262 nonpayment of premiums or fraud was due to acts of an employer
263 or person other than the individual;
264 (d) Who, having been offered the option of continuation

265 coverage under a COBRA continuation provision or under s.
266 627.6692, elected such coverage; and
267 (e) Who, if the individual elected such continuation
268 provision, has exhausted such continuation coverage under such
269 provision or program.
270 Section 11. Section 627.64871, Florida Statutes, is
271 repealed.
272 Section 12. Section 627.6512, Florida Statutes, is amended
273 to read:
274 627.6512 Exemption of certain group health insurance
275 policies.—Sections ~~627.6561,~~ 627.65615, 627.65625, and 627.6571
276 do not apply to~~:~~
277 ~~(1)~~ any group insurance policy in relation to its provision
278 of ~~excepted~~ benefits described in s. 627.6513(1)-(14) ~~s.~~
279 ~~627.6561(5)(b)~~.
280 ~~(2) Any group health insurance policy in relation to its~~
281 ~~provision of excepted benefits described in s. 627.6561(5)(c),~~
282 ~~if the benefits:~~
283 ~~(a) Are provided under a separate policy, certificate, or~~
284 ~~contract of insurance; or~~
285 ~~(b) Are otherwise not an integral part of the policy.~~
286 ~~(3) Any group health insurance policy in relation to its~~
287 ~~provision of excepted benefits described in s. 627.6561(5)(d),~~
288 ~~if all of the following conditions are met:~~
289 ~~(a) The benefits are provided under a separate policy,~~
290 ~~certificate, or contract of insurance;~~
291 ~~(b) There is no coordination between the provision of such~~
292 ~~benefits and any exclusion of benefits under any group policy~~
293 ~~maintained by the same policyholder; and~~

294 ~~(c) Such benefits are paid with respect to an event without~~
295 ~~regard to whether benefits are provided with respect to such an~~
296 ~~event under any group health policy maintained by the same~~
297 ~~policyholder.~~
298 ~~(4) Any group health policy in relation to its provision of~~
299 ~~excepted benefits described in s. 627.6561(5)(e), if the~~
300 ~~benefits are provided under a separate policy, certificate, or~~
301 ~~contract of insurance.~~
302 Section 13. Section 627.6513, Florida Statutes, is amended
303 to read:
304 627.6513 Scope.—Section 641.312 and the provisions of the
305 Employee Retirement Income Security Act of 1974, as implemented
306 by 29 C.F.R. s. 2560.503-1, relating to internal grievances,
307 apply to all group health insurance policies issued under this
308 part. This section does not apply to a group health insurance
309 policy that is subject to the Subscriber Assistance Program in
310 s. 408.7056 or to: ~~the types of benefits or coverages provided~~
311 ~~under s. 627.6561(5)(b)-(e) issued in any market.~~
312 (1) Coverage only for accident insurance or disability
313 income insurance, or any combination thereof.
314 (2) Coverage issued as a supplement to liability insurance.
315 (3) Liability insurance, including general liability
316 insurance and automobile liability insurance.
317 (4) Workers' compensation or similar insurance.
318 (5) Automobile medical payment insurance.
319 (6) Credit-only insurance.
320 (7) Coverage for onsite medical clinics, including prepaid
321 health clinics under part II of chapter 641.
322 (8) Other similar insurance coverage, specified in rules

323 adopted by the commission, under which benefits for medical care
324 are secondary or incidental to other insurance benefits. To the
325 extent possible, such rules must be consistent with regulations
326 adopted by the United States Department of Health and Human
327 Services.
328 (9) Limited scope dental or vision benefits, if offered
329 separately.
330 (10) Benefits for long-term care, nursing home care, home
331 health care, or community-based care, or any combination
332 thereof, if offered separately.
333 (11) Other similar limited benefits, if offered separately,
334 as specified in rules adopted by the commission.
335 (12) Coverage only for a specified disease or illness, if
336 offered as independent, noncoordinated benefits.
337 (13) Hospital indemnity or other fixed indemnity insurance,
338 if offered as independent, noncoordinated benefits.
339 (14) Benefits provided through a Medicare supplemental
340 health insurance policy, as defined under s. 1882(g)(1) of the
341 Social Security Act, coverage supplemental to the coverage
342 provided under 10 U.S.C. chapter 55, and similar supplemental
343 coverage provided to coverage under a group health plan, which
344 are offered as a separate insurance policy and as independent,
345 noncoordinated benefits.
346 Section 14. Section 627.6561, Florida Statutes, is
347 repealed.
348 Section 15. Subsection (3) of section 627.6562, Florida
349 Statutes, is amended to read:
350 627.6562 Dependent coverage.—
351 (3) If, pursuant to subsection (2), a child is provided

352 coverage under the parent’s policy after the end of the calendar
353 year in which the child reaches age 25 and coverage for the
354 child is subsequently terminated, the child is not eligible to
355 be covered under the parent’s policy unless the child was
356 continuously covered by other creditable coverage without a gap
357 in coverage of more than 63 days.
358 (a) For the purposes of this subsection, the term
359 “creditable coverage” means, with respect to an individual,
360 coverage of the individual under any of the following: ~~has the~~
361 ~~same meaning as provided in s. 627.6561(5).~~
362 1. A group health plan, as defined in s. 2791 of the Public
363 Health Service Act.
364 2. Health insurance coverage consisting of medical care
365 provided directly through insurance or reimbursement or
366 otherwise, and including terms and services paid for as medical
367 care, under any hospital or medical service policy or
368 certificate, hospital or medical service plan contract, or
369 health maintenance contract offered by a health insurance
370 issuer.
371 3. Part A or part B of Title XVIII of the Social Security
372 Act.
373 4. Title XIX of the Social Security Act, other than
374 coverage consisting solely of benefits under s. 1928.
375 5. 10 U.S.C. chapter 55.
376 6. A medical care program of the Indian Health Service or
377 of a tribal organization.
378 7. The Florida Comprehensive Health Association or another
379 state health benefit risk pool.
380 8. A health plan offered under 5 U.S.C. chapter 89.

381 9. A public health plan as defined by rules adopted by the
382 commission. To the greatest extent possible, such rules must be
383 consistent with regulations adopted by the United States
384 Department of Health and Human Services.
385 10. A health benefit plan under s. 5(e) of the Peace Corps
386 Act, 22 U.S.C. s. 2504(e).
387 (b) Creditable coverage does not include coverage that
388 consists of one or more, or any combination thereof, of the
389 following excepted benefits:
390 1. Coverage only for accident insurance or disability
391 income insurance, or any combination thereof.
392 2. Coverage issued as a supplement to liability insurance.
393 3. Liability insurance, including general liability
394 insurance and automobile liability insurance.
395 4. Workers’ compensation or similar insurance.
396 5. Automobile medical payment insurance.
397 6. Credit-only insurance.
398 7. Coverage for onsite medical clinics, including prepaid
399 health clinics under part II of chapter 641.
400 8. Other similar insurance coverage specified in rules
401 adopted by the commission under which benefits for medical care
402 are secondary or incidental to other insurance benefits. To the
403 extent possible, such rules must be consistent with regulations
404 adopted by the United States Department of Health and Human
405 Services.
406 (c) The following benefits are not subject to the
407 creditable coverage requirements, if offered separately:
408 1. Limited scope dental or vision benefits.
409 2. Benefits for long-term care, nursing home care, home

410 health care, or community-based care, or any combination
411 thereof.
412 3. Other similar, limited benefits specified in rules
413 adopted by the commission.
414 (d) The following benefits are not subject to creditable
415 coverage requirements if offered as independent, noncoordinated
416 benefits:
417 1. Coverage only for a specified disease or illness.
418 2. Hospital indemnity or other fixed indemnity insurance.
419 (e) Benefits provided through a Medicare supplemental
420 health insurance policy, as defined under s. 1882(g)(1) of the
421 Social Security Act, coverage supplemental to the coverage
422 provided under 10 U.S.C. chapter 55, and similar supplemental
423 coverage provided to coverage under a group health plan are not
424 considered creditable coverage if offered as a separate
425 insurance policy.
426 Section 16. Subsection (1) of section 627.65626, Florida
427 Statutes, is amended to read:
428 627.65626 Insurance rebates for healthy lifestyles.—
429 (1) Any rate, rating schedule, or rating manual for a
430 health insurance policy that provides creditable coverage as
431 defined in s. 627.6562(3) ~~s. 627.6561(5)~~ filed with the office
432 shall provide for an appropriate rebate of premiums paid in the
433 last policy year, contract year, or calendar year when the
434 majority of members of a health plan have enrolled and
435 maintained participation in any health wellness, maintenance, or
436 improvement program offered by the group policyholder and health
437 plan. The rebate may be based upon premiums paid in the last
438 calendar year or policy year. The group must provide evidence of

439 demonstrative maintenance or improvement of the enrollees'
440 health status as determined by assessments of agreed-upon health
441 status indicators between the policyholder and the health
442 insurer, including, but not limited to, reduction in weight,
443 body mass index, and smoking cessation. The group or health
444 insurer may contract with a third-party administrator to
445 assemble and report the health status required in this
446 subsection between the policyholder and the health insurer. Any
447 rebate provided by the health insurer is presumed to be
448 appropriate unless credible data demonstrates otherwise, or
449 unless the rebate program requires the insured to incur costs to
450 qualify for the rebate which equal or exceed the value of the
451 rebate, but the rebate may not exceed 10 percent of paid
452 premiums.
453 Section 17. Paragraphs (e), (l), and (n) of subsection (3),
454 paragraphs (c) and (d) of subsection (5), and paragraph (b) of
455 subsection (6) of section 627.6699, Florida Statutes, are
456 amended to read:
457 627.6699 Employee Health Care Access Act.—
458 (3) DEFINITIONS.—As used in this section, the term:
459 (e) "Creditable coverage" has the same meaning ascribed in
460 s. 627.6562(3) ~~s. 627.6561~~.
461 (l) "Late enrollee" means an eligible employee or dependent
462 who, with respect to coverage under a group health policy, is a
463 participant or beneficiary who enrolls under the policy other
464 than during:
465 1. The first period in which the individual is eligible to
466 enroll under the policy.
467 2. A special enrollment period, as provided under s.

627.65615 ~~as defined under s. 627.6561(1)(b)~~.

(n) “Modified community rating” means a method used to develop carrier premiums which spreads financial risk across a large population; allows the use of separate rating factors for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(e) ~~(5)(f)~~; and allows adjustments for~~:~~ claims experience, health status, or duration of coverage as permitted under subparagraph (6)(b)5.; and administrative and acquisition expenses as permitted under subparagraph (6)(b)5.

(5) AVAILABILITY OF COVERAGE.—

~~(c) Except as provided in paragraph (d), a health benefit plan covering small employers must comply with preexisting condition provisions specified in s. 627.6561 or, for health maintenance contracts, in s. 641.31071.~~

(c)~~(d)~~ A health benefit plan covering small employers, issued or renewed on or after January 1, 1994, must comply with the following conditions:

1. All health benefit plans must be offered and issued on a guaranteed-issue basis. Additional or increased benefits may only be offered by riders.

~~2. Paragraph (c) applies to health benefit plans issued to a small employer who has two or more eligible employees and to health benefit plans that are issued to a small employer who has fewer than two eligible employees and that cover an employee who has had creditable coverage continually to a date not more than 63 days before the effective date of the new coverage.~~

2.~~3.~~ For health benefit plans that are issued to a small employer who has fewer than two employees and that cover an

employee who has not been continually covered by creditable coverage within 63 days before the effective date of the new coverage, preexisting condition provisions must not exclude coverage for a period beyond 24 months following the employee’s effective date of coverage and may relate only to:

a. Conditions that, during the 24-month period immediately preceding the effective date of coverage, had manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received; or

b. A pregnancy existing on the effective date of coverage.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.—

(b) For all small employer health benefit plans that are subject to this section and issued by small employer carriers on or after January 1, 1994, premium rates for health benefit plans are subject to the following:

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer is determined solely on the basis of the eligible employee’s and eligible dependent’s gender, age, family composition, tobacco use, or geographic area as determined under paragraph (5)(e) ~~(5)(f)~~ and in which the premium may be adjusted as permitted by this paragraph. A small employer carrier is not required to use gender as a rating factor for a nongrandfathered health plan.

2. Rating factors related to age, gender, family composition, tobacco use, or geographic location may be developed by each carrier to reflect the carrier’s experience. The factors used by carriers are subject to office review and

526 approval.
527 3. Small employer carriers may not modify the rate for a
528 small employer for 12 months from the initial issue date or
529 renewal date, unless the composition of the group changes or
530 benefits are changed. However, a small employer carrier may
531 modify the rate one time within the 12 months after the initial
532 issue date for a small employer who enrolls under a previously
533 issued group policy that has a common anniversary date for all
534 employers covered under the policy if:
535 a. The carrier discloses to the employer in a clear and
536 conspicuous manner the date of the first renewal and the fact
537 that the premium may increase on or after that date.
538 b. The insurer demonstrates to the office that efficiencies
539 in administration are achieved and reflected in the rates
540 charged to small employers covered under the policy.
541 4. A carrier may issue a group health insurance policy to a
542 small employer health alliance or other group association with
543 rates that reflect a premium credit for expense savings
544 attributable to administrative activities being performed by the
545 alliance or group association if such expense savings are
546 specifically documented in the insurer's rate filing and are
547 approved by the office. Any such credit may not be based on
548 different morbidity assumptions or on any other factor related
549 to the health status or claims experience of any person covered
550 under the policy. This subparagraph does not exempt an alliance
551 or group association from licensure for activities that require
552 licensure under the insurance code. A carrier issuing a group
553 health insurance policy to a small employer health alliance or
554 other group association shall allow any properly licensed and

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

555 appointed agent of that carrier to market and sell the small
556 employer health alliance or other group association policy. Such
557 agent shall be paid the usual and customary commission paid to
558 any agent selling the policy.
559 5. Any adjustments in rates for claims experience, health
560 status, or duration of coverage may not be charged to individual
561 employees or dependents. For a small employer's policy, such
562 adjustments may not result in a rate for the small employer
563 which deviates more than 15 percent from the carrier's approved
564 rate. Any such adjustment must be applied uniformly to the rates
565 charged for all employees and dependents of the small employer.
566 A small employer carrier may make an adjustment to a small
567 employer's renewal premium, up to 10 percent annually, due to
568 the claims experience, health status, or duration of coverage of
569 the employees or dependents of the small employer. If the
570 aggregate resulting from the application of such adjustment
571 exceeds the premium that would have been charged by application
572 of the approved modified community rate by 4 percent for the
573 current policy term, the carrier shall limit the application of
574 such adjustments only to minus adjustments. For any subsequent
575 policy term, if the total aggregate adjusted premium actually
576 charged does not exceed the premium that would have been charged
577 by application of the approved modified community rate by 4
578 percent, the carrier may apply both plus and minus adjustments.
579 A small employer carrier may provide a credit to a small
580 employer's premium based on administrative and acquisition
581 expense differences resulting from the size of the group. Group
582 size administrative and acquisition expense factors may be
583 developed by each carrier to reflect the carrier's experience

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

584 and are subject to office review and approval.
585 6. A small employer carrier rating methodology may include
586 separate rating categories for one dependent child, for two
587 dependent children, and for three or more dependent children for
588 family coverage of employees having a spouse and dependent
589 children or employees having dependent children only. A small
590 employer carrier may have fewer, but not greater, numbers of
591 categories for dependent children than those specified in this
592 subparagraph.
593 7. Small employer carriers may not use a composite rating
594 methodology to rate a small employer with fewer than 10
595 employees. For the purposes of this subparagraph, the term
596 "composite rating methodology" means a rating methodology that
597 averages the impact of the rating factors for age and gender in
598 the premiums charged to all of the employees of a small
599 employer.
600 8. A carrier may separate the experience of small employer
601 groups with fewer than 2 eligible employees from the experience
602 of small employer groups with 2-50 eligible employees for
603 purposes of determining an alternative modified community
604 rating.
605 a. If a carrier separates the experience of small employer
606 groups, the rate to be charged to small employer groups of fewer
607 than 2 eligible employees may not exceed 150 percent of the rate
608 determined for small employer groups of 2-50 eligible employees.
609 However, the carrier may charge excess losses of the experience
610 pool consisting of small employer groups with less than 2
611 eligible employees to the experience pool consisting of small
612 employer groups with 2-50 eligible employees so that all losses

613 are allocated and the 150-percent rate limit on the experience
614 pool consisting of small employer groups with less than 2
615 eligible employees is maintained.
616 b. Notwithstanding s. 627.411(1), the rate to be charged to
617 a small employer group of fewer than 2 eligible employees,
618 insured as of July 1, 2002, may be up to 125 percent of the rate
619 determined for small employer groups of 2-50 eligible employees
620 for the first annual renewal and 150 percent for subsequent
621 annual renewals.
622 9. A carrier shall separate the experience of grandfathered
623 health plans from nongrandfathered health plans for determining
624 rates.
625 Section 18. Subsection (1) and paragraph (c) of subsection
626 (2) of section 627.6741, Florida Statutes, are amended to read:
627 627.6741 Issuance, cancellation, nonrenewal, and
628 replacement.—
629 (1)(a) An insurer issuing Medicare supplement policies in
630 this state shall offer the opportunity of enrolling in a
631 Medicare supplement policy, without conditioning the issuance or
632 effectiveness of the policy on, and without discriminating in
633 the price of the policy based on, the medical or health status
634 or receipt of health care by the individual:
635 1. To any individual who is 65 years of age or older, or
636 under 65 years of age and eligible for Medicare by reason of
637 disability or end-stage renal disease, and who resides in this
638 state, upon the request of the individual during the 6-month
639 period beginning with the first month in which the individual
640 has attained 65 years of age and is enrolled in Medicare Part B,
641 or is eligible for Medicare by reason of a disability or end-

642 stage renal disease, and is enrolled in Medicare Part B; or
643 2. To any individual who is 65 years of age or older, or
644 under 65 years of age and eligible for Medicare by reason of a
645 disability or end-stage renal disease, who is enrolled in
646 Medicare Part B, and who resides in this state, upon the request
647 of the individual during the 2-month period following
648 termination of coverage under a group health insurance policy.
649 (b) The 6-month period to enroll in a Medicare supplement
650 policy for an individual who is under 65 years of age and is
651 eligible for Medicare by reason of disability or end-stage renal
652 disease and otherwise eligible under subparagraph (a)1. or
653 subparagraph (a)2. and first enrolled in Medicare Part B before
654 October 1, 2009, begins on October 1, 2009.
655 (c) A company that has offered Medicare supplement policies
656 to individuals under 65 years of age who are eligible for
657 Medicare by reason of disability or end-stage renal disease
658 before October 1, 2009, may, for one time only, effect a rate
659 schedule change that redefines the age bands of the premium
660 classes without activating the period of discontinuance required
661 by s. 627.410(6)(e)2.
662 (d) As a part of an insurer’s rate filings, before and
663 including the insurer’s first rate filing for a block of policy
664 forms in 2015, notwithstanding the provisions of s.
665 627.410(6)(e)3., an insurer shall consider the experience of the
666 policies or certificates for the premium classes including
667 individuals under 65 years of age and eligible for Medicare by
668 reason of disability or end-stage renal disease separately from
669 the balance of the block so as not to affect the other premium
670 classes. For filings in such time period only, credibility of

671 that experience shall be as follows: if a block of policy forms
672 has 1,250 or more policies or certificates in force in the age
673 band including ages under 65 years of age, full or 100-percent
674 credibility shall be given to the experience; and if fewer than
675 250 policies or certificates are in force, no or zero-percent
676 credibility shall be given. Linear interpolation shall be used
677 for in-force amounts between the low and high values. Florida-
678 only experience shall be used if it is 100-percent credible. If
679 Florida-only experience is not 100-percent credible, a
680 combination of Florida-only and nationwide experience shall be
681 used. If Florida-only experience is zero-percent credible,
682 nationwide experience shall be used. The insurer may file its
683 initial rates and any rate adjustment based upon the experience
684 of these policies or certificates or based upon expected claim
685 experience using experience data of the same company, other
686 companies in the same or other states, or using data publicly
687 available from the Centers for Medicaid and Medicare Services if
688 the insurer’s combined Florida and nationwide experience is not
689 100-percent credible, separate from the balance of all other
690 Medicare supplement policies.
691
692 A Medicare supplement policy issued to an individual under
693 subparagraph (a)1. or subparagraph (a)2. may not exclude
694 benefits based on a preexisting condition if the individual has
695 a continuous period of creditable coverage, as defined in <u>s.</u>
696 <u>627.6562(3)</u> ~~s. 627.6561(5)~~, of at least 6 months as of the date
697 of application for coverage.
698 (2) For both individual and group Medicare supplement
699 policies:

700 (c) If a Medicare supplement policy or certificate replaces
701 another Medicare supplement policy or certificate or creditable
702 coverage as defined in s. 627.6562(3) ~~s. 627.6561(5)~~, the
703 replacing insurer shall waive any time periods applicable to
704 preexisting conditions, waiting periods, elimination periods,
705 and probationary periods in the new Medicare supplement policy
706 for similar benefits to the extent such time was spent under the
707 original policy~~, subject to the requirements of s. 627.6561(6)-~~
708 ~~(11)~~.
709 Section 19. Paragraphs (f) and (h) of subsection (1) of
710 section 641.185, Florida Statutes, are amended to read:
711 641.185 Health maintenance organization subscriber
712 protections.—
713 (1) With respect to the provisions of this part and part
714 III, the principles expressed in the following statements shall
715 serve as standards to be followed by the commission, the office,
716 the department, and the Agency for Health Care Administration in
717 exercising their powers and duties, in exercising administrative
718 discretion, in administrative interpretations of the law, in
719 enforcing its provisions, and in adopting rules:
720 (f) A health maintenance organization subscriber should
721 receive the flexibility to transfer to another Florida health
722 maintenance organization, regardless of health status, pursuant
723 to ss. 641.228, 641.3104, ~~641.3107,~~ 641.3111, 641.3921, and
724 641.3922.
725 (h) A health maintenance organization that issues a group
726 health contract must~~: provide coverage for preexisting~~
727 ~~conditions pursuant to s. 641.31071;~~ guarantee renewability of
728 coverage pursuant to s. 641.31074,~~;~~ provide notice of

729 cancellation pursuant to s. 641.3108,~~;~~ provide extension of
730 benefits pursuant to s. 641.3111,~~;~~ provide for conversion on
731 termination of eligibility pursuant to s. 641.3921,~~;~~ and provide
732 for conversion contracts and conditions pursuant to s. 641.3922.
733 Section 20. Subsection (2) and paragraph (a) of subsection
734 (40) of section 641.31, Florida Statutes, are amended to read:
735 641.31 Health maintenance contracts.—
736 (2) The rates charged by any health maintenance
737 organization to its subscribers shall not be excessive,
738 inadequate, or unfairly discriminatory or follow a rating
739 methodology that is inconsistent, indeterminate, or ambiguous or
740 encourages misrepresentation or misunderstanding. ~~A law~~
741 ~~restricting or limiting deductibles, coinsurance, copayments, or~~
742 ~~annual or lifetime maximum payments shall not apply to any~~
743 ~~health maintenance organization contract that provides coverage~~
744 ~~as described in s. 641.31071(5)(a)2., offered or delivered to an~~
745 ~~individual or a group of 51 or more persons.~~ The commission, in
746 accordance with generally accepted actuarial practice as applied
747 to health maintenance organizations, may define by rule what
748 constitutes excessive, inadequate, or unfairly discriminatory
749 rates and may require whatever information it deems necessary to
750 determine that a rate or proposed rate meets the requirements of
751 this subsection.
752 (40)(a) Any group rate, rating schedule, or rating manual
753 for a health maintenance organization policy, which provides
754 creditable coverage as defined in s. 627.6562(3) ~~s. 627.6561(5)~~,
755 filed with the office shall provide for an appropriate rebate of
756 premiums paid in the last policy year, contract year, or
757 calendar year when the majority of members of a health plan are

758 enrolled in and have maintained participation in any health
759 wellness, maintenance, or improvement program offered by the
760 group contract holder. The group must provide evidence of
761 demonstrative maintenance or improvement of his or her health
762 status as determined by assessments of agreed-upon health status
763 indicators between the group and the health insurer, including,
764 but not limited to, reduction in weight, body mass index, and
765 smoking cessation. Any rebate provided by the health maintenance
766 organization is presumed to be appropriate unless credible data
767 demonstrates otherwise, or unless the rebate program requires
768 the insured to incur costs to qualify for the rebate which
769 equals or exceeds the value of the rebate but the rebate may not
770 exceed 10 percent of paid premiums.
771 Section 21. Section 641.31071, Florida Statutes, is
772 repealed.
773 Section 22. Subsection (4) of section 641.3111, Florida
774 Statutes, is amended to read:
775 641.3111 Extension of benefits.—
776 ~~(4) Except as provided in subsection (1), no subscriber is~~
777 ~~entitled to an extension of benefits if the termination of the~~
778 ~~contract by the health maintenance organization is based upon~~
779 ~~any event referred to in s. 641.3922(7)(a), (b), or (e).~~
780 Section 23. Section 641.312, Florida Statutes, is amended
781 to read:
782 641.312 Scope.—The Office of Insurance Regulation may adopt
783 rules to administer the provisions of the National Association
784 of Insurance Commissioners' Uniform Health Carrier External
785 Review Model Act, issued by the National Association of
786 Insurance Commissioners and dated April 2010. This section does

787 not apply to a health maintenance contract that is subject to
788 the Subscriber Assistance Program under s. 408.7056 or to the
789 types of benefits or coverages provided under s. 627.6513(1)-
790 (14) ~~s. 627.6561(5)(b)-(e)~~ issued in any market.
791 Section 24. This act shall take effect July 1, 2016.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: SB 1144

INTRODUCER: Senator Gaetz

SUBJECT: Certificates of Need for Health Care-related Projects

DATE: February 9, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Favorable**
2.	Brown	Pigott	AHS	**Pre-meeting**
3.			AP	

I. Summary:

SB 1144 creates a new exemption from the Certificate of Need (CON) review process for any project subject to CON, on the condition that the licensee commits to improve access to care for uninsured, low-income residents in its service district. If a licensee chooses to use the exemption, the bill requires that the licensee sign an agreement with the Agency for Health Care Administration (AHCA) stating that the licensee will provide charity care to low-income patients within its service district as specified in the bill. The bill also establishes penalties for licensees that fail to provide the required charity care.

The bill's fiscal impact is indeterminate.

The bill has an effective date of July 1, 2016.

II. Present Situation:

Florida's CON Program

Overview

In Florida, a CON is a written statement issued by the AHCA evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility or health service, including hospices. The Florida CON program has three levels of review: full, expedited and exempt.[1] Unless a project is exempt from the CON program, it must undergo a full comparative review. Expedited review is primarily targeted towards nursing home projects.

[1] Section 408.036, F.S.

Full CON Review Process

Full CON review is a lengthy process that starts with the AHCA determining need for a specific facility type or service. Upon determining that a need exists, AHCA accepts applications for CON based on batching cycles. At least 30 days prior to the application deadline for a batch cycle, an applicant must file a letter of intent with AHCA.[2] A letter of intent must describe the proposal, specify the number of beds sought, and identify the services to be provided and the location of the project.[3] Applications for CON review must be submitted by the specified deadline for the particular batch cycle.[4] The AHCA must review the application within 15 days of the filing deadline and, if necessary, request additional information for an incomplete application.[5] The applicant then has 21 days to complete the application or it is deemed withdrawn from consideration.[6]

Within 60 days of receipt of the completed applications for that batch, the AHCA must issue a State Agency Action Report and Notice of Intent to grant a CON for a project in its entirety, to grant a CON for identifiable portions of a project, or to deny a CON for a project.[7] The AHCA must then publish the decision, within 14 days, in the Florida Administrative Register.[8] If no administrative hearing is requested within 21 days of the publication, the State Agency Action Report and the Notice of Intent become a final order of the AHCA.[9]

An applicant for CON review must submit a fee to the AHCA at the time of application submission. The minimum CON application filing fee is $10,000.[10] In addition to the base fee, an applicant must pay a fee of 1.5 percent of each dollar of the proposed expenditure; however the total fee may not exceed $50,000.[11]

Projects Subject to Full CON Review

Section 408.036(1), F.S., lists projects that are required to undergo a full comparative CON review, including:

- The addition of beds by new construction or alteration in a community nursing home or intermediate care facility for the developmentally disabled;
- The new construction or establishment of additional health care facilities,[12] including the replacement of a health care facility that is not located within one mile of an existing health care facility, if the number of beds in each licensed bed category will not increase;
- The conversion from one type of health care facility to another, including from a general hospital to a specialty hospital;

[2] Section 408.039(2)(a), F.S.
[3] Section 408.039(2)(c), F.S.
[4] Rule 59C-1.008(1)(g), F.A.C.
[5] Section 408.039(3)(a), F.S.
[6] Id.
[7] Section 408.039(4)(b), F.S.
[8] Section 408.039(4)(c), F.S.
[9] Section 408.039(4)(d), F.S.
[10] Section 408.038, F.S.
[11] Id.
[12] Section 408.032, F.S., defines “health care facility” as a hospital, long-term care hospital, skilled nursing facility, hospice, or intermediate care facility for the developmentally disabled.

- The establishment of a hospice or hospice inpatient facility;
- An increase in the number of beds for comprehensive rehabilitation; and
- The establishment of tertiary health services,[13] including inpatient comprehensive rehabilitation.

Projects Subject to Expedited CON Review

Section 408.036(2), F.S., permits certain projects to undergo expedited CON review. Applicants for expedited review are not subject to the application deadlines associated with full comparative review and may submit an application at any time. Projects subject to an expedited review include the transfer of a CON and certain replacements, relocations, and new construction of nursing homes.[14]

Exemptions from CON Review

Section 408.036(3), F.S., provides many exemptions to CON review. Exempted projects must only submit an application for exemption to the AHCA and pay a $250 fee. Exempted projects include:

Hospital Exemptions

- Adding hospice services or swing beds[15] in a rural hospital, the total of which does not exceed one-half of its licensed beds;
- Converting licensed acute care hospital beds to Medicare and Medicaid certified skilled nursing beds in a rural hospital, as defined in s. 395.602, F.S., so long as the conversion of the beds does not involve the construction of new facilities;
- Adding hospital beds licensed under ch. 395, F.S., for comprehensive rehabilitation, the total of which may not exceed 10 total beds or 10 percent of the licensed capacity, whichever is greater;
- Establishing a Level II neonatal intensive care unit (NICU) if the unit has at least 10 beds, and if the hospital had a minimum of 1,500 births during the previous 12 months;
- Establishing a Level III NICU if the unit has at least 15 beds, and if the hospital had a Level II NICU and a minimum of at least 3,500 births during the previous 12 months;
- Establishing a Level III NICU if the unit has at least five beds, is a verified trauma center,[16] and has a Level II NICU;

[13] Tertiary health services include: pediatric cardiac catheterization, pediatric open-heart surgery, organ transplantation, neonatal intensive care units, comprehensive rehabilitation, medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service, heart transplantation, kidney transplantation, liver transplantation, bone marrow transplantation, lung transplantation, pancreas and islet cells transplantation, heart/lung transplantation, adult open heart surgery, neonatal and pediatric cardiac and vascular surgery, and pediatric oncology and hematology. See s. 408.032(17), F.S., and rule 59C-1.002(41), F.A.C.

[14] See s. 408.036(2), F.S.

[15] Section 395.602(2)(g), F.S., defines "swing bed" as a bed which can be used interchangeably as either a hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) bed pursuant to 42 C.F.R. parts 405, 435, 440, 442, and 447.

[16] Section 395.4001(14), F.S., defines "trauma center" as a hospital that has been verified by the Department of Health to be in substantial compliance with the requirements in s. 395.4025, F.S., and has been approved to operate as a Level I trauma center, Level II trauma center, or pediatric trauma center, or is designated as a Level II trauma center pursuant to s. 395.4025(14), F.S.

- Providing percutaneous coronary intervention for patients presenting with emergency myocardial infarctions in a hospital that does not have an approved adult open-heart-surgery program;[17]
- Adding mental health services or beds if the applicant commits to providing services to Medicaid or charity care patients as a level equal to or greater than the district average; and
- Establishing an adult open-heart surgery program in a hospital located within the boundaries of a health service planning district, which:[18]
  - Has experienced an annual net out-migration of at least 600 open heart surgery cases for three consecutive years; and
  - Has a population that exceeds the state average of population per licensed and operational open-heart programs by at least 25 percent.

Nursing Home Exemptions

- Adding nursing home beds at a skilled nursing facility that is part of a retirement community that provides a variety of residential settings and supportive services and that has been incorporated and operated in Florida for at least 65 years on or before July 1, 1994, if the nursing home beds are for the exclusive use of the community residents;
- Adding nursing home beds up to the lesser of 30 total beds or 25 percent of the current facility's beds when a nursing home is being replaced;
- Combining or dividing facilities with nursing home beds;
- Adding nursing home beds up to the greater of 10 beds (20 beds for a designated Gold Seal nursing home) or 10 percent of the number of beds at the licensed facility;
- Replacing a licensed nursing home on the same site or within five miles in the same sub-district if the new nursing home only has the lesser of 30 total beds or 25 percent of the current facility's beds; and
- Consolidating or combining of licensed nursing homes or transferring beds between licensed nursing homes with shared controlling interests within 30 miles and within the AHCA district where both nursing homes are located.

State-run Facility Exemptions

- Building an inmate health care facility that is for the exclusive use of the Department of Corrections (DOC);
- Adding mobile surgical facilities and related health care services under contract with the DOC or a private correctional facility;
- Constructing state veterans' nursing homes operated by or on behalf of the Florida Department of Veterans' Affairs or adding beds to such a facility;
- Adding beds in a state mental health facility or state mental health forensic facility; and
- Adding beds in state developmental disabilities centers.

[17] Id.
[18] This exemption is obsolete and is replaced by a licensure process under s. 408.0361, F.S.

Florida Health Choices Corporation, Inc.

In 2008, the Legislature created the Florida Health Choices Program to address the issue of Florida's uninsured.[19] The Legislature created the Florida Health Choices Corporation (corporation) to administer the program as a private, non-profit, corporation under s. 408.910, F.S. The corporation must operate in compliance with part III of chapter 112 (Public Officers and Employees) and chapters 119 (Public Records), 286 (Public Business), and 617 (Corporations Not for Profit), F.S.[20]

The corporation is led by a 15-member board of directors, three of whom are ex-officio, non-voting board members. Board members may not include insurers, health insurance agents or brokers, health care providers, health maintenance organizations (HMOs), prepaid service providers, or any other entity or affiliate or subsidiary of eligible vendors. Conflict of interest provisions govern board member participation.

The program is designed as a single, centralized marketplace for the purchase of health products, including, but not limited to, health insurance plans, HMO plans, prepaid services, and flexible spending accounts. Policies sold as part of the program are exempt from regulation under the Insurance Code and laws governing HMOs. The following entities are authorized to be eligible vendors:

- Insurers authorized under ch. 624, F.S., of the Insurance Code, such as self-insurers, indemnity plans, life and health insurers, church benefit plans, disability, and multi-employer welfare arrangements, and the Florida Healthy Kids Corporation;
- HMOs authorized under part I of ch. 641, F.S., relating to Health Service Programs, including health maintenance organization contracts, limited benefit policies, and other risk-bearing coverage, benefits, and products;
- Prepaid limited health service organizations and discount medical plans under ch. 636, F.S.;
- Prepaid health clinics licensed under part II, of ch. 641, F.S.;
- Health care providers, including hospitals and other licensed health facilities, health care clinics, pharmacies, licensed health care professionals, and other licensed health care providers;
- Provider organizations, including service networks, group practices, and professional associations; and
- Corporate entities providing specific health services.

The corporation's Florida Health Insurance Marketplace (marketplace) currently includes individual health plans, discount plans, and limited benefit plans.

The corporation is authorized to collect premiums and other payments from employers. The law further specifies who may participate as either an employer or an individual. Employers eligible to enroll include those that meet criteria established by the corporation along with their individual employees and other individuals meeting criteria established by the corporation.[21]

[19] *See* Chapter 2008-32, Laws of Fla.
[20] Section 408.910(11), F.S.
[21] Section 408.910(4)(a), F.S.

III. Effect of Proposed Changes:

SB 1144 amends s. 408.036, F.S., to create a new exemption to the CON process for any project subject to CON on the condition that the licensee commits to improve access to care for uninsured, low-income residents in its service district. In order to demonstrate such commitment, the facility must sign an agreement with the AHCA to:

- Provide, once the project is operational and at the end of the first four calendar quarters after the project becomes operational, an amount equal to 1.5 percent of gross revenues earned by the project to the AHCA to be deposited in the Public Medical Assistance Trust Fund;
- Provide, beginning in the fifth calendar quarter after the project becomes operational, charity care in an amount equal to or greater than the average for facilities in the same district that provide similar services; and
- Submit reports and data to the AHCA to monitor compliance with the charity care threshold.

The bill defines "charity care" as uncompensated care delivered to uninsured patients with incomes at or below 200 percent of federal poverty level[22] when preauthorized by the licensee and not subject to collection procedures. The bill specifies that the valuation of charity care must be based on Medicaid reimbursement rates.

If the licensee provides less charity care than required, the licensee must donate:

- Payments for charity care provided to residents of the service district pursuant to a written agreement with a charity care provider and equal to or greater than the difference between the value of the charity care provided by the licensee and the average among similar providers; or
- Payments to Florida Health Choices for health care coverage financial assistance that are equal to or greater than the difference between the value of the charity care provided and the district average among similar providers.

Such payments to Florida Health Choices must be made in increments sufficient to purchase silver-level health care coverage for an individual for at least one year. An individual receiving the assistance must have been uninsured during the previous 12 months. The licensee and Florida Health Choices must cooperate to identify individuals from the service district who are qualified to receive the available assistance.

The bill also establishes penalties for licensees that are noncompliant with the charity care requirements, as follows:

- For the first quarter of noncompliance, the fine is equal to twice the amount of the shortfall and is double for each subsequent quarter up to a maximum of four quarters.
- Following the fifth quarter of noncompliance, the AHCA is required to suspend the licensee's license until the licensee implements a corrective action plan approved by the AHCA.
- If the licensee fails to comply with the corrective action plan, the AHCA is required to revoke the licensee's license.

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[22] At 200 percent the required annual income equals between $23,540 for individuals and $81,780 for a family of eight, see https://www.healthcare.gov/glossary/federal-poverty-level-FPL/ (last visited on Jan. 27, 2016).

The bill has an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 1144 may have a positive fiscal impact on Florida residents that would qualify for any new charity care services generated by the provisions in the bill.

The bill may have an indeterminate impact on facilities that are subject to CON review. Such facilities will be able to avoid costs related to the CON process but may incur additional costs related to providing the required charity care or due to penalties assessed by the AHCA for not providing such care as required.

C. Government Sector Impact:

The AHCA has new duties under the bill which include entering into written agreements with licensees, monitoring compliance with the bill's charity care requirements, enforcing corrective action plans, and revoking licenses, if necessary. However, the number of licensees that may seek a CON exemption under the bill is indeterminate, which makes the fiscal impact indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 408.036 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

223842

LEGISLATIVE ACTION

Senate	.	House
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Appropriations Subcommittee on Health and Human Services (Richter) recommended the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Present paragraphs (a) through (t) of subsection
6 (3) of section 408.036, Florida Statutes, are redesignated as
7 paragraphs (c) through (v), respectively, new paragraphs (a) and
8 (b) are added to that subsection, present subsections (4) and
9 (5) of that section are redesignated as subsections (5) and (6),
10 respectively, and a new subsection (4) is added to that section,

223842

11 to read:
12 408.036 Projects subject to review; exemptions.—
13 (3) EXEMPTIONS.—Upon request, the following projects are
14 subject to exemption from the provisions of subsection (1):
15 (a) Except for projects described in paragraphs (b) and
16 (c), any project conditioned upon a significant, active, and
17 continuing commitment to improved access to care for uninsured
18 and low-income residents of the applicable service district.
19 Such commitment is demonstrated by compliance with the following
20 conditions and requirements which the project applicant must
21 accept in a signed agreement with the agency:
22 1. The project licensee must contribute, once the project
23 is operational and at the end of each of the first four calendar
24 quarters of the project's operations, an amount equal to 1.5
25 percent of the gross revenues earned by the exempt project.
26 Contributions shall be made to the agency and deposited in the
27 Public Medical Assistance Trust Fund.
28 2.a. Beginning in the fifth calendar quarter of the exempt
29 project's operations, the licensee must provide charity care in
30 an amount equal to twice the applicable district average among
31 licensed providers of similar services. For purposes of this
32 section, the term "charity care" means uncompensated care
33 delivered to uninsured patients having incomes at or below 200
34 percent of the federal poverty level when such services are
35 preauthorized by the licensee and not subject to collection
36 procedures. The valuation of charity care must be based on
37 Medicaid reimbursement rates.
38 b. Alternatively, if the licensee provides less charity
39 care than is required by sub-subparagraph a., the licensee must

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40 donate:
41 (I) Pursuant to a written agreement with a charity care
42 provider in the service district, payments for charity care
43 provided to residents of the service district in total amounts
44 equal to or greater than the difference between the value of the
45 charity care provided in sub-subparagraph a. and the applicable
46 district average among licensed providers of similar services;
47 or
48 (II) Payments to Florida Health Choices for health care
49 coverage financial assistance in total amounts equal to or
50 greater than the difference between the value of the charity
51 care provided in sub-subparagraph a. and the applicable district
52 average among licensed providers of similar services. The
53 payments for financial assistance must be made in increments
54 sufficient to purchase silver-level health care coverage for an
55 individual for at least 1 year. The individual receiving this
56 assistance must have been uninsured during the previous 12
57 months. The licensee and Florida Health Choices shall cooperate
58 to identify individuals from the service district who are
59 qualified to receive the available assistance.
60 c. The agreement between the agency and the applicant for
61 an exemption must require the licensee to submit reports and
62 data necessary to monitor compliance with the charity care
63 threshold.
64 (b) Any project to construct or establish a new skilled
65 nursing facility or increase the licensed bed capacity of an
66 existing skilled nursing facility conditioned on a significant,
67 active, and continuing commitment by the facility to improved
68 access to Medicaid long-term care services. Such commitment is

223842

69 demonstrated by an applicant by compliance with a signed
70 agreement between the applicant and the agency which, upon the
71 project becoming operational, requires the project licensee to
72 contribute an amount equal to the state share of one-fourth of
73 the cost of enrolling a person in the long-term care waiver
74 program established pursuant to Part IV of Chapter 409 times
75 twice the number of new beds included in the project. The
76 contribution shall be paid by the project licensee to the agency
77 at the end of each calendar quarter that the project is
78 operational and deposited in the Public Medical Assistance Trust
79 Fund. The agreement between the agency and the applicant must
80 require the licensee to submit reports and data necessary to
81 monitor compliance with the charity care threshold.
82 (4) PENALTIES.—A facility licensed based on the exemption
83 established in subsection (3)(a)-(b) is subject to the following
84 penalties for noncompliance with its specific commitment to
85 improve access to care for uninsured and low-income persons in
86 the service district:
87 (a) For the first quarter in which the value of services,
88 donations, and financial assistance falls below the specified
89 threshold, the fine is equal to twice the amount of the
90 shortfall. The fine is doubled in each subsequent quarter of
91 noncompliance up to a maximum of four quarters.
92 (b) Following a fifth quarter of noncompliance, the exempt
93 license shall be suspended until the licensee implements a
94 corrective action plan that the agency has approved.
95 (c) Failure by the facility to maintain compliance
96 following the implementation of a corrective action plan shall
97 result in revocation of the exempt license.

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98 Section 2. This act shall take effect July 1, 2016.
99
100 ================= T I T L E A M E N D M E N T ================
101 And the title is amended as follows:
102 Delete everything before the enacting clause
103 and insert:
104 A bill to be entitled
105 An act relating to certificates of need for health
106 care-related projects; amending s. 408.036, F.S.;
107 providing an exemption from certificate of need review
108 for certain health care-related projects; specifying
109 conditions and requirements for the exemption;
110 requiring that project applicants enter into an
111 agreement with the Agency for Health Care
112 Administration as a condition of eligibility for the
113 exemption; requiring specified monetary contributions;
114 providing penalties for failure to comply with the
115 terms of the agreement; providing an effective date.

492782

LEGISLATIVE ACTION

Senate	.	House
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Appropriations Subcommittee on Health and Human Services (Richter) recommended the following:

1 **Senate Amendment to Amendment (223842)**

2

3 Delete lines 15 - 16

4 and insert:

5 (a) Except for projects described in paragraph (b), any

6 project conditioned upon a significant, active, and

By Senator Gaetz

1 A bill to be entitled
2 An act relating to certificates of need for health
3 care-related projects; amending s. 408.036, F.S.;
4 providing an exemption from certificate of need review
5 for certain health care-related projects; specifying
6 conditions and requirements for the exemption;
7 requiring a certain agreement between the project
8 applicant and the Agency for Health Care
9 Administration; providing penalties for failure to
10 comply with certain requirements for an exemption to a
11 certificate of need review; providing an effective
12 date.
13
14 Be It Enacted by the Legislature of the State of Florida:
15
16 Section 1. Present paragraphs (a) through (t) of subsection
17 (3) of section 408.036, Florida Statutes, are redesignated as
18 paragraphs (b) through (u), respectively, a new paragraph (a) is
19 added to that subsection, present subsections (4) and (5) of
20 that section are redesignated as subsections (5) and (6),
21 respectively, and a new subsection (4) is added to that section,
22 to read:
23 408.036 Projects subject to review; exemptions.—
24 (3) EXEMPTIONS.—Upon request, the following projects are
25 subject to exemption from the provisions of subsection (1):
26 (a) Any project conditioned upon a significant, active, and
27 continuing commitment to improved access to care for uninsured
28 and low-income residents of the applicable service district.
29 Such commitment is demonstrated by compliance with the following
30 conditions and requirements which the project applicant must
31 accept in a signed agreement with the agency:
32 1. The project licensee must contribute, once the project

33 is operational and at the end of each of the first four calendar
34 quarters of the project's operations, an amount equal to 1.5
35 percent of the gross revenues earned by the exempt project.
36 Contributions shall be made to the agency and deposited in the
37 Public Medical Assistance Trust Fund.
38 2.a. Beginning in the fifth calendar quarter of the exempt
39 project's operations, the licensee must provide charity care in
40 an amount equal to or greater than the applicable district
41 average among licensed providers of similar services. For
42 purposes of this section, the term "charity care" means
43 uncompensated care delivered to uninsured patients having
44 incomes at or below 200 percent of the federal poverty level
45 when such services are preauthorized by the licensee and not
46 subject to collection procedures. The valuation of charity care
47 must be based on Medicaid reimbursement rates.
48 b. Alternatively, if the licensee provides less charity
49 care than is required by sub-subparagraph a., the licensee must
50 donate:
51 (I) Pursuant to a written agreement with a charity care
52 provider in the service district, payments for charity care
53 provided to residents of the service district in total amounts
54 equal to or greater than the difference between the value of the
55 charity care provided in sub-subparagraph a. and the applicable
56 district average among licensed providers of similar services;
57 or
58 (II) Payments to Florida Health Choices for health care
59 coverage financial assistance in total amounts equal to or
60 greater than the difference between the value of the charity
61 care provided in sub-subparagraph a. and the applicable district

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62 average among licensed providers of similar services. The
63 payments for financial assistance must be made in increments
64 sufficient to purchase silver-level health care coverage for an
65 individual for at least 1 year. The individual receiving this
66 assistance must have been uninsured during the previous 12
67 months. The licensee and Florida Health Choices shall cooperate
68 to identify individuals from the service district who are
69 qualified to receive the available assistance.
70 c. The agreement between the agency and the applicant for
71 an exemption must require the licensee to submit reports and
72 data necessary to monitor compliance with the charity care
73 threshold.
74 (4) PENALTIES.—A facility licensed based on the exemption
75 established in subsection (3)(a) is subject to the following
76 penalties for noncompliance with its specific commitment to
77 improve access to care for uninsured and low-income persons in
78 the service district:
79 (a) For the first quarter in which the value of services,
80 donations, and financial assistance falls below the specified
81 threshold, the fine is equal to twice the amount of the
82 shortfall. The fine is doubled in each subsequent quarter of
83 noncompliance up to a maximum of four quarters.
84 (b) Following a fifth quarter of noncompliance, the exempt
85 license shall be suspended until the licensee implements a
86 corrective action plan that the agency has approved.
87 (c) Failure by the facility to maintain compliance
88 following the implementation of a corrective action plan shall
89 result in revocation of the exempt license.
90 Section 2. This act shall take effect July 1, 2016.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR DON GAETZ
1st District

COMMITTEES:
Appropriations Subcommittee on Education, *Chair*
Appropriations
Education Pre-K - 12
Ethics and Elections
Health Policy
Higher Education
Rules

SENATE APPROPRIATIONS RECEIVED
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STAFF DIR. ____ STAFF ____

Committee Request

To: Senator Rene Garcia, Chair
Appropriations Subcommittee on Health and Human Services

Subject: Committee Agenda Request

Date: January 27, 2016

I respectfully request that Senate Bill 212, Ambulatory Surgical Centers, be placed on the agenda for the Appropriations Subcommittee on Health and Human Services at your convenience. Thank you for your time and consideration.

Respectfully,

Senator Don Gaetz

REPLY TO:
- ☐ 4300 Legendary Drive, Suite 230, Destin, FL 32541 (850) 897-5747 FAX: (888) 263-2259
- ☐ 420 Senate Office Building, 404 South Monroe Street, Tallahassee, FL 32399-1100 (850) 487-5001
- ☐ 5230 West U.S. Highway 98, Administration Building, 2nd Floor, Panama City, FL 32401 (850) 747-5856

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: CS/SB 212

INTRODUCER: Health Policy Committee and Senator Gaetz

SUBJECT: Ambulatory Surgical Centers

DATE: February 9, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Fav/CS**
2.	Brown	Pigott	AHS	**Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 212 allows patients in an ambulatory surgical center (ASC) to stay in the center for up to 24 hours. Current law requires that patients in an ASC be discharged on the same working day and restricts patients from staying overnight in an ASC.

The bill also requires, as a condition of licensure, that an ASC must provide services to Medicaid and Medicare patients and to patients who qualify for charity care. The bill defines "charity care" as uncompensated care delivered to uninsured patients having incomes at or below 200 percent of the federal poverty level when such services are preauthorized by the licensee and not subject to collection procedures.

The bill is not estimated to have a fiscal impact on state government.

The bill has an effective date of July 1, 2016.

II. Present Situation:

Ambulatory Surgical Centers

An ASC is a facility, that is not a part of a hospital, with a primary purpose to provide elective surgical care, in which the patient is admitted and discharged within the same working day and is not permitted to stay overnight.[1]

In Florida, ambulatory procedures are performed in two settings, hospital-based outpatient facilities and freestanding ASCs. Currently, there are 431 licensed ASCs in Florida.[2] Of these, 413 are Medicare and/or Medicaid certified, and 381 are accredited by either the Accreditation Association for Ambulatory Health Care (AAAHC) or by the Joint Commission.[3] In 2008, Medicare paid for 39.1 percent of all procedures performed in ASCs while Medicaid paid for 5.6 percent and commercial payers paid for 46.6 percent.

Between April 2014 and March 2015, there were 2,933,433 visits to ASCs or hospital outpatient facilities in Florida.[4] Hospital outpatient facilities accounted for 31 percent and free standing ASCs accounted for 59 percent. Freestanding ASC average charges range from $2,930 to $7,333 and hospital outpatient facility average charges range from $7,727 to $26,034 for the same time period.[5] Two of the most popular procedures that are performed on adults at an ASC include cataract procedures with 249,184 performed and colonoscopies with 218,745 performed, also during the same time period.[6]

In a survey of ASC research and literature, the Office of Program Policy Analysis and Government Accountability (OPPAGA) found that, generally, the impact on hospitals from competition from ASCs was limited and that ASCs can result in cost savings when performing certain procedures. Additionally, the OPPAGA did not identify any patterns associated with access to services in ASCs and found that the studies largely agree that ASCs, in general, provide timely service and had low rates of unexpected adverse safety events.[7]

[1] Section 395.002(3), F.S, defines "Ambulatory surgical center" or "mobile surgical facility" to mean a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003, F.S. Any structure or vehicle in which a physician maintains an office and practices surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, shall be construed to be a mobile surgical facility.
[2] See AHCA presentation on Ambulatory Surgical Centers, slide 10, presented to the Health Policy Committee on June 10, 2015, (on file with the Senate Committee on Health Policy).
[3] Id.
[4] Agency for Health Care Administration, Florida Health Finder Search, http://www.floridahealthfinder.gov/CompareCare/CompareFacilities.aspx (last viewed January 14, 2016).
[5] Id.
[6] Id.
[7] Ambulatory Surgical Centers and Recovery Care Centers, OPPAGA, January 19, 2016, on file with Senate Health Policy Committee staff.

ASC Licensure

ASCs are licensed and regulated by the AHCA under the same regulatory framework as hospitals.[8] Applicants for ASC licensure must submit certain information to the AHCA prior to accepting patients for care or treatment, including registration of articles of incorporation and a zoning certificate or proof of compliance with zoning requirements.[9]

Upon receipt of an initial application, the AHCA is required to conduct a survey to determine compliance with all laws and rules. ASCs are required to provide certain information during the initial inspection, including:

- The governing body's bylaws, rules, and regulations;
- The roster of registered nurses and licensed practical nurses with current license numbers;
- A fire plan; and
- A comprehensive emergency management plan.[10]

Rules for ASCs

Pursuant to s. 395.1055, F.S., the AHCA is authorized to adopt rules for hospitals and ASCs. Separate standards may be provided for general and specialty hospitals, ASCs, and statutory rural hospitals, but the rules for all hospitals and ASCs must include minimum standards for ensuring that:

- A sufficient number of qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care;
- Infection control, housekeeping, sanitary conditions, and medical record procedures are established and implemented to adequately protect patients;
- A comprehensive emergency management plan is prepared and updated annually;
- A licensed facility is established, organized, and operated consistent with established standards and rules; and
- A licensed facility conforms to minimum space, equipment, and furnishing standards for the beds in the facility.

AHCA rule ch. 59A-5, F.A.C., implements the minimum standards for ASCs. Those rules also require policies and procedures to ensure the protection of patient rights.

Staff and Personnel Rules

ASCs are required to have written policies and procedures for surgical services, anesthesia services, nursing services, pharmaceutical services, laboratory services, and radiologic services. In providing these services, ACSs are required to have certain professional staff available, including:

- A qualified person responsible for the daily functioning and maintenance of the surgical suite;
- An anesthesiologist, physician, a certified registered nurse anesthetist under the on-site medical direction of a licensed physician, or an anesthesiologist assistant under the direct

[8] Sections 395.001-395.1065, F.S., and Part II, Chapter 408, F.S.
[9] Rule 59A-5.003(4), F.A.C.
[10] Rule 59A-5.003(5), F.A.C.

supervision of an anesthesiologist who must be in the ASC during the anesthesia and post-anesthesia recovery period until all patients are alert or discharged;
- A registered professional nurse who is responsible for coordinating and supervising all nursing services;
- A registered professional circulating nurse for a patient during that patient's surgical procedure; and
- A registered professional nurse who must be in the recovery area at all times when any patients are present.[11]

Infection Control Rules

ASCs are required to establish an infection control program involving members of the medical, nursing, and administrative staff. The program must include written policies and procedures reflecting the scope of the infection control program. The written policies and procedures must be reviewed at least every two years by the infection control program members. The infection control program must include:
- Surveillance, prevention, and control of infection among patients and personnel;
- A system for identifying, reporting, evaluating and maintaining records of infections;
- Ongoing review and evaluation of aseptic, isolation, and sanitation techniques employed by the ASC; and
- Development and coordination of training programs in infection control for all personnel.[12]

Emergency Management Plan Rules

ASCs are required to develop and adopt a written comprehensive emergency management plan for emergency care during an internal or external disaster or emergency. The ASC must review the plan and update it annually.[13]

Accreditation

ASCs may seek voluntary accreditation by the Joint Commission or the AAAHC. The AHCA is required to conduct an annual licensure inspection survey for non-accredited ASCs. The AHCA is authorized to accept survey reports of accredited ASCs from accrediting organizations if the standards included in the survey report are determined to document that the ASC is in substantial compliance with state licensure requirements. The AHCA is required to conduct annual validation inspections on a minimum of five percent of the ASCs which were inspected by an accreditation organization.[14]

AHCA is required to conduct annual life safety inspections of all ASCs to ensure compliance with life safety codes and disaster preparedness requirements. However, the life-safety inspection may be waived if an accreditation inspection was conducted on an ASC by a certified life safety inspector and the ASC was found to be in compliance with the life safety requirements.[15]

[11] Rule 59A-5.0085, F.A.C.
[12] Rule 59A-5.011, F.A.C.
[13] Rule 59A-5.018, F.A.C.
[14] Rule 59A-5.004, F.A.C.
[15] Id.

Medicare Requirements

ASCs are required to have an agreement with the federal Centers for Medicare & Medicaid Services (CMS) in order to participate in Medicare. ASCs are also required to comply with specific conditions for coverage. CMS defines "ASC" as any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission.[16]

CMS may deem an ASC to be in compliance with all of the conditions for coverage if the ASC is accredited by a national accrediting body, or licensed by a state agency, and CMS determines that such accreditation or licensure provides reasonable assurance that the conditions for coverage are met.[17] All of the CMS conditions for coverage requirements are specifically required in AHCA rule ch. 59A-5, F.A.C., and apply to all ASCs in Florida. The conditions for coverage require ASCs to have:

- A governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation;
- A quality assessment and performance improvement program;
- A transfer agreement with one or more acute care general hospitals, which will admit any patient referred who requires continuing care;
- A disaster preparedness plan;
- An organized medical staff;
- A fire control plan;
- A sanitary environment;
- An infection control program; and
- A procedure for patient admission, assessment, and discharge.

III. Effect of Proposed Changes:

The bill amends the definition of "ambulatory surgical center" in s. 395.002, F.S., to allow a patient to be admitted and discharged from an ASC within 24 hours. Current law requires that patients be discharged from an ASC within the same working day and restricts patients from staying at an ASC overnight.

The bill also amends s. 395.003, F.S., to require, as a condition of licensure, that ASCs provide services to Medicaid and Medicare patients and to patients who qualify for charity care. The bill defines "charity care" as uncompensated care delivered to uninsured patients having incomes at or below 200 percent of the federal poverty level when such services are preauthorized by the licensee and not subject to collection procedures.

The bill also includes conforming changes for statutory cross-references.

The bill establishes an effective date of July 1, 2016.

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[16] 42 C.F.R. §416.2

[17] 42 C.F.R. §416.26(a)(1)

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CS/SB 212 may have an indeterminate positive fiscal impact on patients in Florida who are able to have a surgical procedure performed in an ASC if the costs are less in these settings than in a hospital.

The bill may have an indeterminate negative fiscal impact on hospitals if more patients choose to have their procedures performed in an ASC rather than in a hospital.

The bill may have a negative fiscal impact on ASCs that are required to provide services to Medicare and Medicaid patients as well as patients who qualify for charity care if the ASCs do not currently provide such services.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.002 and 395.003.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on January 19, 2016:
The CS amends SB 212 to remove all provisions of the bill except a change to the definition of "ambulatory surgical center" which allows patients to recover in an ASC for 24 hours, rather than requiring that patients be released on the same business day. The CS also requires that ASCs provide services to Medicaid and Medicare patients as well as patients who qualify for charity care. The CS defines "charity care" as uncompensated care delivered to uninsured patients having incomes at or below 200 percent of the federal poverty level when such services are preauthorized by the licensee and not subject to collection procedures.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By the Committee on Health Policy; and Senator Gaetz

588-02302-16 2016212c1

A bill to be entitled

An act relating to ambulatory surgical centers; amending s. 395.002, F.S.; revising the definition of the term “ambulatory surgical center” or “mobile surgical facility”; amending s. 395.003, F.S.; requiring, as a condition of licensure and license renewal, that ambulatory surgical centers provide services to specified patients; defining a term; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (3) of section 395.002, Florida Statutes, is amended to read:

395.002 Definitions.—As used in this chapter:

(3) “Ambulatory surgical center” or “mobile surgical facility” means a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within 24 hours ~~the same working day and is not permitted to stay overnight~~, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003. Any structure or vehicle in which a physician maintains an office and practices surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, shall be construed to be a mobile surgical

facility.

Section 2. Present subsections (6) through (10) of section 395.003, Florida Statutes, are redesignated as subsections (7) through (11), respectively, a new subsection (6) is added to that section, and present subsections (9) and (10) of that section are amended, to read:

395.003 Licensure; denial, suspension, and revocation.—

(6) An ambulatory surgical center, as a condition of initial licensure and license renewal, must provide services to Medicare patients, Medicaid patients, and patients who qualify for charity care. For the purposes of this subsection, “charity care” means uncompensated care delivered to uninsured patients with incomes at or below 200 percent of the federal poverty level when such services are preauthorized by the licensee and not subject to collection procedures.

(10)~~(9)~~ A hospital licensed as of June 1, 2004, shall be exempt from subsection (9) ~~subsection (8)~~ as long as the hospital maintains the same ownership, facility street address, and range of services that were in existence on June 1, 2004. Any transfer of beds, or other agreements that result in the establishment of a hospital or hospital services within the intent of this section, shall be subject to subsection (9) ~~subsection (8)~~. Unless the hospital is otherwise exempt under subsection (9) ~~subsection (8)~~, the agency shall deny or revoke the license of a hospital that violates any of the criteria set forth in that subsection.

(11)~~(10)~~ The agency may adopt rules implementing the licensure requirements set forth in subsection (9) ~~subsection (8)~~. Within 14 days after rendering its decision on a license

588-02302-16 2016212c1

62 application or revocation, the agency shall publish its proposed
63 decision in the Florida Administrative Register. Within 21 days
64 after publication of the agency's decision, any authorized
65 person may file a request for an administrative hearing. In
66 administrative proceedings challenging the approval, denial, or
67 revocation of a license pursuant to <u>subsection (9)</u> ~~subsection~~
68 ~~(8)~~, the hearing must be based on the facts and law existing at
69 the time of the agency's proposed agency action. Existing
70 hospitals may initiate or intervene in an administrative hearing
71 to approve, deny, or revoke licensure under <u>subsection (9)</u>
72 ~~subsection (8)~~ based upon a showing that an established program
73 will be substantially affected by the issuance or renewal of a
74 license to a hospital within the same district or service area.
75 Section 3. This act shall take effect July 1, 2016.

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on Transportation, Tourism, and Economic Development, *Chair*
Appropriations
Commerce and Tourism
Governmental Oversight and Accountability
Regulated Industries
Rules

SENATOR JACK LATVALA
20th District

February 2, 2016

The Honorable Rene Garcia, Chair
Senate Appropriations Subcommittee on Health and Human Services
201 The Capitol
404 South Monroe Street
Tallahassee, FL 32399-1100

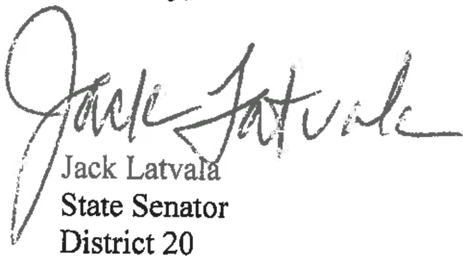
Dear Chairman Garcia:

I respectfully request consideration of Senate Bill 818/Instruction on Human Trafficking by the Senate Appropriations Subcommittee on Health and Human Services at your earliest convenience.

This bill requires that certain licensing boards must require specified licensees to complete a continuing education course containing instruction on human trafficking as a condition of relicensure or recertification.

If you have any questions regarding this legislation, please contact me. This bill favorable passed the Senate Committee on Health Policy unanimously. Thank you in advance for your consideration.

Sincerely,



Jack Latvala
State Senator
District 20

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☐ 408 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5020

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ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: CS/SB 818

INTRODUCER: Health Policy Committee and Senator Latvala and others

SUBJECT: Instruction on Human Trafficking

DATE: February 9, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Stovall	HP	**Fav/CS**
2.	Brown	Pigott	AHS	**Favorable**
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 818 requires allopathic and osteopath physicians, physician assistants, anesthesiology assistants, nurses, dentists, dental hygienists, dental lab personnel, psychologists, social workers, mental health counselors, and marriage and family therapists to complete two hours of continuing medical education (CE) on domestic violence and human trafficking, approved by the respective board, every third biennial re-licensure or recertification cycle. The bill sets requirements for the course content, reporting requirements, and penalties for failure to comply with the CE requirements. The bill grants the boards authority to adopt rules to implement the requirement.

The Department of Health (DOH) indicates that the cost of implementing the bill can be absorbed within existing resources.

The effective date of the bill is July 1, 2016.

II. Present Situation:

Section 456.031, F.S., requires allopathic and osteopath physicians, physician assistants, anesthesiology assistants, nurses, dentists, dental hygienists, dental lab personnel, psychologists, social workers, mental health counselors, and marriage and family therapists licensed under chs. 458, 459, Part I of chs. 464, 466, 490 and 491, F.S., to obtain two hours of CE on domestic

violence every third biennium, or every six years. The law allows each board to approve equivalent courses to satisfy this requirement. Reporting of CE hours is mandatory for these professions through the licensee's CE Broker account.

Florida law defines "domestic violence" as any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member.[1]

Section 456.031, F.S., sets out the required CE course content for domestic violence, as follows:

- Data and information on the number of patients in that professional's practice who are likely to be victims of domestic violence;
- The number who are likely to be perpetrators of domestic violence;
- Screening procedures for determining whether a patient has any history of being either a victim or a perpetrator of domestic violence; and
- Instruction on how to provide patients with information on resources in the local community, such as domestic violence centers and other advocacy groups, that provide legal aid, shelter, victim counseling, batterer counseling, or child protection services.

Florida law defines "human trafficking" to mean transporting, soliciting, recruiting, harboring, providing, enticing, maintaining, or obtaining another person for the purpose of exploitation of that person.[2]

Currently there is no requirement for an allopathic and osteopath physicians, physician assistants, anesthesiology assistants, nurses, dentists, dental hygienists, dental lab personnel, psychologists, social workers, mental health counselors, or marriage and family therapists, to complete any CEs on human trafficking, either at initial licensure or renewal.

According to the Department of Health's Division of Medical Quality Assurance (MQA) Annual Report and Long Range Plan for Fiscal Year 2014-2015, there are 48,941 in-state allopathic physicians,[3] 6,216 osteopathic physicians,[4] 6,744 physician assistants, 197 anesthesiologist assistants, 304,666 nurses,[5] 10,981 dentists, 11,589 dental hygienists, 1,023 dental lab personnel, 5,086 psychologists, 7,971 social workers, 9,054 mental health counselors and 1,667 marriage and family therapists holding active licenses in Florida.[6]

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[1] *See* s. 741.28, F.S.

[2] *See* s. 787.06(2)(d), F.S.

[3] Florida Dep't of Health, Division of Medical Quality Assurance, *Annual Report and Long Range Plan Fiscal Year 2014-2015,* p. 11-13, *available at* http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-1415.pdf, (last visited Jan. 26, 2016). The 48,941 active allopathic physicians includes: 226 house physicians; 146 limited license physicians; 335 critical need physicians, 8 medical expert physicians, 1 Mayo Clinic limited license physician; 40 medical facility physicians; 2 public health physicians; and 1 public psychiatry physician.

[4] *Id*. The 7216 osteopathic physicians includes 5,264 osteopathic physicians, 5 osteopathic limited license physicians, and 2 osteopathic expert physicians.

[5] *Id.* The 304,566 nurses includes 18,250 ARNPs, 26 ARNP/CNS, 131 CNS, 217,315 RNs, and 68,844 LPNs,

[6] *See* supra note 3.

III. Effect of Proposed Changes:

The bill amends s. 456.031, F.S., to require allopathic and osteopath physicians, physician assistants, anesthesiology assistants, nurses, dentists, dental hygienists, dental lab personnel, psychologists, social workers, mental health counselors, and marriage and family therapists to complete two hours of CE on domestic violence and human trafficking as part of every third biennial license renewal, which is every six years. The course content for domestic violence remains unchanged.

The bill sets out the required course content for the human trafficking portion of the course as follows:

- Data and information on the types and extent of labor and sex trafficking;
- Factors that place a person at greater risk of being a trafficking victim;
- Patient safety and security;
- Management of medical records of patients who are trafficking victims;
- Public and private social services available for rescue, food, clothing, and shelter referrals;
- Hotlines for reporting human trafficking maintained by the National Human Trafficking Resource Center and the U.S. Department of Homeland Security;
- Validated assessment tools for the identification of trafficking victims;
- General indicators that a person may be a victim of human trafficking;
- Procedures for sharing information related to human trafficking with a patient; and
- Referral options for legal and social services as appropriate.

Confirmation of completing the CE hours is due when submitting fees for every third biennial re-licensure or recertification. The form of the confirmation is left to the discretion of the respective board.[7] The board may approve equivalent courses to satisfy this statute's requirements. The two CE hours on domestic violence and human trafficking may be included in the total CE hours required by the profession, unless the CE requirement for the profession is less than 30 hours biennially. A person holding two or more licenses under this section may satisfy the CE requirements for each license upon proof of completion of one, two-hour, course during the time frame.

The bill provides for disciplinary action under s. 456.072(1)(k), F.S., for failure to comply with the CE requirements and requires the respective board to include completion of a board-approved course as part of any discipline imposed. The bill allows each board to adopt rules to carry out this statute.

The bill has an effective date of July 1, 2016.

[7] See The Department of Health, *Continuing Education – CE,* http://www.floridahealth.gov/licensing-and-regulation/ce.html, (last visited Jan. 22, 2016). Currently, the DOH requires all licensees to report all CEs at the time of renewal through the department's electronic tracking system. It happens automatically when a licensee attempts to renew his or her license. If the licensee's CE records are complete, they will be able to renew without interruption. If the licensee's CE records are not complete, they will be prompted to enter their remaining CE hours before proceeding with their license renewal.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Licensees listed in s. 456.031, F.S., are required to complete a two-hour course on domestic violence every six years. Under CS/SB 818, they may incur additional costs to satisfy the requirement after human trafficking is added to the required subject matter, if the cost of the course is increased accordingly.

C. Government Sector Impact:

The boards will incur costs for rulemaking. The DOH and boards will incur costs for handling complaints and discipline. The DOH has indicated that these costs can be absorbed within existing resources.[8]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 456.031 of the Florida Statutes.

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[8] *See* Florida Dep't of Health, *Senate Bill 818 Analysis,* p. 46, (Nov. 16, 2015) (on file with the Senate Committee on Health Policy).

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on January 26, 2016:
The committee substitute deletes the creation of new s. 456.0315, F.S., on CEs for human trafficking. It amends existing s. 456.031, F.S., on domestic violence CEs, and adds human trafficking to the required domestic violence CE, making the required course a 2-hour course on both domestic violence and human trafficking due every third biennium. It also increases the number of professions required to take the CEs to all those listed in s. 456.031, F.S.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By the Committee on Health Policy; and Senators Latvala and Sobel

588-02621-16 2016818c1

1 A bill to be entitled
2 An act relating to instruction on human trafficking;
3 amending s. 456.031, F.S.; providing that certain
4 licensing boards must require specified licensees to
5 complete a specified continuing education course that
6 includes a section on human trafficking as a condition
7 of relicensure or recertification; providing
8 requirements and procedures related to the course;
9 providing an effective date.
10
11 Be It Enacted by the Legislature of the State of Florida:
12
13 Section 1. Section 456.031, Florida Statutes, is amended to
14 read:
15 456.031 Requirement for instruction on domestic violence
16 and human trafficking.—
17 (1)(a) The appropriate board shall require each person
18 licensed or certified under chapter 458, chapter 459, part I of
19 chapter 464, chapter 466, chapter 467, chapter 490, or chapter
20 491 to complete a 2-hour continuing education course, approved
21 by the board, on domestic violence, as defined in s. 741.28, and
22 on human trafficking, as defined in s. 787.06(2), as part of
23 every third biennial relicensure or recertification.
24 1. The domestic violence section of the course must ~~shall~~
25 consist of data and information on the number of patients in
26 that professional's practice who are likely to be victims of
27 domestic violence and the number who are likely to be
28 perpetrators of domestic violence, screening procedures for
29 determining whether a patient has any history of being either a
30 victim or a perpetrator of domestic violence, and instruction on
31 how to provide such patients with information on, or how to

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32 refer such patients to, resources in the local community, such
33 as domestic violence centers and other advocacy groups, that
34 provide legal aid, shelter, victim counseling, batterer
35 counseling, or child protection services.
36 2. The human trafficking section of the course must consist
37 of data and information on the types of human trafficking, such
38 as labor and sex, and the extent of human trafficking; factors
39 that place a person at greater risk for being a victim of human
40 trafficking; management of medical records of patients who are
41 human trafficking victims; patient safety and security; public
42 and private social services available for rescue, food,
43 clothing, and shelter referrals; hotlines for reporting human
44 trafficking maintained by the National Human Trafficking
45 Resource Center and the United States Department of Homeland
46 Security; validated assessment tools for identifying human
47 trafficking victims and general indicators that a person may be
48 a victim of human trafficking; procedures for sharing
49 information related to human trafficking with a patient; and
50 referral options for legal and social services.
51 (b) Each ~~such~~ licensee or certificateholder shall submit
52 confirmation of having completed the continuing education ~~such~~
53 course, on a form provided by the board, when submitting fees
54 for every third biennial relicensure or recertification ~~renewal~~.
55 (c) The board may approve additional equivalent courses
56 that may be used to satisfy the requirements of paragraph (a).
57 Each licensing board that requires a licensee to complete a
58 continuing ~~an~~ educational course pursuant to this subsection may
59 include the hour required for completion of the course in the
60 total hours of continuing education required by law for the ~~such~~

61 profession, unless the continuing education requirements for the
62 ~~such~~ profession consist of fewer than 30 hours of continuing
63 education biennially.
64 (d) Any person holding two or more licenses subject to ~~the~~
65 ~~provisions of~~ this subsection shall be permitted to show proof
66 of completion of ~~having taken~~ one board-approved course on
67 domestic violence and human trafficking, for purposes of
68 relicensure or recertification for additional licenses.
69 (e) Failure to comply with the requirements of this
70 subsection shall constitute grounds for disciplinary action
71 under each respective practice act and under s. 456.072(1)(k).
72 In addition to discipline by the board, the licensee shall be
73 required to complete the board-approved ~~such~~ course under this
74 subsection.
75 (2) Each board may adopt rules to carry out the provisions
76 of this section.
77 Section 2. This act shall take effect July 1, 2016.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: SB 1336

INTRODUCER: Senator Latvala

SUBJECT: Behavioral Health Care Services

DATE: February 9, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Crosier	Hendon	CF	**Favorable**
2.	Brown	Pigott	AHS	**Favorable**
3.			AP	

I. Summary:

SB 1336 addresses Florida's system for the delivery of behavioral health services when persons with complex, persistent, and co-occurring mental health and substance dependency disorders obtain services.

The bill directs behavioral health managing entities[1] (MEs) to develop a plan with each county or circuit in its geographic area to ensure all persons with mental health or substance use disorders subject to involuntary admission receive prompt assessment of their needs for evaluation and treatment. MEs are to develop a transportation plan for each county or circuit within its assigned region in consultation with county officials, law enforcement agencies, and local acute care providers.

The criteria for involuntary admission, stabilization, and treatment of persons with substance use or mental health disorders are revised. Additionally, the bill specifies certain professionals who are authorized to execute a certificate for emergency admission. The bill prohibits the courts from charging a filing fee for a petition for involuntary assessment and stabilization.

The bill creates the "Jennifer Act" which addresses the use of mental health and substance abuse treatment advance directives, which includes the allowable provisions, the process for the execution and revocation of such directives, and a suggested form to be used.

The bill's fiscal impact is indeterminate.

[1] *See* s. 394.9082, F.S. A managing entity is a not-for-profit corporation organized in Florida which is under contract with the Dept. of Children and Families on a regional basis to manage the day-to-day operational delivery of behavioral health services through an organized system of care and a network of providers who are contracted with the managing entity to provide a comprehensive array of emergency, acute care, residential, outpatient, recovery support, and consumer support services related to behavioral health.

The bill has an effective date of July 1, 2016.

II. Present Situation:

Mental Health and Substance Abuse

Mental illness creates enormous social and economic costs.[2] Unemployment rates for persons with mental disorders are high relative to the overall population.[3] People with severe mental illness have exceptionally high rates of unemployment, between 60 percent and 100 percent.[4] Mental illness increases a person's risk of homelessness in America threefold.[5] Studies show that approximately 33 percent of our nation's homeless live with a serious mental disorder, such as schizophrenia, for which they are not receiving treatment.[6] Often the combination of homelessness and mental illness leads to incarceration, which further decreases a person's chance of receiving proper treatment and leads to future re-offenses.[7]

According to the National Alliance on Mental Illness (NAMI), approximately 50 percent of individuals with severe mental health disorders are affected by substance abuse.[8] NAMI also estimates that 29 percent of all people diagnosed as mentally ill abuse alcohol or other drugs.[9] When mental health disorders are left untreated, substance abuse is likely to increase. When substance abuse increases, mental health symptoms often increase as well or new symptoms may be triggered. This could also be due to discontinuation of taking prescribed medications or the contraindications for substance abuse and mental health medications. When taken with other medications, mental health medications can become less effective.[10]

Behavioral Health Managing Entities

In 2008, the Legislature required the Department of Children and Families (DCF) to implement a system of behavioral health managing entities that would serve as regional agencies to manage and pay for mental health and substance abuse services.[11] Prior to this time, the DCF, through its regional offices, contracted directly with behavioral health service providers. The Legislature found that a management structure that places the responsibility for publicly-financed behavioral health treatment and prevention services within a single private, nonprofit entity at the local level, would promote improved access to care, promote service continuity, and provide for more

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[2] Mental Illness: The Invisible Menace, *Economic Impact* http://www.mentalmenace.com/economicimpact.php
[3] Mental Illness: The Invisible Menace, *More impacts and facts* http://www.mentalmenace.com/impactsfacts.php
[4] *Id.*
[5] Family Guidance Center, *How does Mental Illness Impact Rates of Homelessness?* (February 4, 2014) *available at* http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/
[6] *Id.*
[7] *Id.*
[8] Donna M. White, LPCI, CACP, Psych Central.com, *Living with Co-Occurring Mental & Substance Abuse Disorders,* (October 2, 2013) *available at* http://psychcentral.com/blog/archives/2013/10/02/living-with-co-occurring-mental-substance-abuse-disorders/
[9] *Id.*
[10] *Id.*
[11] *See* s. 394.9082, F.S., as created by Chapter 2008-243, Laws of Fla.

efficient and effective delivery of substance abuse and mental health services. There are currently seven managing entities across the state.[12]

Baker Act

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.[13] The Baker Act authorizes treatment programs for mental, emotional, and behavioral disorders. The Baker Act requires programs to include comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short-term and continued treatment to facilitate recovery. Additionally, the Baker Act provides protections and rights to individuals examined or treated for mental illness. Legal procedures are addressed for mental health examination and treatment, including voluntary admission, involuntary admission, involuntary inpatient treatment, and involuntary outpatient treatment.

Marchman Act

In 1993, the Legislature adopted the Hal S. Marchman Alcohol and Other Drug Services Act. The Marchman Act provides a comprehensive continuum of accessible and quality substance abuse prevention, intervention, clinical treatment, and recovery support services. Services must be provided in the least restrictive environment to promote long-term recovery. The Marchman Act includes various protections and rights of patients served.

Transportation to a Facility

The Marchman Act authorizes an applicant seeking to have a person admitted to a facility, the person's spouse or guardian, a law enforcement officer, or a health officer to transport the individual for an emergency assessment and stabilization.[14]

The Baker Act requires each county to designate a single law enforcement agency to transfer the person in need of services. If the person is in custody based on noncriminal or minor criminal behavior, the law enforcement officer will transport the person to the nearest receiving facility. If, however, the person is arrested for a felony the person must first be processed in the same manner as any other criminal suspect. The law enforcement officer must then transport the person to the nearest facility, unless the facility is unable to provide adequate security.[15]

The Marchman Act allows law enforcement officers, however, to temporarily detain substance-impaired persons in a jail setting. An adult not charged with a crime may be detained for his or her own protection in a municipal or county jail or other appropriate detention facility. Detention in jail is not considered to be an arrest, is temporary, and requires the detention facility to provide if necessary transfer of the detainee to an appropriate licensed service provider with an

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[12] Department of Children and Families website, http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities, (last visited Jan. 11, 2016).
[13] Chapter 71-131, Laws of Fla.; The Baker Act is contained in ch. 394, F.S.
[14] Section 397.6795, F.S.
[15] Section 394.462(1)(f) and (g), F.S.

available bed.[16] However, the Baker Act prohibits the detention in jail of a mentally ill person if he or she has not been charged with a crime.[17]

Involuntary Admission to a Facility

Criteria for Involuntary Admission

The Marchman Act provides that a person meets the criteria for involuntary admission if a good-faith reason exists to believe that the person is substance-impaired and, because of the impairment:

- Has lost the power of self-control with respect to substance abuse; and either:
  - Has inflicted, threatened to or attempted to inflict self-harm; or
  - Is in need of services and due to the impairment, judgment is so impaired that the person is incapable of appreciating the need for services.[18]

Protective Custody

A person who meets the criteria for involuntary admission under the Marchman Act may be taken into protective custody by a law enforcement officer.[19] The person may consent to have the law enforcement officer transport the person to his or her home, a hospital, or a licensed detoxification or addictions receiving facility.[20] If the person does not consent, the law enforcement officer may transport the person without using unreasonable force.[21]

Time Limits

A critical 72-hour period applies under both the Marchman Act and the Baker Act. Under the Marchman Act, a person may be held in protective custody for no more than 72 hours, unless a petition for involuntary assessment or treatment has been timely filed with the court within that timeframe to extend protective custody.[22]

The Baker Act provides that a person cannot be held in a receiving facility for involuntary examination for more than 72 hours.[23] Within that 72-hour examination period, or, if the 72 hours ends on a weekend or holiday, no later than the next working day, one of the following must happen:

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will resume custody;
- The patient must be released into voluntary outpatient treatment;
- The patient must be asked to give consent to be placed as a voluntary patient if placement is recommended; or

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[16] Section 397.6772(1), F.S.
[17] Section 394.459(1), F.S.
[18] Section 397.675, F.S.
[19] Section 397.677, F.S.
[20] Section 397.6771, F.S.
[21] Section 397.6772(1), F.S.
[22] Section 397.6773(1) and (2), F.S.
[23] Section 394.463(2)(f), F.S.

- A petition for involuntary placement must be filed in circuit court for outpatient or inpatient treatment.[24]

Under the Marchman Act, if the court grants the petition for involuntary admission, the person may be admitted for a period of five days to a facility for involuntary assessment and stabilization.[25] If the facility needs more time, the facility may request a seven-day extension from the court.[26] Based on the involuntary assessment, the facility may retain the person pending a court decision on a petition for involuntary treatment.[27]

Under the Baker Act, the court must hold a hearing on involuntary inpatient or outpatient placement within five working days after a petition for involuntary placement is filed.[28] The petitioner must show, by clear and convincing evidence, all available less-restrictive treatment alternatives are inappropriate and that the individual:

- Is mentally ill and because of the illness has refused voluntary placement for treatment or is unable to determine the need for placement; and
- Is manifestly incapable of surviving alone or with the help of willing and responsible family and friends, and without treatment is likely suffer neglect that poses a real and present threat of substantial harm to his or her well-being, or substantial likelihood exists that in the near future he or she will inflict serious bodily harm on himself or herself or another person.[29]

Advance Directives for Mental Health or Substance Abuse Treatment

Florida law currently allows an individual to create an advance directive to designate a surrogate to make health care decisions and provide a process for the execution of the directive.[30] Currently law also allows an individual to designate a separate surrogate to consent to mental health treatment if the individual is determined by a court to be incompetent to consent to mental health treatment.[31]

A mental health or substance abuse treatment advance directive is much like a living will for health care.[32] Acute episodes of mental illness temporarily destroy the capacity required to give informed consent and often prevent people from realizing they are sick, causing them to refuse intervention.[33] Even in the midst of acute episodes, many people do not meet commitment criteria because they are not likely to injure themselves or others and are still able to care for

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[24] Section 394.463(2)(i)4., F.S.
[25] Section 397.6811, F.S.
[26] Section 397.6821, F.S.
[27] Section 397.6822, F.S.
[28] Sections 394.4655(6) and 394.467(6), F.S.
[29] Section 394.467(1), F.S.
[30] Section 765.202, F.S.
[31] Section 765.202(5), F.S.
[32] Washington State Hospital Association, *Mental Health Advance Directives,* copy on file with the Senate Committee on Children, Families and Elder Affairs.
[33] Judy A. Clausen, *Making the Case for a Model Mental Health Advance Directive Statute,* 14 Yale Journal of Health Policy, Law & Ethics, Winter 2014 on file with the Senate Committee on Children, Families and Elder Affairs.

their own basic needs.[34] If left untreated, acute episodes may spiral out of control before the person meets commitment criteria.[35]

The Uniform Law Commission[36] drafted the "Health-Care Decisions Act" (HCDA) in 1993 as a model statute to address all types of advance health care planning, including planning for mental illness. However, the HCDA focuses largely on end-of-life care and fails to address many issues faced by people with mental illness.[37] A key failure of the HCDA is that it does not empower patients to form self-binding arrangements for care.[38] Such a self-binding arrangement is known as a Ulysses arrangement. A Ulysses arrangement is a type of mental health advance directive that serves as a preventative measure for a patient to obtain treatment during an episode because the patient has learned that episodes cause him or her to refuse needed intervention.[39] A Ulysses arrangement is entered into while the individual has capacity.

A Ulysses arrangement authorizes doctors to treat the patient during a future episode when he or she lacks capacity, even if the episode causes the individual to refuse treatment at that time. Without a Ulysses arrangement, an individual whose illness causes him to revoke his mental health advance directive and refuse treatment, has no mechanism to secure intervention unless he or she meets involuntary commitment criteria.[40] Ulysses arrangements are sometimes viewed as superior to involuntary commitment because the latter often comes too late and is often traumatic; the proceedings can be dehumanizing; and police intervention and apprehension can be dangerous.[41] Additionally, a Ulysses arrangement allows an individual to secure treatment from the individual's regular mental health treatment provider who understands the patient's illness and history, and in a facility the individual chooses.[42]

III. Effect of Proposed Changes:

Section 1 amends s. 394.453, F.S., to include in the legislative findings that mental health and substance use disorders are diseases of the brain, are complex medical conditions that encompass biological, genetic, psychological, cultural, and social factors; and are sub-specialties within the field of medical practice. The legislative intent is further amended to authorize licensed, qualified health professionals to exercise the full authority of their respective scopes of practice in the performance of professional functions necessary to carry out the intent of part 1 of ch. 394, L.O.F. Additionally, the intent to ensure that local systems of acute care services use a common

[34] *Id.*
[35] *Id.*
[36] The Uniform Law Commission (also known as the National Conference of Commissioners on Uniform State Laws) was established in 1892 and provides states with draft legislation that seeks to bring clarity and stability to critical areas of state statutory law. *See* "About the ULC," available at http://www.uniformlaws.org/Narrative.aspx?title=About%20the%20ULC (last visited Feb. 4, 2016)
[37] *Supra,* note 33.
[38] *Id.*
[39] *Id at 2.*
[40] *Id at 6.*
[41] *Id.*
[42] Judy Ann Clausen, *Bring Ulysses to Florida: Proposed Legislative Relief for Mental Health Patients,* article to be published in Marquette University's Elder's Advisor Law Review. Copy on file with the Senate Committee on Children, Families and Elder Affairs.

protocol and that services are provided using the coordination of care principles characteristic of recovery-oriented services, is added to the statute's legislative intent.

Section 2 amends s. 394.66, F.S., to provide that with respect to mental health and substance abuse services, it is the Legislature's intent to recognize that mental health and substance use disorders are diseases of the brain; are complex medical conditions that encompass biological, genetic, psychological, cultural, and social factors; and are sub-specialties within the field of medical practice.

Section 3 amends s. 394.9082, F.S., to provide direction to managing entities (MEs) in their geographic regions to develop a plan to establish and maintain a behavioral health service system with sufficient capacity to ensure all persons with mental health or substance use disorders who are subject to involuntary admission receive prompt assessment of their need for evaluation and treatment. The bill requires that the plan must include components such as the designation of a receiving facility that must be used by law enforcement and may be used by other authorized persons and that without such designation, a facility may not hold or treat involuntary patients under chapter 394.

The bill also requires MEs to coordinate and develop a local plan that includes a county or circuit, establish specifications and minimum standards for access to care in each community, and develop a local transportation plan, including an option to procure nonmedical transportation of persons between facilities. The MEs must also conduct a needs assessment that incorporates community resources designated in such plans and coordinate the resources within their respective regions.

The transportation plan must:
- Address the designated public or private substance abuse receiving facility or residential detoxification facility to be used by local law enforcement as the primary receiving facility;
- Address the process for a person to be transported after law enforcement relinquishes physical custody; and
- Specify responsibility for and the means by which transportation to and between facilities will be implemented.

Section 4 amends s. 397.305, F.S., to provide that the Legislature finds that mental health and substance use disorders are diseases of the brain; are complex medical conditions that encompass biological, genetic, psychological, cultural, and social factors; and are subspecialties within the field of medical practice. Under the bill, the Legislature recognizes that behavioral health disorders may temporarily or permanently affect a person's ability to reason, exercise good judgment, recognize the need for services, or sufficiently provide self-care, and that responsibility for such a person's care must be delegated to a third party and may be vested in an authorized, licensed, qualified health professional who can provide behavioral health services.

The bill provides that it is the intent of the Legislature:
- To authorize licensed, qualified health professionals to exercise the full authority of their respective scopes of practice in the performance of professional functions necessary to carry out the intent of ch. 397, F.S.;

- That state policy and funding decisions be driven by data that is representative of the populations served and the effectiveness of services provided; and
- To establish expectations that services provided to persons in this state use the coordination-of-care principles characteristic of recovery-oriented services and include social support services, such as housing support, life skills and vocational training, and employment assistance, necessary for persons with mental health and substance use disorders to live successfully in their communities.

The bill also repeals a provision in s. 397.505(2), F.S., which stated legislative intent "to require the collaboration of state agencies, service systems, and program offices to achieve the goals of [ch. 397, F.S.,] and address the needs of the public; to establish a comprehensive system of care for substance abuse; and to reduce duplicative requirements across state agencies."

Section 5 amends s. 397.675, F.S., to revise the criteria for involuntary admission for persons with substance use or a co-occurring mental health disorder to include the refusal or inability to determine whether examination is necessary and that without care or treatment, the person is likely to neglect or refuse care to the extent that:

- The neglect or refusal poses a real and present threat of substantial harm to his or her well-being;
- There is risk of deterioration of his or her physical or mental health; or
- There is substantial likelihood that the person will cause serious bodily harm to himself or herself or others.

Section 6 amends s. 397.6793, F.S., to expand the list of professionals who may initiate a certificate for emergency admission of a person to a hospital or licensed detoxification facility to include a physician, a clinical psychologist, physician's assistant working under the scope of practice of the supervising physician, psychiatric nurse, advanced registered nurse practitioner, licensed mental health counselor, licensed marriage and family therapist, master's level-certified addiction professional for substance abuse services, or a licensed clinical social worker. The professional executing the certificate must have examined the person within the preceding five days and state the observations upon which the conclusion is based that the person appears to meet the criteria for emergency admission.

Section 7 amends s. 397.681, F.S., to specify that a court may not charge a fee for the filing of a petition for involuntary assessment and stabilization.

Section 8 amends s. 397.6811, F.S., to allow a petition for involuntary assessment and stabilization to be filed by a person who has direct knowledge that the person is a threat to himself or herself or others.

Section 9 amends s. 397.6818, F.S., to provide that the court's order for involuntary admission is valid until executed or for the period specified in the order. If the order does not provide a time limit, the order is valid for seven days after the date the order is signed.

Section 10 amends s. 397.697, F.S., to increase the time a court may order a person to undergo involuntary treatment by a licensed service provider from 60 days to 90 days.

Section 11 amends s. 397.6971, F.S., to allow for early release from involuntary substance abuse treatment before the end of the 90 day treatment period if the individual no longer meets the criteria specified in s. 397.675, F.S.

Section 12 amends s. 397.6977, F.S., to reflect that the time frame that an individual may be ordered into involuntary substance abuse treatment is increased from 60 days to 90 days.

Section 13 amends s. 397.6955, F.S., to require the court to schedule a hearing on the petition for involuntary treatment within five days instead of 10 days unless a continuance is granted.

Section 14 creates an undesignated section of Florida law to provide that the Louis de la Parte Florida Mental Health Institute within the University of South Florida will provide the Department of Children and Families (DCF) copies of documents regarding involuntary examination and outpatient or inpatient placement orders on a monthly basis.

Section 15 amends s. 397.6773, F.S., to correct a cross-reference.

Section 16 redesignates Part V of chapter 765, F.S., as Part IV, and creates a new Part V of chapter 765, F.S., and entitles it as "Mental Health and Substance Abuse Treatment Advance Directives."

Section 17 creates s. 765.501, F.S., to provide that ss. 765.501-765.509, F.S., and this law may be cited as the "Jennifer Act".

Section 18 creates s. 765.502, F.S., to provide legislative findings that individuals with capacity have the ability to control decisions relating to his or her own mental health or substance abuse treatment. The Legislature further finds that substance abuse and mental illness cause individuals to fluctuate between capacity and incapacity; the individual may be unable to provide informed consent necessary to access needed treatment during a time when the individual's capacity is unclear; early treatment may prevent the individual from becoming so ill that involuntary treatment is necessary; and individuals with mental illness and substance abuse impairment need an established procedure to express their instructions and preferences for treatment and to provide advance consent to or refusal of treatment.

Under the bill, mental health or substance abuse treatment advance directives must provide the individual with a full range of choices, including the right of revocation during periods of inability to consent to treatment or of incapacity, and allow the individual to choose how to apply his or her directives. Treatment providers must abide by the individual's treatment choices.

Section 19 creates s. 765.503, F.S., to provide definitions for terms used in this section.

Section 20 creates s. 765.504, F.S., to provide for the creation, execution and allowable provisions of mental health or substance abuse treatment advance directives. An adult with capacity may execute a mental health or substance abuse impairment advance directive. A directive executed in accordance with this part is presumed valid; however, the inability to honor one or more of the provisions of the advance directive does not invalidate the remaining provisions. The directive may include any provision related to mental health or substance abuse

treatment or the care of the principal or the principal's personal affairs. Without limitation, the directive may include an individual's:

- Preferences and instructions for mental health or substance abuse treatment;
- Refusal to consent to specific types of mental health or substance abuse treatment;
- Descriptions of situations that may cause the individual to experience a mental health or substance abuse crisis;
- Suggested alternative responses that may supplemental or be in lieu of direct mental health or substance abuse treatment, such as treatment approaches from other providers; and
- The nomination of a guardian, limited guardian, or guardian advocate.

The directive may be independent of or combined with a nomination of a guardian or other durable power of attorney.

Section 21 creates s. 765.505, F.S., to provide for the execution, effective date, and expiration of a mental health or substance abuse advance directive. The bill provides that the advance directive must be in writing and must clearly indicate that the individual intends to create a directive. The directive must be witnessed by two adults who must declare they were present when the individual dated and signed the directive and that the individual did not appear to be incapacitated, acting under fraud, or acting under undue influence or duress. A surrogate named in the directive cannot act as a witness to the execution of the directive and at least one witness must not be the spouse or blood relative of the individual executing the directive.

The bill provides that the directive is valid upon execution but all or part may take effect at a later date as designated in the directive. It also provides that a directive may be revoked in whole or in part or expire under its own terms. Under the bill, a directive cannot create an entitlement to mental health, substance abuse, or medical treatment or supersede a determination of medical necessity. The directive does not obligate any health care provider, professional person, or health care facility to pay the costs associated with requested treatment or to be responsible for the lack of treatment or personal care of the individual or his or her affairs outside the facilities' scope of services. Additionally, the bill provides that a directive does not replace or supersede any will, testamentary document, or the provision of intestate succession.

Section 22 creates s. 765.506, F.S., to provide for the revocation or waiver of an advance directive. A copy of the revocation of the advance directive must be provided by the individual, and is effective upon receipt by his or her agent, each health care provider, professional person, or health care facility that received a copy of the individual's advance directive. The bill provides that a directive that would have otherwise expired but is effective because the individual is incapacitated remains effective until the individual is no longer incapacitated, unless the individual elected to be able to revoke the directive while incapacitated and has revoked the directive.

Section 23 creates s. 765.507, F.S., to provide that a surrogate, health care facility, health care provider, or other person who acts under the direction of a health care facility or provider, is not subject to criminal prosecution or civil liability or to have engaged in unprofessional conduct as a result of carrying out a mental health or substance abuse treatment decision contained in a directive.

Section 24 creates s. 765.508, F.S., to provide for the recognition of mental health and substance abuse treatment, advance directives that are executed in another state in compliance with the laws of that state, are valid.

Section 25 creates s. 765.509, F.S., to provide that a service provider is to give information relating to mental health or substance abuse treatment advance directives to its patients and assist competent and willing patients in completing a directive. The service provider may not require patients to execute a mental health or substance abuse treatment advance directive; however, an executed mental health or substance abuse treatment advance directive shall be part of the patient's medical record. The DCF is directed to develop and publish on its website information on the creation, execution and purpose of mental health or substance abuse treatment advance directives, including a form for such document.

Section 26 amends s. 406.11, F.S., to correct cross-references.

Section 27 amends s. 408.802, F.S., to correct cross-references.

Section 28 amends s. 408.820, F.S., to correct cross-references.

Section 29 amends s. 765.101, F.S., to correct cross-references.

Section 30 amends s. 765.203, F.S., to create a suggested form for a mental health or substance abuse treatment advance directive and the designation of a health care surrogate.

Section 31 provides for an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

SB 1336 prohibits a fee for filing a petition under the Marchman Act. No such fees are currently assessed; therefore, the bill will not reduce any fee revenue to the clerks of the circuit court and the state court system.

B. Private Sector Impact:

None

C. Government Sector Impact:

To the extent that the Department of Children and Families (DCF) must develop and publish information on the creation, execution, and purpose of mental health or substance abuse treatment advance directives, there may be an indeterminate fiscal impact.

VI. Technical Deficiencies:

In Section 3, the bill directs managing entities to *develop* a plan to establish and maintain a behavioral health service system. Subsequently, in the same section, managing entities are directed to *coordinate* the development of a local plan and provide technical assistance to counties or circuits for the development, receipt, and approval of such plans.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.453, 394.66, 394.9082, 397.305, 397.675, 397.6793, 397.681, 397.6811, 397.6818, 397.697, 397.6971, 397.6977, 397.6955, 397.6773, 406.11, 408.802, 408.820, 765.101, and 765.203.

This bill creates the following sections of the Florida Statutes: 765.501, 765.502, 765.503, 765.504, 765.505, 765.506, 765.507, 765.508, and 765.509.

The bill creates an undesignated section of Florida law.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Latvala

20-01629B-16 20161336__

1 A bill to be entitled
2 An act relating to behavioral health care services;
3 amending s. 394.453, F.S.; revising legislative intent
4 and providing legislative findings for the Florida
5 Mental Health Act; amending ss. 394.66 and 397.305,
6 F.S.; revising legislative intent with respect to
7 mental health and substance abuse treatment services;
8 amending s. 394.9082, F.S.; requiring behavioral
9 health managing entities to coordinate service
10 delivery plans with their respective counties or
11 circuits; providing responsibilities of county
12 governments for designation of receiving facilities
13 for the examination and assessment of persons with
14 mental health or substance use disorders; authorizing
15 the Department of Children and Families to monitor and
16 enforce compliance with ch. 394, F.S., relating to
17 mental health; requiring managing entities to
18 coordinate the development of a certain local plan;
19 requiring managing entities to provide certain
20 technical assistance; requiring managing entities to
21 develop and implement transportation plans; requiring
22 local law enforcement agencies, local governments, and
23 certain providers to review and approve transportation
24 plans; providing departmental authority for final
25 approval of such plans; amending s. 397.675, F.S.;
26 revising criteria for involuntary admission for
27 assessment, stabilization, and treatment of persons
28 with substance use or mental health disorders;
29 amending s. 397.6793, F.S.; specifying professionals
30 authorized to execute a certificate for emergency
31 admission; providing criteria for emergency admission;
32 amending s. 397.681, F.S.; prohibiting a court from

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

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33 charging a fee for the filing of a petition for
34 involuntary assessment and stabilization; amending s.
35 397.6811, F.S.; revising who may file a petition for
36 involuntary assessment and stabilization; amending s.
37 397.6818, F.S.; providing a time limitation on a court
38 order authorizing involuntary assessment and
39 stabilization; amending ss. 397.697, 397.6971, and
40 397.6977, F.S.; revising the maximum duration of
41 court-ordered involuntary treatment and conforming
42 provisions; amending s. 397.6955, F.S.; revising
43 requirements for scheduling a hearing on a petition
44 for involuntary treatment; requiring the Louis de la
45 Parte Florida Mental Health Institute within the
46 University of South Florida to provide certain
47 information to the department on a monthly basis;
48 amending s. 397.6773, F.S.; conforming a cross-
49 reference; redesignating part V of ch. 765, F.S., as
50 part VI of ch. 765, F.S.; creating a new part V of ch.
51 765, F.S., entitled “Mental Health and Substance Abuse
52 Treatment Advance Directives”; creating s. 765.501,
53 F.S.; providing a short title; creating s. 765.502,
54 F.S.; providing legislative findings; creating s.
55 765.503, F.S.; defining terms; creating s. 765.504,
56 F.S.; authorizing the execution of mental health or
57 substance abuse treatment advance directives;
58 authorizing directive provisions; creating s. 765.505,
59 F.S.; providing requirements for the execution of a
60 mental health or substance abuse treatment advance
61 directive; creating s. 765.506, F.S.; providing

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62 requirements for the revocation or waiver of a mental
63 health or substance abuse treatment advance directive;
64 creating s. 765.507, F.S.; providing an immunity from
65 liability; providing applicability; creating s.
66 765.508, F.S.; providing for the recognition of a
67 mental health or substance abuse treatment advance
68 directive executed in another state; creating s.
69 765.509, F.S.; requiring service providers to give
70 patients information relating to mental health or
71 substance abuse treatment advance directives;
72 prohibiting a service provider from requiring a
73 patient to execute a mental health or substance abuse
74 treatment advance directive; requiring the Department
75 of Children and Families to provide information and
76 forms on its website relating to mental health or
77 substance abuse treatment advance directives; amending
78 ss. 406.11, 408.802, 408.820, 765.101, and 765.203,
79 F.S.; conforming cross-references; providing an
80 effective date.
81
82 Be It Enacted by the Legislature of the State of Florida:
83
84 Section 1. Section 394.453, Florida Statutes, is amended to
85 read:
86 394.453 Legislative findings and intent.—
87 (1) The Legislature finds that mental health and substance
88 use disorders are diseases of the brain; are complex medical
89 conditions that encompass biological, genetic, psychological,
90 cultural, and social factors; and are subspecialties within the

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91 field of medical practice. The Legislature recognizes that
92 behavioral health disorders may temporarily or permanently
93 affect a person’s ability to reason, exercise good judgment,
94 recognize the need for services, or sufficiently provide self-
95 care; thus responsibility for such a person’s care must be
96 delegated to a third party and may be vested in an authorized,
97 licensed, qualified health professional who can provide
98 behavioral health services.
99 (2) It is the intent of the Legislature:
100 (a) To authorize licensed, qualified health professionals
101 to exercise the full authority of their respective scopes of
102 practice in the performance of professional functions necessary
103 to carry out the intent of this part.
104 (b) To ensure that local systems of acute care services use
105 a common protocol and apply consistent practice standards that
106 provide for nondiscriminatory and equitable access to the level
107 and duration of care based on the specific needs and preferences
108 of the persons served.
109 (c) That services provided to persons in this state use the
110 coordination-of-care principles characteristic of recovery-
111 oriented services and include social support services, such as
112 housing support, life skills and vocational training, and
113 employment assistance, necessary for persons with mental health
114 and substance use disorders to live successfully in their
115 communities.
116 (d) To authorize and direct the Department of Children and
117 Families to evaluate, research, plan, and recommend to the
118 Governor and the Legislature programs designed to reduce the
119 occurrence, severity, duration, and disabling aspects of mental,

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120 emotional, and behavioral disorders.
121 (e) That state policy and funding decisions be driven by
122 data that is representative of the populations served and the
123 effectiveness of services provided.
124 (f) ~~It is the intent of the Legislature~~ That treatment
125 programs for such disorders shall include, but not be limited
126 to, comprehensive health, social, educational, and
127 rehabilitative services to persons requiring intensive short-
128 term and continued treatment in order to encourage them to
129 assume responsibility for their treatment and recovery. It is
130 intended that:
131 1. Such persons be provided with emergency service and
132 temporary detention for evaluation when required;
133 2. Such persons ~~that they~~ be admitted to treatment
134 facilities on a voluntary basis when extended or continuing care
135 is needed and unavailable in the community;
136 3. ~~that~~ Involuntary placement be provided only when expert
137 evaluation determines that it is necessary;
138 4. ~~that~~ Any involuntary treatment or examination be
139 accomplished in a setting that ~~which~~ is clinically appropriate
140 and most likely to facilitate the person's return to the
141 community as soon as possible; and
142 5. ~~that~~ Individual dignity and human rights be guaranteed
143 to all persons who are admitted to mental health facilities or
144 who are being held under s. 394.463. ~~It is the further intent of~~
145 ~~the Legislature that the least restrictive means of intervention~~
146 ~~be employed based on the individual needs of each person, within~~
147 ~~the scope of available services.~~
148 (3) It is the policy of this state that the use of

149 restraint and seclusion on clients is justified only as an
150 emergency safety measure to be used in response to imminent
151 danger to the client or others. It is, therefore, the intent of
152 the Legislature to achieve an ongoing reduction in the use of
153 restraint and seclusion in programs and facilities serving
154 persons with mental illness.
155 Section 2. Subsection (2) of section 394.66, Florida
156 Statutes, is amended to read:
157 394.66 Legislative intent with respect to substance abuse
158 and mental health services.—It is the intent of the Legislature
159 to:
160 (2) Recognize that mental health and substance use
161 disorders are diseases of the brain; are complex medical
162 conditions that encompass biological, genetic, psychological,
163 cultural, and social factors; and are subspecialties within the
164 field of medical practice. The Legislature recognizes that
165 behavioral health disorders may temporarily or permanently
166 affect a person's ability to reason, exercise good judgment,
167 recognize the need for services, or sufficiently provide self-
168 care, thus responsibility for such a person's care must be
169 delegated to a third party and may be vested in an authorized,
170 licensed, qualified health professional who can provide
171 behavioral health services ~~mental illness and substance abuse~~
172 ~~impairment are diseases that are responsive to medical and~~
173 ~~psychological interventions and management that integrate~~
174 ~~treatment, rehabilitative, and support services to achieve~~
175 ~~recovery~~.
176 Section 3. Subsections (4) through (12) of section
177 394.9082, Florida Statutes, are renumbered as subsections (6)

178 though (14), respectively, and new subsections (4) and (5) are
179 added to that section, to read:
180 394.9082 Behavioral health managing entities.—
181 (4) COMMUNITY PLANNING.—Each managing entity shall develop
182 a plan with each county or circuit in its geographic area to
183 establish and maintain a behavioral health service system that
184 has sufficient capacity to ensure that all persons with mental
185 health or substance use disorders who are subject to involuntary
186 admission under this chapter receive prompt assessment of the
187 need for evaluation and treatment. At a minimum, the plan must
188 include the following components:
189 (a) Each county shall work with managing entities, the
190 department, community-based treatment providers, private
191 providers, local hospitals and health departments, law
192 enforcement agencies, the courts, and other local governmental
193 agencies to designate a receiving facility that shall be used by
194 law enforcement officers, but may be used by other authorized
195 persons, for voluntary and involuntary assessments or
196 examinations.
197 1. A county may have more than one facility or may use or
198 share the resources of adjacent counties.
199 2. The department shall suspend or withdraw such
200 designation for failure to comply with this chapter and rules
201 adopted under this chapter. Unless designated by the department,
202 a facility may not hold or treat involuntary patients under this
203 chapter.
204 (b) A managing entity shall coordinate the development of a
205 local plan that:
206 1. Includes the county or circuit.

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207 2. Establishes the specifications and minimum standards for
208 access to care available in each community and specifies the
209 roles, processes, and responsibilities of community intervention
210 programs for the diversion of persons from acute care
211 placements.
212 3. Specifies the method by which local hospitals,
213 ambulatory centers, designated receiving facilities, and acute
214 care inpatient and detoxification providers will coordinate
215 activities to assess, examine, triage, intake, and process
216 persons presented on an involuntary basis.
217 4. Includes a local transportation plan as provided in s.
218 394.462.
219 5. Provides an option to procure nonmedical transportation
220 contracts for the transportation of patients between facilities.
221 (c) A managing entity shall provide technical assistance to
222 counties or circuits for the development, receipt, and approval
223 of such plans and incorporate the community resources designated
224 in such plans when conducting the needs assessment and
225 coordinating the resources within its assigned region.
226 (5) TRANSPORTATION PLANS.—
227 (a) Each managing entity shall develop, in consultation
228 with local law enforcement agencies, county officials, and local
229 acute care providers, a transportation plan for each county or
230 circuit within its assigned region. At a minimum, the plan must
231 address the following:
232 1. The designated public or private substance abuse
233 receiving facility or residential detoxification facility to be
234 used by local law enforcement agencies as their primary
235 receiving facility.

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2. The method of transporting a person after a law enforcement officer has relinquished physical custody of the person at a designated public or private substance abuse receiving facility or residential detoxification facility.

3. Provide for consumer choice with respect to a receiving facility or other designated facility, or other acute care service provider capable of meeting the person's needs, within reasonable parameters of funding, geography, and safety.

4. Specify responsibility for and the means by which transportation to and between facilities of persons in need of behavioral health services will be implemented to support involuntary assessments or examinations, provision of emergency services, acute care placements, and attendance at involuntary court proceedings and resulting commitments.

(b) The transportation plan shall be initiated by the local managing entity and must be reviewed and approved by local law enforcement agencies, county commissioners, and designated acute care providers in the county or circuit before submission to the managing entity. The department has final review and approval authority for the transportation plan.

Section 4. Section 397.305, Florida Statutes, is amended to read:

397.305 Legislative findings, intent, and purpose.—

(1) The Legislature finds that mental health and substance use disorders are diseases of the brain; are complex medical conditions that encompass biological, genetic, psychological, cultural, and social factors; and are subspecialties within the field of medical practice. The Legislature recognizes that behavioral health disorders may temporarily or permanently

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affect a person's ability to reason, exercise good judgment, recognize the need for services, or sufficiently provide self-care, thus responsibility for such a person's care must be delegated to a third party and may be vested in an authorized, licensed, qualified health professional who can provide behavioral health services.

(2)~~(1)~~ Substance abuse is a major health problem that affects multiple service systems and leads to such profoundly disturbing consequences as serious impairment, chronic addiction, criminal behavior, vehicular casualties, spiraling health care costs, AIDS, and business losses, and significantly affects the culture, socialization, and learning ability of children within our schools and educational systems. Substance abuse impairment is a disease which affects the whole family and the whole society and requires a system of care that includes prevention, intervention, clinical treatment, and recovery support services that support and strengthen the family unit. ~~Further, it is the intent of the Legislature to require the collaboration of state agencies, service systems, and program offices to achieve the goals of this chapter and address the needs of the public; to establish a comprehensive system of care for substance abuse; and to reduce duplicative requirements across state agencies.~~ This chapter is designed to provide for substance abuse services.

(3)~~(2)~~ It is the goal of the Legislature to discourage substance abuse by promoting healthy lifestyles; healthy families; and drug-free schools, workplaces, and communities.

(4)~~(3)~~ It is the purpose of this chapter to provide for a comprehensive continuum of accessible and quality substance

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abuse prevention, intervention, clinical treatment, and recovery support services in the least restrictive environment which promotes long-term recovery while protecting and respecting the rights of individuals, primarily through community-based private not-for-profit providers working with local governmental programs involving a wide range of agencies from both the public and private sectors.

(5) It is the intent of the Legislature to authorize licensed, qualified health professionals to exercise the full authority of their respective scopes of practice in the performance of professional functions necessary to carry out the intent of this chapter.

(6) It is the intent of the Legislature that state policy and funding decisions be driven by data that is representative of the populations served and the effectiveness of services provided.

(7) It is the intent of the Legislature to establish expectations that services provided to persons in this state use the coordination-of-care principles characteristic of recovery-oriented services and include social support services, such as housing support, life skills and vocational training, and employment assistance, necessary for persons with mental health and substance use disorders to live successfully in their communities.

(8) ~~(4)~~ It is the intent of the Legislature to ensure within available resources a full system of care for substance abuse services based on identified needs, delivered without discrimination and with adequate provision for specialized needs.

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(9) ~~(5)~~ It is the intent of the Legislature to establish services for individuals with co-occurring substance abuse and mental disorders.

(10) ~~(6)~~ It is the intent of the Legislature to provide an alternative to criminal imprisonment for substance abuse impaired adults and juvenile offenders by encouraging the referral of such offenders to service providers not generally available within the juvenile justice and correctional systems, instead of or in addition to criminal penalties.

(11) ~~(7)~~ It is the intent of the Legislature to provide, within the limits of appropriations and safe management of the juvenile justice and correctional systems, substance abuse services to substance abuse impaired offenders who are placed by the Department of Juvenile Justice or who are incarcerated within the Department of Corrections, in order to better enable these offenders or inmates to adjust to the conditions of society presented to them when their terms of placement or incarceration end.

(12) ~~(8)~~ It is the intent of the Legislature to provide for assisting substance abuse impaired persons primarily through health and other rehabilitative services in order to relieve the police, courts, correctional institutions, and other criminal justice agencies of a burden that interferes with their ability to protect people, apprehend offenders, and maintain safe and orderly communities.

(13) ~~(9)~~ It is the intent of the Legislature that the freedom of religion of all citizens ~~shall~~ be inviolate. ~~Nothing in~~ This act does not ~~shall~~ give any governmental entity jurisdiction to regulate religious, spiritual, or ecclesiastical

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352 services.
353 Section 5. Section 397.675, Florida Statutes, is amended to
354 read:
355 397.675 Criteria for involuntary admissions, including
356 protective custody, emergency admission, and other involuntary
357 assessment, involuntary treatment, and alternative involuntary
358 assessment for minors, for purposes of assessment and
359 stabilization, and for involuntary treatment.—A person meets the
360 criteria for involuntary admission if there is good faith reason
361 to believe the person has a substance use or co-occurring mental
362 health disorder and, because of this condition, has refused or
363 is unable to determine whether examination is necessary. The
364 refusal of services is insufficient evidence of an inability to
365 determine whether an examination is necessary unless, without
366 care or treatment ~~is substance abuse impaired and, because of~~
367 ~~such impairment~~:
368 (1) The person is likely to neglect or refuse care for
369 himself or herself to the extent that the neglect or refusal
370 poses a real and present threat of substantial harm to his or
371 her well-being;
372 (2) The person is at risk of the deterioration of his or
373 her physical or mental health and this condition may not be
374 avoided despite assistance from willing family members, friends,
375 or other services; or
376 (3) There is a substantial likelihood that the person will
377 cause serious bodily harm to himself or herself or others, as
378 shown by the person's recent behavior. ~~Has lost the power of~~
379 ~~self-control with respect to substance use; and either~~
380 ~~(2)(a) Has inflicted, or threatened or attempted to~~

381 ~~inflict, or unless admitted is likely to inflict, physical harm~~
382 ~~on himself or herself or another; or~~
383 ~~(b) Is in need of substance abuse services and, by reason~~
384 ~~of substance abuse impairment, his or her judgment has been so~~
385 ~~impaired that the person is incapable of appreciating his or her~~
386 ~~need for such services and of making a rational decision in~~
387 ~~regard thereto; however, mere refusal to receive such services~~
388 ~~does not constitute evidence of lack of judgment with respect to~~
389 ~~his or her need for such services.~~
390 Section 6. Section 397.6793, Florida Statutes, is amended
391 to read:
392 397.6793 Professional ~~Physician's~~ certificate for emergency
393 admission.—
394 (1) A physician, clinical psychologist, physician's
395 assistant working under the scope of practice of the supervising
396 physician, psychiatric nurse, advanced registered nurse
397 practitioner, licensed mental health counselor, licensed
398 marriage and family therapist, master's level-certified
399 addiction professional for substance abuse services, or licensed
400 clinical social worker may execute a certificate stating that he
401 or she has examined a person within the preceding 5 days and
402 finds that the person appears to meet the criteria for emergency
403 admission and stating the observations upon which that
404 conclusion is based. The professional ~~physician's~~ certificate
405 must include the name of the person to be admitted, the
406 relationship between the person and the professional executing
407 the certificate ~~physician~~, the relationship between the
408 applicant and the professional executing the certificate
409 ~~physician~~, and any relationship between the professional

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410 executing the certificate ~~physician~~ and the licensed service
411 provider~~, and a statement that the person has been examined and~~
412 ~~assessed within 5 days of the application date,~~ and must include
413 factual allegations with respect to the need for emergency
414 admission, including:
415 (a) The reason for the ~~physician's~~ belief that the person
416 is substance abuse impaired; and
417 (b) The reason for the ~~physician's~~ belief that because of
418 such impairment the person has lost the power of self-control
419 with respect to substance abuse; and either
420 (c)~~1.~~ The reason for the belief that, without care or
421 treatment:
422 1. The person is likely to neglect or refuse to care for
423 himself or herself to the extent that the neglect or refusal
424 poses a real and present threat of substantial harm to his or
425 her well-being;
426 2. The person is at risk of the deterioration of his or her
427 physical or mental health and that this condition may not be
428 avoided despite assistance from willing family members, friends,
429 or other services; or
430 3. There is a substantial likelihood that the person will
431 cause serious bodily harm to himself or herself or others, as
432 shown by the person's recent behavior. ~~the physician believes~~
433 ~~that the person has inflicted or is likely to inflict physical~~
434 ~~harm on himself or herself or others unless admitted; or~~
435 ~~2. The reason the physician believes that the person's~~
436 ~~refusal to voluntarily receive care is based on judgment so~~
437 ~~impaired by reason of substance abuse that the person is~~
438 ~~incapable of appreciating his or her need for care and of making~~

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439 ~~a rational decision regarding his or her need for care.~~
440 (2) The professional ~~physician's~~ certificate must recommend
441 the least restrictive type of service that is appropriate for
442 the person. The certificate must be signed by the professional
443 ~~physician~~. If other less restrictive means are not available,
444 such as voluntary appearance for outpatient evaluation, a law
445 enforcement officer shall take the person named in the
446 certificate into custody and deliver him or her to the nearest
447 facility selected by the county for emergency admission.
448 (3) A signed copy of the professional ~~physician's~~
449 certificate shall accompany the person, and shall be made a part
450 of the person's clinical record, together with a signed copy of
451 the application. The application and professional ~~physician's~~
452 certificate authorize the involuntary admission of the person
453 pursuant to, and subject to the provisions of, ss. 397.679-
454 397.6797.
455 (4) The professional ~~physician's~~ certificate must indicate
456 whether the person requires transportation assistance for
457 delivery for emergency admission and specify, pursuant to s.
458 397.6795, the type of transportation assistance necessary.
459 Section 7. Subsection (1) of section 397.681, Florida
460 Statutes, is amended to read:
461 397.681 Involuntary petitions; general provisions; court
462 jurisdiction and right to counsel.—
463 (1) JURISDICTION.—The courts have jurisdiction of
464 involuntary assessment and stabilization petitions and
465 involuntary treatment petitions for substance abuse impaired
466 persons, and such petitions must be filed with the clerk of the
467 court in the county where the person is located. The court may

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468 not charge a fee for the filing of a petition under this
469 section. The chief judge may appoint a general or special
470 magistrate to preside over all or part of the proceedings. The
471 alleged impaired person is named as the respondent.
472 Section 8. Subsection (1) of section 397.6811, Florida
473 Statutes, is amended to read:
474 397.6811 Involuntary assessment and stabilization.—A person
475 determined by the court to appear to meet the criteria for
476 involuntary admission under s. 397.675 may be admitted for a
477 period of 5 days to a hospital or to a licensed detoxification
478 facility or addictions receiving facility, for involuntary
479 assessment and stabilization or to a less restrictive component
480 of a licensed service provider for assessment only upon entry of
481 a court order or upon receipt by the licensed service provider
482 of a petition. Involuntary assessment and stabilization may be
483 initiated by the submission of a petition to the court.
484 (1) If the person upon whose behalf the petition is being
485 filed is an adult, a petition for involuntary assessment and
486 stabilization may be filed by the respondent's spouse or
487 guardian, any relative, a private practitioner, the director of
488 a licensed service provider or the director's designee, or any
489 adult willing to provide testimony that he or she has personally
490 observed the actions of that person and believes that person to
491 be a threat to himself or herself or others ~~three adults who~~
492 ~~have personal knowledge of the respondent's substance abuse~~
493 ~~impairment~~.
494 Section 9. Subsection (4) is added to section 397.6818,
495 Florida Statutes, to read:
496 397.6818 Court determination.—At the hearing initiated in

497 accordance with s. 397.6811(1), the court shall hear all
498 relevant testimony. The respondent must be present unless the
499 court has reason to believe that his or her presence is likely
500 to be injurious to him or her, in which event the court shall
501 appoint a guardian advocate to represent the respondent. The
502 respondent has the right to examination by a court-appointed
503 qualified professional. After hearing all the evidence, the
504 court shall determine whether there is a reasonable basis to
505 believe the respondent meets the involuntary admission criteria
506 of s. 397.675.
507 (4) The order is valid only until executed or, if not
508 executed, for the period specified in the order. If no time
509 limit is specified in the order, the order is valid for 7 days
510 after the date the order is signed.
511 Section 10. Subsection (1) of section 397.697, Florida
512 Statutes, is amended to read:
513 397.697 Court determination; effect of court order for
514 involuntary substance abuse treatment.—
515 (1) When the court finds that the conditions for
516 involuntary substance abuse treatment have been proved by clear
517 and convincing evidence, it may order the respondent to undergo
518 involuntary treatment by a licensed service provider for a
519 period not to exceed 90 ~~60~~ days. If the court finds it
520 necessary, it may direct the sheriff to take the respondent into
521 custody and deliver him or her to the licensed service provider
522 specified in the court order, or to the nearest appropriate
523 licensed service provider, for involuntary treatment. When the
524 conditions justifying involuntary treatment no longer exist, the
525 individual must be released as provided in s. 397.6971. When the

conditions justifying involuntary treatment are expected to exist after 90 ~~60~~ days of treatment, a renewal of the involuntary treatment order may be requested pursuant to s. 397.6975 before ~~prior to~~ the end of the 90-day ~~60-day~~ period.

Section 11. Section 397.6971, Florida Statutes, is amended to read:

397.6971 Early release from involuntary substance abuse treatment.—

(1) At any time before ~~prior to~~ the end of the 90-day ~~60-day~~ involuntary treatment period, or before ~~prior to~~ the end of any extension granted pursuant to s. 397.6975, an individual admitted for involuntary treatment may be determined eligible for discharge to the most appropriate referral or disposition for the individual when:

(a) The individual no longer meets the criteria specified in s. 397.675 for involuntary admission and has given his or her informed consent to be transferred to voluntary treatment status;

(b) If the individual was admitted on the grounds of likelihood of infliction of physical harm upon himself or herself or others, such likelihood no longer exists; ~~or~~

(c) If the individual was admitted on the grounds of need for assessment and stabilization or treatment, accompanied by inability to make a determination respecting such need, either:

1. Such inability no longer exists; or

2. It is evident that further treatment will not bring about further significant improvements in the individual's condition;

(d) The individual is no longer in need of services; or

(e) The director of the service provider determines that the individual is beyond the safe management capabilities of the provider.

(2) Whenever a qualified professional determines that an individual admitted for involuntary treatment is ready for early release for any of the reasons listed in subsection (1), the service provider shall immediately discharge the individual~~,~~ and must notify all persons specified by the court in the original treatment order.

Section 12. Section 397.6977, Florida Statutes, is amended to read:

397.6977 Disposition of individual upon completion of involuntary substance abuse treatment.—At the conclusion of the 90-day ~~60-day~~ period of court-ordered involuntary treatment, the individual is automatically discharged unless a motion for renewal of the involuntary treatment order has been filed with the court pursuant to s. 397.6975.

Section 13. Section 397.6955, Florida Statutes, is amended to read:

397.6955 Duties of court upon filing of petition for involuntary treatment.—Upon the filing of a petition for the involuntary treatment of a substance abuse impaired person with the clerk of the court, the court shall immediately determine whether the respondent is represented by an attorney or whether the appointment of counsel for the respondent is appropriate. The court shall schedule a hearing to be held on the petition within 5 ~~10~~ days, unless a continuance is granted. A copy of the petition and notice of the hearing must be provided to the respondent; the respondent's parent, guardian, or legal

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584 custodian, in the case of a minor; the respondent’s attorney, if
585 known; the petitioner; the respondent’s spouse or guardian, if
586 applicable; and such other persons as the court may direct, and
587 have such petition and order personally delivered to the
588 respondent if he or she is a minor. The court shall also issue a
589 summons to the person whose admission is sought.
590 Section 14. In order to maximize efficiency, avoid
591 duplication, and provide cost savings, the Louis de la Parte
592 Florida Mental Health Institute within the University of South
593 Florida shall provide monthly to the Department of Children and
594 Families copies of each of the following:
595 (1) Ex parte orders for involuntary examination.
596 (2) Professional certificates for initiating involuntary
597 examination.
598 (3) Law enforcement reports on involuntary examination.
599 (4) Involuntary outpatient placement orders.
600 (5) Involuntary inpatient placement orders.
601 Section 15. Subsection (1) of section 397.6773, Florida
602 Statutes, is amended to read:
603 397.6773 Dispositional alternatives after protective
604 custody.—
605 (1) An individual who is in protective custody must be
606 released by a qualified professional when:
607 (a) The individual no longer meets the involuntary
608 admission criteria in s. 397.675 ~~s. 397.675(1)~~;
609 (b) The 72-hour period has elapsed; or
610 (c) The individual has consented to remain voluntarily at
611 the licensed service provider.
612 Section 16. Part V of chapter 765, Florida Statutes, is

613 redesignated as part VI, and a new part V of chapter 765,
614 Florida Statutes, consisting of ss. 765.501-765.509, is created
615 and entitled “Mental Health and Substance Abuse Treatment
616 Advance Directives.”
617 Section 17. Section 765.501, Florida Statutes, is created
618 to read:
619 765.501 Short title.—Sections 765.501-765.509 may be cited
620 as the “Jennifer Act”.
621 Section 18. Section 765.502, Florida Statutes, is created
622 to read:
623 765.502 Legislative findings.—
624 (1) The Legislature recognizes that an individual with
625 capacity has the ability to control decisions relating to his or
626 her own mental health care or substance abuse treatment. The
627 Legislature also makes the following findings:
628 (a) Substance abuse and some mental illnesses cause
629 individuals to fluctuate between capacity and incapacity.
630 (b) During periods when an individual’s capacity is
631 unclear, the individual may be unable to provide informed
632 consent necessary to access needed treatment.
633 (c) Early treatment may prevent an individual from becoming
634 so ill that involuntary treatment is necessary.
635 (d) Individuals with substance abuse impairment or mental
636 illness need an established procedure to express their
637 instructions and preferences for treatment and provide advance
638 consent to or refusal of treatment. This procedure should be
639 less expensive and less restrictive than guardianship.
640 (2) The Legislature further recognizes the following:
641 (a) A mental health or substance abuse treatment advance

642 directive must provide the individual with a full range of
643 choices.
644 (b) For a mental health or substance abuse treatment
645 advance directive to be an effective tool, individuals must be
646 able to choose how they want their directives to be applied
647 during periods when they are incompetent to consent to
648 treatment.
649 (c) There must be a clear process so that treatment
650 providers can abide by an individual's treatment choices.
651 Section 19. Section 765.503, Florida Statutes, is created
652 to read:
653 765.503 Definitions.—As used in this part, the term:
654 (1) "Adult" means any individual who has attained the age
655 of majority or is an emancipated minor.
656 (2) "Capacity" means that an adult has not been found to be
657 incapacitated pursuant to s. 394.463.
658 (3) "Health care facility" means a hospital, nursing home,
659 hospice, home health agency, or health maintenance organization
660 licensed in this state, or any facility subject to part I of
661 chapter 394.
662 (4) "Incapacity" or "incompetent" means one or more of the
663 following conditions when present in an adult:
664 (a) An inability to understand the nature, character, and
665 anticipated results of proposed treatment or alternatives or the
666 recognized serious possible risks, complications, and
667 anticipated benefits of treatments and alternatives, including
668 nontreatment.
669 (b) An inability to physically or mentally communicate a
670 willful and knowing decision about mental health care or

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671 substance abuse treatment.
672 (c) An inability to communicate his or her understanding or
673 treatment decisions.
674 (d) Criteria exist for an involuntary examination pursuant
675 to s. 394.463.
676 (5) "Informed consent" means consent voluntarily given by a
677 person after a sufficient explanation and disclosure of the
678 subject matter involved to enable that person to have a general
679 understanding of the treatment or procedure and the medically
680 acceptable alternatives, including the substantial risks and
681 hazards inherent in the proposed treatment or procedures or
682 nontreatment, and to make knowing mental health care or
683 substance abuse treatment decisions without coercion or undue
684 influence.
685 (6) "Interested person" means any person who may reasonably
686 be expected to be affected by the outcome of the particular
687 proceeding involved, including anyone interested in the welfare
688 of an incapacitated person.
689 (7) "Mental health or substance abuse treatment advance
690 directive" means a written document in which the principal makes
691 a declaration of instructions or preferences or appoints a
692 surrogate to make decisions on behalf of the principal regarding
693 the principal's mental health or substance abuse treatment, or
694 both.
695 (8) "Mental health professional" means a psychiatrist,
696 psychologist, psychiatric nurse, or social worker, and such
697 other mental health professionals licensed pursuant to chapter
698 458, chapter 459, chapter 464, chapter 490, or chapter 491.
699 (9) "Principal" means a competent adult who executes a

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700 mental health or substance abuse treatment advance directive and
701 on whose behalf mental health care or substance abuse treatment
702 decisions are to be made.
703 (10) “Service provider” means a mental health receiving
704 facility, a facility licensed under chapter 397, a treatment
705 facility, an entity under contract with the department to
706 provide mental health or substance abuse services, a community
707 mental health center or clinic, a psychologist, a clinical
708 social worker, a marriage and family therapist, a mental health
709 counselor, a physician, a psychiatrist, an advanced registered
710 nurse practitioner, or a psychiatric nurse.
711 (11) “Surrogate” means any competent adult expressly
712 designated by a principal to make mental health care or
713 substance abuse treatment decisions on behalf of the principal
714 as set forth in the principal’s mental health or substance abuse
715 treatment advance directive created pursuant to this part.
716 Section 20. Section 765.504, Florida Statutes, is created
717 to read:
718 765.504 Mental health or substance abuse treatment advance
719 directive; execution; allowable provisions.—
720 (1) An adult with capacity may execute a mental health or
721 substance abuse treatment advance directive.
722 (2) A directive executed in accordance with this section is
723 presumed to be valid. The inability to honor one or more
724 provisions of a directive does not affect the validity of the
725 remaining provisions.
726 (3) A directive may include any provision relating to
727 mental health or substance abuse treatment or the care of the
728 principal for whom the directive is executed. Without

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729 limitation, a directive may include one or more of the
730 following:
731 (a) Preferences and instructions for mental health or
732 substance abuse treatment.
733 (b) Consent to specific types of mental health or substance
734 abuse treatment.
735 (c) Refusal of and direction not to administer specific
736 types of mental health or substance abuse treatment.
737 (d) Descriptions of situations that may cause the principal
738 to experience a mental health or substance abuse crisis.
739 (e) Suggested alternative responses that may supplement or
740 be in lieu of direct mental health or substance abuse treatment,
741 such as treatment approaches from other providers.
742 (f) The principal’s nomination of a guardian, limited
743 guardian, or guardian advocate as provided under chapter 744.
744 (4) A directive may be combined with or be independent of a
745 nomination of a guardian, a durable power of attorney, or other
746 advance directive.
747 Section 21. Section 765.505, Florida Statutes, is created
748 to read:
749 765.505 Execution of a mental health or substance abuse
750 treatment advance directive.—
751 (1) A directive must have all of the following
752 characteristics:
753 (a) Be in writing.
754 (b) Contain language that clearly indicates that the
755 principal intends to create a directive pursuant to this part.
756 (c) Be dated and signed by the principal or, if the
757 principal is unable to sign, at the principal’s direction in the

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758 principal's presence.
759 (d) Be witnessed by two adults, each of whom must declare
760 that he or she personally knows the principal and was present
761 when the principal dated and signed the directive, and that the
762 principal did not appear to be incapacitated or acting under
763 fraud, undue influence, or duress. The person designated as the
764 surrogate may not act as a witness to the execution of a
765 document designating the mental health care or substance abuse
766 treatment surrogate. At least one person who acts as a witness
767 may not be the principal's spouse or his or her blood relative.
768 (2) A directive is valid upon execution, but all or part of
769 the directive may take effect at a later date as designated by
770 the principal in the directive.
771 (3) A directive may be revoked, in whole or in part,
772 pursuant to s. 765.506 or expire under its own terms.
773 (4) A directive does not or may not:
774 (a) Create an entitlement to mental health, substance
775 abuse, or medical treatment or supersede a determination of
776 medical necessity.
777 (b) Obligate any health care provider, professional person,
778 or health care facility to pay the costs associated with the
779 treatment requested.
780 (c) Obligate a health care provider, professional person,
781 or health care facility to be responsible for the nontreatment
782 or personal care of the principal or the principal's personal
783 affairs outside the scope of services the facility normally
784 provides.
785 (d) Replace or supersede any will or testamentary document
786 or supersede the application of intestate succession.

787 Section 22. Section 765.506, Florida Statutes, is created
788 to read:
789 765.506 Revocation; waiver.—
790 (1) A principal with capacity may, by written statement of
791 the principal or at the principal's direction in the principal's
792 presence, revoke a directive in whole or in part.
793 (2) The principal shall provide a copy of his or her
794 written statement of revocation to his or her agent, if any, and
795 to each health care provider, professional person, or health
796 care facility that received a copy of the directive from the
797 principal.
798 (3) The written statement of revocation is effective as to
799 a health care provider, professional person, or health care
800 facility upon the individual's or entity's receipt of the
801 statement. The professional person, health care provider, or
802 health care facility, or persons acting under their direction,
803 shall make the statement of revocation part of the principal's
804 medical record.
805 (4) A directive also may:
806 (a) Be revoked, in whole or in part, expressly or to the
807 extent of any inconsistency, by a subsequent directive; or
808 (b) Be superseded or revoked by a court order, including
809 any order entered in a criminal matter. The principal's family,
810 a health care facility, an attending physician, or any other
811 interested person who may be directly affected by a surrogate's
812 decision relating to the principal's health care may seek
813 expedited judicial intervention pursuant to rule 5.900 of the
814 Florida Probate Rules, if that person believes:
815 1. The surrogate's decision is not in accord with the

816 principal's known desires;
817 2. The advance directive is ambiguous, or the principal has
818 changed his or her mind after execution of the advance
819 directive;
820 3. The surrogate was improperly designated or appointed, or
821 the designation of the surrogate is no longer effective or has
822 been revoked;
823 4. The surrogate has failed to discharge duties, or
824 incapacity or illness renders the surrogate incapable of
825 discharging duties;
826 5. The surrogate has abused his or her power or authority;
827 or
828 6. The principal has sufficient capacity to make his or her
829 own health care decisions.
830 (5) A directive that would have otherwise expired but is
831 effective because the principal is incapacitated remains
832 effective until the principal is no longer incapacitated, unless
833 the principal elected in the directive to be able to revoke
834 while incapacitated and has revoked the directive.
835 (6) When a principal with capacity consents to treatment
836 that differs from, or refuses treatment consented to in, his or
837 her directive, the consent or refusal constitutes a waiver of a
838 particular provision of the directive and does not constitute a
839 revocation of that provision or the directive unless the
840 principal also expressly revokes the provision or directive.
841 Section 23. Section 765.507, Florida Statutes, is created
842 to read:
843 765.507 Immunity from liability; weight of proof;
844 presumption.—

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845 (1) A health care facility, provider, or other person who
846 acts under the direction of a health care facility or provider
847 is not subject to criminal prosecution or civil liability, and
848 may not be deemed to have engaged in unprofessional conduct, as
849 a result of carrying out a mental health care or substance abuse
850 treatment decision made in accordance with this part. The
851 surrogate who makes a mental health care or substance abuse
852 treatment decision on a principal's behalf, pursuant to this
853 part, is not subject to criminal prosecution or civil liability
854 for such action.
855 (2) This section does not apply if it is shown by a
856 preponderance of the evidence that the person authorizing or
857 carrying out a mental health care or substance abuse treatment
858 decision did not exercise reasonable care or, in good faith,
859 comply with this part.
860 Section 24. Section 765.508, Florida Statutes, is created
861 to read:
862 765.508 Recognition of mental health or substance abuse
863 treatment advance directive executed in another state.—A mental
864 health or substance abuse treatment advance directive executed
865 in another state in compliance with the laws of that state is
866 validly executed for the purposes of this part.
867 Section 25. Section 765.509, Florida Statutes, is created
868 to read:
869 765.509 Dissemination of information.—
870 (1) A service provider shall give information relating to
871 mental health or substance abuse treatment advance directives to
872 its patients and assist competent and willing patients in
873 completing mental health or substance abuse treatment advance

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directives.

(2) A service provider may not require a patient to execute a mental health or substance abuse treatment advance directive or to execute a new mental health or substance abuse treatment advance directive using the service provider’s forms. The principal’s mental health or substance abuse treatment advance directives shall travel with the principal as part of his or her medical record.

(3) The Department of Children and Families shall develop, and publish on its website, information on the creation, execution, and purpose of mental health or substance abuse treatment advance directives and the distinction between mental health treatment advance directives created under this part and those created under part I of this chapter. The department shall also develop, and publish on its website, a mental health treatment advance directive form and a substance abuse treatment advance directive form that may be used by an individual to direct future care.

Section 26. Paragraph (b) of subsection (2) of section 406.11, Florida Statutes, is amended to read:

406.11 Examinations, investigations, and autopsies.—

(2)

(b) The Medical Examiners Commission shall adopt rules, pursuant to chapter 120, providing for the notification of the next of kin that an investigation by the medical examiner’s office is being conducted. A medical examiner may not retain or furnish any body part of the deceased for research or any other purpose which is not in conjunction with a determination of the identification of or cause or manner of death of the deceased or

the presence of disease or which is not otherwise authorized by this chapter, part VI ~~part V~~ of chapter 765, or chapter 873, without notification of and approval by the next of kin.

Section 27. Subsection (29) of section 408.802, Florida Statutes, is amended to read:

408.802 Applicability.—The provisions of this part apply to the provision of services that require licensure as defined in this part and to the following entities licensed, registered, or certified by the agency, as described in chapters 112, 383, 390, 394, 395, 400, 429, 440, 483, and 765:

(29) Organ, tissue, and eye procurement organizations, as provided under part VI ~~part V~~ of chapter 765.

Section 28. Subsection (28) of section 408.820, Florida Statutes, is amended to read:

408.820 Exemptions.—Except as prescribed in authorizing statutes, the following exemptions shall apply to specified requirements of this part:

(28) Organ, tissue, and eye procurement organizations, as provided under part VI ~~part V~~ of chapter 765, are exempt from s. 408.810(5)-(10).

Section 29. Subsection (1) and paragraph (d) of subsection (6) of section 765.101, Florida Statutes, are amended to read:

765.101 Definitions.—As used in this chapter:

(1) “Advance directive” means a witnessed written document or oral statement in which instructions are given by a principal or in which the principal’s desires are expressed concerning any aspect of the principal’s health care or health information, and includes, but is not limited to, the designation of a health care surrogate, a living will, or an anatomical gift made

932 pursuant to part VI ~~part V~~ of this chapter.
933 (6) “Health care decision” means:
934 (d) The decision to make an anatomical gift pursuant to
935 part VI ~~part V~~ of this chapter.
936 Section 30. Section 765.203, Florida Statutes, is amended
937 to read:
938 765.203 Suggested form of designation.—A written
939 designation of a health care surrogate executed pursuant to this
940 chapter may, but need not be, in the following form:
941
942 DESIGNATION OF HEALTH CARE SURROGATE
943
944 I, ...(name)..., designate as my health care surrogate under s.
945 765.202, Florida Statutes:
946
947 Name: ...(name of health care surrogate)...
948 Address: ...(address)...
949 Phone: ...(telephone)...
950
951 If my health care surrogate is not willing, able, or reasonably
952 available to perform his or her duties, I designate as my
953 alternate health care surrogate:
954
955 Name: ...(name of alternate health care surrogate)...
956 Address: ...(address)...
957 Phone: ...(telephone)...
958
959 INSTRUCTIONS FOR HEALTH CARE
960

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961 I authorize my health care surrogate to:
962 ...(Initial here)... Receive any of my health information,
963 whether oral or recorded in any form or medium, that:
964 1. Is created or received by a health care provider, health
965 care facility, health plan, public health authority, employer,
966 life insurer, school or university, or health care
967 clearinghouse; and
968 2. Relates to my past, present, or future physical or
969 mental health or condition; the provision of health care to me;
970 or the past, present, or future payment for the provision of
971 health care to me.
972 I further authorize my health care surrogate to:
973 ...(Initial here)... Make all health care decisions for me,
974 which means he or she has the authority to:
975 1. Provide informed consent, refusal of consent, or
976 withdrawal of consent to any and all of my health care,
977 including life-prolonging procedures.
978 2. Apply on my behalf for private, public, government, or
979 veterans’ benefits to defray the cost of health care.
980 3. Access my health information reasonably necessary for
981 the health care surrogate to make decisions involving my health
982 care and to apply for benefits for me.
983 4. Decide to make an anatomical gift pursuant to part VI
984 ~~part V~~ of chapter 765, Florida Statutes.
985 ...(Initial here)... Specific instructions and
986 restrictions: ....
987 ....
988 ....
989

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990 While I have decisionmaking capacity, my wishes are controlling
991 and my physicians and health care providers must clearly
992 communicate to me the treatment plan or any change to the
993 treatment plan prior to its implementation.
994
995 To the extent I am capable of understanding, my health care
996 surrogate shall keep me reasonably informed of all decisions
997 that he or she has made on my behalf and matters concerning me.
998
999 THIS HEALTH CARE SURROGATE DESIGNATION IS NOT AFFECTED BY MY
1000 SUBSEQUENT INCAPACITY EXCEPT AS PROVIDED IN CHAPTER 765, FLORIDA
1001 STATUTES.
1002
1003 PURSUANT TO SECTION 765.104, FLORIDA STATUTES, I UNDERSTAND THAT
1004 I MAY, AT ANY TIME WHILE I RETAIN MY CAPACITY, REVOKE OR AMEND
1005 THIS DESIGNATION BY:
1006 (1) SIGNING A WRITTEN AND DATED INSTRUMENT WHICH EXPRESSES
1007 MY INTENT TO AMEND OR REVOKE THIS DESIGNATION;
1008 (2) PHYSICALLY DESTROYING THIS DESIGNATION THROUGH MY OWN
1009 ACTION OR BY THAT OF ANOTHER PERSON IN MY PRESENCE AND UNDER MY
1010 DIRECTION;
1011 (3) VERBALLY EXPRESSING MY INTENTION TO AMEND OR REVOKE
1012 THIS DESIGNATION; OR
1013 (4) SIGNING A NEW DESIGNATION THAT IS MATERIALLY DIFFERENT
1014 FROM THIS DESIGNATION.
1015
1016 MY HEALTH CARE SURROGATE’S AUTHORITY BECOMES EFFECTIVE WHEN MY
1017 PRIMARY PHYSICIAN DETERMINES THAT I AM UNABLE TO MAKE MY OWN
1018 HEALTH CARE DECISIONS UNLESS I INITIAL EITHER OR BOTH OF THE

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1019 FOLLOWING BOXES:
1020
1021 IF I INITIAL THIS BOX [....], MY HEALTH CARE SURROGATE’S
1022 AUTHORITY TO RECEIVE MY HEALTH INFORMATION TAKES EFFECT
1023 IMMEDIATELY.
1024
1025 IF I INITIAL THIS BOX [....], MY HEALTH CARE SURROGATE’S
1026 AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR ME TAKES EFFECT
1027 IMMEDIATELY. PURSUANT TO SECTION 765.204(3), FLORIDA STATUTES,
1028 ANY INSTRUCTIONS OR HEALTH CARE DECISIONS I MAKE, EITHER
1029 VERBALLY OR IN WRITING, WHILE I POSSESS CAPACITY SHALL SUPERSEDE
1030 ANY INSTRUCTIONS OR HEALTH CARE DECISIONS MADE BY MY SURROGATE
1031 THAT ARE IN MATERIAL CONFLICT WITH THOSE MADE BY ME.
1032
1033 SIGNATURES: Sign and date the form here:
1034 ...(date)... ...(sign your name)...
1035 ...(address)... ...(print your name)...
1036 ...(city)... ...(state)...
1037
1038 SIGNATURES OF WITNESSES:
1039 First witness Second witness
1040 ...(print name)... ...(print name)...
1041 ...(address)... ...(address)...
1042 ...(city)... ...(state)... ...(city)... ...(state)...
1043 ...(signature of witness)... ...(signature of witness)...
1044 ...(date)... ...(date)...
1045 Section 31. This act shall take effect July 1, 2016.

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The Florida Senate

Committee Agenda Request

To:	Senator Rene Garcia Committee on Health and Human Services Appropriations
Subject:	Committee Agenda Request
Date:	January 20, 2016

I respectfully request that **Senate Bill #998**, relating to Residential Treatment Facilities, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Jeremy Ring

Senator Jeremy Ring
Florida Senate, District 29

File signed original with committee office

S-020 (03/2004)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: CS/SB 998

INTRODUCER: Health Policy Committee and Senator Ring

SUBJECT: Adolescent and Child Treatment Programs

DATE: February 9, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Stovall	HP	**Fav/CS**
2.	Brown	Pigott	AHS	**Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 998 establishes licensure, regulatory, operational, and administrative standards for adolescent and child residential treatment programs (ACRT) and adolescent and child outdoor programs (ACO). An ACRT offers room and board, and provides specialized treatment, specialized therapies, and rehabilitation or habilitation services for an adolescent or child between the ages of 6 and 18, with emotional, psychological, developmental, or behavioral problems or disorders or substance abuse problems. An ACO offers wilderness hiking and camping experiences as a form or rehabilitation and treatment for the same population group of ACRTs. Both of these programs are intended to assist an adolescent or child acquire the social and behavioral skills necessary for healthy adjustment to school, family life, and community.

The Agency for Health Care Administration (AHCA) estimates that 19 new full-time-equivalent positions will be necessary to implement the bill, at a recurring annual cost of $1.16 million from the Health Care Trust Fund, and that those costs will be offset by revenue to the trust fund due to the collection of licensing fees.

The effective date of the bill is July 1, 2016.

II. Present Situation:

Current law provides for a variety of residential programs for persons with emotional maladies, substance abuse dependencies, and developmental disabilities. Multiple state agencies have

responsibility for establishing and enforcing regulatory standards for these programs, including the Department of Children and Families (DCF), the AHCA, and the Agency for Persons with Disabilities (APD).

Residential Treatment Facilities

Mental Health

Mental health residential treatment centers are licensed under s. 394.875, F.S. Long-term residential facilities include facilities for adult residential treatment and resident treatment centers for children and adolescents.[1]

The purpose of a residential treatment facility is to be part of a comprehensive treatment program for mentally ill individuals in a community-based residential setting.[2] A mental health residential treatment facility must provide a long-term, homelike residential environment that provides care, support, assistance, and limited supervision in daily living to adults diagnosed with a serious and persistent major mental illness who do not have another primary residence. The average length of stay must be 60 days or longer. Residential treatment centers are divided into five licensure classifications, referred to as levels. The level designation depends upon the functional capabilities of the residents and the care and supervision needed by those residents. Different regulatory standards apply to each level.[3]

The purpose of a residential treatment center for children and adolescents is to provide mental health assessment and treatment services to children and adolescents who are experiencing an acute mental or emotional crisis, have a serious emotional disturbance or mental illness,[4] or have an emotional disturbance.[5,6] Children may be admitted through the mental health system or through the protective custody provisions in ch. 39, F.S.[7] Similar residential settings include therapeutic group homes. The DCF, in consultation with the AHCA, has adopted rules governing a residential treatment center for children and adolescents which specify licensure standards for: admission; length of stay; program and staffing; discharge and discharge planning; treatment

[1] "Child" means a person from birth until the person's 13th birthday. *See* s. 394.492(3), F.S. "Adolescent" means a person who is at least 13 years of age but under 18 years of age. *See* s. 394.492(1), F.S.
[2] Section 394.875(1)(b), F.S.
[3] Rule 65E-4.016(1), F.A.C.
[4] "Child or adolescent who has a serious emotional disturbance or mental illness" means a person under 18 years of age who is diagnosed as having a mental, emotional, or behavioral disorder that meets one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association; and exhibits behaviors that substantially interfere with or limit his or her role or ability to function in the family, school, or community, which behaviors are not considered to be a temporary response to a stressful situation. The term includes a child or adolescent who meets the criteria for involuntary placement under s. 394.467(1), F.S.
[5] "Child or adolescent who has an emotional disturbance" means a person under 18 years of age who is diagnosed with a mental, emotional, or behavioral disorder of sufficient duration to meet one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, but who does not exhibit behaviors that substantially interfere with or limit his or her role or ability to function in the family, school, or community. The emotional disturbance must not be considered to be a temporary response to a stressful situation. The term does not include a child or adolescent who meets the criteria for involuntary placement under s. 394.467(1). 394.492(5), F.S.
[6] Section 394.875(1)(c), F.S.
[7] Rule chapter 65E-9, F.A.C.

planning; seclusion, restraints and time-out; rights of patients; use of psychotropic medications; and standards for the operation of such facilities.[8]

A license issued by the AHCA is required in order to operate or act as a residential treatment center or a residential treatment center for children and adolescents in this state.[9] In addition to other documentation required for licensure, applicants must provide proof of liability insurance coverage in amounts set by the DCF and the AHCA by rule.[10] The AHCA and the DCF may enter and inspect any licensed facility and access clinical records of any client to determine compliance with applicable laws and rules and may inspect an unlicensed premises with the permission of the person in charge or pursuant to a warrant.[11]

Substance Abuse Services

Under ch. 397, F.S., relating to substance abuse services, residential treatment is defined as a service provided in a structured, live-in environment within a non-hospital setting on a 24-hours-per-day, seven-days-per-week basis, and is intended for individuals who meet the placement criteria for this component.[12] The DCF is responsible for licensing and regulating licensable service components delivering substance abuse services on behalf of service providers under ch. 397, F.S.[13] The DCF has adopted rules relating to the licensure and operation of providers of substances abuse services.[14]

Developmental Disabilities

Residential facilities also exist for persons with developmental disabilities. For example, a group home facility is a residential facility which provides a family living environment including supervision and care necessary to meet the physical, emotional, and social needs of its residents.[15] The capacity of a group home facility is at least four but not more than 15 residents.

An intermediate care facility for the developmentally disabled (ICF/DD) is a residential facility licensed and certified under state law and also certified by the federal government, pursuant to the federal Social Security Act, as a provider of Medicaid services to persons who have developmental disabilities.[16]

The APD provides, through its licensing authority and by rule, license application procedures, provider qualifications, facility and client care standards, requirements for client records, requirements for staff qualifications and training, and requirements for monitoring foster care

[8] *See* Section 394.875(8), F.S., and Rule Chapters 65E-9, and 65G-2, F.A.C.
[9] Section 394.875(2), F.S.
[10] Section 394.876(2), F.S.
[11] Section 394.90(1) and (2), F.S.
[12] Section 394.311(22)(a)9., F.S.
[13] Section 397.321(6), F.S.
[14] *See* Rule chs. 65D-30 and 65G-2, F.A.C.
[15] Section 393.063(17), F.S.
[16] Section 400.960(6), F.S.

facilities, group home facilities, residential habilitation centers,[17] and comprehensive transitional education programs that serve APD clients.[18]

Wilderness Camps

The DCF regulates wilderness camps as residential child-caring agencies.[19] Rules provide for a short-term wilderness program, which is a residential program of 60 days or less that emphasizes behavioral changes through rigorous fitness training and conditioning in a wilderness environment. Rules also authorize a wilderness camp, which is a residential child caring program that provides a variety of outdoor activities that take place in a wilderness environment. Although wilderness programs are exempted[20] from several regulations applicable to residential programs, these programs are currently subject to existing regulation. [21]

III. Effect of Proposed Changes:

Adolescent and Child Residential Treatment Program

Section 394.88, F.S., is created to establish an ACRT within the statutory chapter relating to mental health. The purpose of the new program is to offer room and board and to provide, or arrange for the provision of, specialized treatment, specialized therapies,[22] and rehabilitation or habilitation[23] services for adolescents and children between 6 and 18 years of age with emotional, psychological, developmental, or behavioral problems or disorders or substance abuse problems. An ACRT assists these youth in acquiring the social and behavioral skills necessary for a healthy adjustment to school, family life, and community.

The term "rehabilitative services" is described within the definition of "mental health services" and "substance abuse services" in the part[24] of the Florida Statutes applicable to the new residential treatment program created in this bill. Within the definition of mental health services, rehabilitative services is described to mean services intended to reduce or eliminate the disability associated with mental illness. Rehabilitative services may include assessment of personal goals and strengths, readiness preparation, specific skill training, and assistance in designing environments that enable individuals to maximize their functioning and community

[17] A residential habilitation center is a community residential facility licensed under this ch. 393, F.S., which provides habilitation services. The capacity these facilities may not be fewer than nine residents. However, licensure of new residential habilitation centers creased after October 1, 1989.
[18] Section 393.067(1), F.S.
[19] Section 409.175(2)(j), F.S.
[20] *See for example* Rule 65C-14.090, F.A.C.
[21] *See* Rules 65C-14.001, and 65C-14.110 – 65C-14.115, F.A.C.
[22] Specialized therapies is defined in s. 393.063, F.S., to mean means those treatments or activities prescribed by and provided by an appropriately trained, licensed, or certified professional or staff person and may include, but are not limited to, physical therapy, speech therapy, respiratory therapy, occupational therapy, behavior therapy, physical management services, and related specialized equipment and supplies.
[23] Habilitation services in defined in s. 393.063, F.S., to mean the process by which a client is assisted to acquire and maintain those life skills which enable the client to cope more effectively with the demands of his or her condition and environment and to raise the level of his or her physical, mental, and social efficiency. It includes, but is not limited to, programs of formal structured education and treatment.
[24] Part IV of ch. 394, F.S., Community Substance Abuse and Mental Health Services.

participation.[25] Within the definition of substance abuse services, rehabilitation services is described to include residential, outpatient, day or night, case management, in-home, psychiatric, and medical treatment, and methadone or medication management.[26]

An ACRT is defined as a 24-hour group living environment for four or more individuals unrelated to the owner or provider. An ACRT must be licensed by the AHCA in accordance with the general facility licensing standards in part II of ch. 408, F.S. The DCF, in consultation with the AHCA and the APD, must adopt rules for licensure, administration, and operation of ACRTs.

The director of an ACRT, who is responsible for the operation of the program, the program facility, and the day-to-day supervision of the residents, must be a psychiatrist or a psychologist. Similar programs currently authorized in statute require a psychiatrist to serve as the medical director and to oversee the development and revision of a treatment plan and the provision of mental health services provided to children.[27] Under the bill, the director, or a staff member who has been appointed by the director to serve at the director's substitute, must be on site at the program facility at all times. The director must maintain a current list of all program residents at the facility.

Additional program staff must include physicians, psychologists, mental health counselors, or advanced registered nurse practitioners who have been trained in providing medical services and treatment to adolescents and children, to provide treatment for the residents. These health care practitioners must also be specifically trained to provide applicable services to adolescents and children diagnosed with mental health and substance abuse problems and for residents with disabilities, depending upon the composition of the facility's residents.

All staff who have contact with residents must undergo a level-2 background screening. The bill establishes minimum staffing ratios of:

- Two health care practitioners licensed in a profession listed in the previous paragraph at all times, and
- A one-to-four professional staff-to-resident ratio during awake hours.

A treatment plan must exist for each resident. The treatment plan must be reviewed and signed when the resident enrolls in the ACRT and periodically thereafter. The director and the resident's parent or legal guardian must sign the treatment plan.

An ACRT is required to maintain documentation evidencing compliance with local zoning, business licenses, building code, fire safety code, and health code requirements. An ACRT also must obtain approval from applicable governmental agencies for new program services or increased resident capacity. If the ACRT provides services to residents with disabilities, it must be located where schools, churches, recreation facilities, and other community facilities are available.

An ACRT must:

---

[25] Section 394.67(15)(b), F.S.
[26] Section 394.67(24)(d), F.S.
[27] *See* Rule 65E-9.007(3), F.A.C., Licensure of Residential Treatment Centers, Staffing.

- Provide a curriculum approved by the Department of Education; and
- Conduct counseling sessions or other appropriate treatments that must be documented in each resident's individual record.

If an ACRT provides its own school, the school must be approved by the State Board of Education, the Southern Association of Colleges and Schools, or another educational accreditation organization.

The DCF may establish by rule additional staffing requirements to ensure resident safety and service delivery as well as other requirements relating to the treatment and care of residents.

Adolescent and Child Outdoor Program

The bill creates s. 394.89, F.S., to establish an ACO within the statutory chapter relating to mental health. The purpose of the new program is to offer wilderness hiking and camping experiences through field group activities and expeditions as a form of rehabilitation and treatment for participants between the ages of 6 and 18 years of age with emotional, psychological, developmental, or behavioral problems or disorders or substance abuse problems. An ACO assists such youths to acquire the social and behavioral skills necessary for a healthy adjustment to school, family life, and community. An ACO may be established as an independent program or as an adjunct and subsidiary program to an ACRT.

The definition of an ACO participant specifically excludes the parent or contracting agent that enrolls the adolescent or child in the program.

An ACO must be licensed by the AHCA in accordance with the general facility licensing standards in part II of ch. 408, F.S. The DCF, in consultation with the AHCA and the APD, must adopt rules to establish requirements for licensure, administration, and operation of ACOs. The DCF is authorized to establish rules relating to staffing requirements in addition to those specifically enumerated in the bill. All local, state, and federal regulations and professional licensing requirements must be met by an ACO as a condition of licensure.

The AHCA is tasked with reviewing and approving a program's training plan that specifies the programs goals and methodologies. This plan must also address governing a participant's conduct and the consequences for his or her conduct while enrolled in the program.

An ACO must employ a psychiatrist or psychologist as its program supervisor, who is responsible for and has authority over all policies and activities of the program. Additional responsibilities of the supervisor include:

- Coordinating office and support services,
- Supervising the operations of the program,
- Ensuring staff is adequately trained,
- Maintaining enrollment records, including a current list of each participant, the participant's group field activity or expedition, and geographic location, and this list must be updated every 24 hours; and
- Developing and signing a written plan for each group field activity and expedition.

The bill requires an ACO to provide an educational component approved by the Department of Education to a participant if he or she is absent from school or an educational setting for more than 30 days. The program supervisor must coordinate with the local school board to provide the educational component as part of a participant's program experience prior to enrolling the participant. To offer educational credit to a participant, the ACO must be recognized and approved by the State Board of Education.

Each ACO must provide to its participants access to a multidisciplinary team of licensed health care practitioners who have been trained in providing medical services and treatment to adolescents and children. This team must include, at a minimum, a physician and at least one of the following: clinical social worker, mental health counselor, marriage and family therapist, and certified school counselor.

Each group field activity or expedition must have field staff working directly with the participants. Support staff must also be assigned responsibility for the delivery of supplies to the field, mail delivery, communications, and first-aid support.

All professional and non-professional staff, as well as all providers who may be in contact with participants, must undergo a level-2 background screening before any contact occurs.

The effective date of the bill is July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The AHCA anticipates that licensure fees would average $4,860 under CS/SB 998 and that approximately 500 licenses would be issued in the first year of implementation, subject to biennial renewal.[28]

C. Government Sector Impact:

The DCF indicates that the bill has no fiscal impact on the department.

The AHCA anticipates the need for 19 full-time-equivalent (FTE) positions in order to implement the bill, with a recurring cost of $1.16 million and a nonrecurring cost of $106,380 for the first year. These costs would be paid through the Health Care Trust Fund. Additionally, the AHCA anticipates collecting $2.43 million in licensure fees biennially. This revenue would be deposited into the Health Care Trust Fund.[29]

Under this projection, the bill has a slightly positive fiscal impact on the AHCA's Health Care Trust Fund on a biennial basis.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill does not specify the amounts of licensure fees for the new programs. The AHCA projects an average licensure fee of $4,860 biennially in order for the programs to be financially self-sustaining.[30]

VIII. Statutes Affected:

This bill creates the following sections of the Florida Statutes: 394.88 and 394.89.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on January 19, 2016:
The committee substitute:
- Changed the title of the two programs from residential treatment programs to adolescent and child residential treatment programs and from outdoor youth programs to adolescent and child outdoor programs.
- Limited the scope of the programs to youth between the ages of 6 – 18.

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[28] The Agency for Health Care Administration, *2016 Agency Legislative Bill Analysis for SB 998,* Dec. 4, 2015. On file with the Senate Appropriations Subcommittee on Health and Human Services.
[29] *Id.*
[30] *Id.*

- Removed most of the prescriptive regulatory structure and substituted a regulatory framework with rulemaking authority.
- Clarified AHCA, DCF, and APD responsibilities for licensure and rulemaking.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By the Committee on Health Policy; and Senator Ring

588-02317-16 2016998c1

1 A bill to be entitled
2 An act relating to adolescent and child treatment
3 programs; creating s. 394.88, F.S.; providing purpose
4 of adolescent and child residential treatment
5 programs; defining terms; requiring licensure by the
6 Agency for Health Care Administration; requiring the
7 Department of Children and Families to adopt rules for
8 the licensure, administration, and operation of
9 programs and program facilities; providing staffing
10 requirements; requiring a treatment plan for each
11 resident; requiring a review of treatment plans;
12 requiring written documentation of compliance with
13 certain local requirements; providing location
14 requirements for program facilities under certain
15 circumstances; authorizing the department to establish
16 certain requirements; requiring a program to provide a
17 curriculum; requiring a program to conduct certain
18 counseling sessions; creating s. 394.89, F.S.;
19 providing purpose of adolescent and child outdoor
20 programs; defining terms; requiring licensure by the
21 agency; requiring the department to adopt rules for
22 the licensure, administration, and operation of
23 programs; providing regulations and licensing
24 requirements for programs; providing administrative
25 requirements for programs; requiring programs to have
26 an educational component approved by the Department of
27 Education under certain circumstances; providing
28 requirements and qualifications for program staff;
29 requiring the program supervisor to maintain a current
30 list and enrollment records of all participants;
31 requiring program supervisors to develop a written
32 plan for each field group activity and expedition;

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33 providing an effective date.
34
35 Be It Enacted by the Legislature of the State of Florida:
36
37 Section 1. Section 394.88, Florida Statutes, is created to
38 read:
39 394.88 Adolescent and child residential treatment
40 programs.—
41 (1) The purpose of an adolescent and child residential
42 treatment program is to offer room and board and to provide, or
43 arrange for the provision of, specialized treatment, specialized
44 therapies as defined in s. 393.063, and services for
45 rehabilitation or habilitation as defined in s. 393.063, for
46 adolescents and children with emotional, psychological,
47 developmental, or behavioral problems or disorders, or substance
48 abuse problems. In an adolescent and child residential treatment
49 program, adolescents and children are assisted in acquiring the
50 social and behavioral skills necessary for a healthy adjustment
51 to school, family life, and community.
52 (2) As used in this section, the term:
53 (a) “Adolescent and child residential treatment program” or
54 “program” means a privately owned and operated 24-hour group
55 living environment for four or more adolescents or children
56 unrelated to the owner or provider.
57 (b) “Program resident” or “resident” means an adolescent or
58 child at least 6 and no more than 18 years of age who enrolls
59 and participates in a program.
60 (3) An adolescent and child residential treatment program
61 must be licensed by the Agency for Health Care Administration in

62 accordance with part II of chapter 408. The department, in
63 consultation with the agency and the Agency for Persons with
64 Disabilities, shall establish by rule requirements for
65 licensure, administration, and operation of programs and program
66 facilities consistent with this section.
67 (4)(a) A program must employ a licensed psychiatrist or a
68 psychologist licensed under chapter 490 as the director of the
69 program. The director is responsible for the operation of the
70 program, the program facility, and the day-to-day supervision of
71 program residents. The director or a member of program staff
72 appointed by the director as his or her substitute must be
73 present at the program facility at all times. The director shall
74 maintain on site a current list of all program residents.
75 (b) Program staff must include, in addition to the
76 director, physicians licensed under chapter 458 or chapter 459,
77 psychologists licensed under chapter 490 or chapter 491, mental
78 health counselors licensed under chapter 491, or advanced
79 registered nurse practitioners licensed under part 1 of chapter
80 464 and certified under s. 464.012 who have been trained in
81 providing medical services and treatment to adolescents and
82 children to serve as professional program staff providing
83 treatment to residents. Such professional program staff must be
84 specifically trained in providing medical services and treatment
85 to adolescents and children diagnosed with mental health and
86 substance abuse problems and to residents with disabilities if
87 the program serves these populations. A program must have a
88 minimum of two such professional staff members on duty at all
89 times and must maintain a professional staff-to-resident ratio
90 of no less than 1 to 4 during awake hours. All program staff,

91 professional and non-professional, and all providers who may be
92 contracted to provide services to residents must undergo a level
93 2 background screening before engaging in any activity that
94 brings them into contact with a resident. The department may
95 establish by rule further staffing requirements to ensure
96 resident safety and service delivery consistent with this
97 section.
98 (5) A program must ensure that a treatment plan exists for
99 each resident. The treatment plan must be reviewed and signed at
100 the time a resident enrolls and periodically after enrollment,
101 as provided in the treatment plan, by the director of the
102 program and the resident's parent or legal guardian. The
103 department may establish by rule further requirements relating
104 to the treatment and care of residents consistent with this
105 section.
106 (6) A program must maintain written documentation of
107 compliance with the following local requirements, as applicable:
108 (a) Zoning ordinances.
109 (b) Business license requirements.
110 (c) Building codes.
111 (d) Firesafety codes and standards.
112 (e) Health codes.
113 (f) Approval from appropriate governmental agencies for new
114 program services or increased consumer capacity.
115
116 A program facility that provides services to residents with
117 disabilities must be located where schools, churches, recreation
118 facilities, and other community facilities are available. The
119 department may establish by rule further requirements relating

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120 to the program facility, including, but not limited to, interior
121 and exterior building dimensions, housing and kitchen standards,
122 meal plan guidelines, medication management, resident privacy
123 and accountability for his or her personal effects, and
124 cleanliness and safety standards, consistent with this section.
125 (7) A program must:
126 (a) Provide a curriculum approved by the Department of
127 Education to residents. A program that provides its own school
128 must be recognized and approved by the State Board of Education,
129 the Southern Association of Colleges and Schools, or another
130 educational accreditation organization.
131 (b) Conduct individual, group, couple, and family
132 counseling sessions or other appropriate treatment, including
133 skills development therapy, at least weekly, or more often if
134 required by a resident's treatment plan. The program must
135 document the time, date, and nature of such services, including
136 the signature of the counselor providing them, in the individual
137 record for each resident.
138 Section 2. Section 394.89, Florida Statutes, is created to
139 read:
140 394.89 Adolescent and child outdoor programs.—
141 (1) The purpose of an adolescent and child outdoor program
142 is to offer wilderness hiking and camping experiences through
143 program field group activities and expeditions as a form of
144 rehabilitation and treatment for adolescents or children with
145 emotional, psychological, developmental, or behavioral problems
146 or disorders, or substance abuse problems. In an adolescent and
147 child outdoor program, adolescents and children are assisted in
148 acquiring the social and behavioral skills necessary for a

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149 healthy adjustment to school, family life, and community.
150 (2) As used in this section, the term:
151 (a) "Adolescent and child outdoor program" or "program"
152 means a privately owned and operated 24-hour group wilderness
153 hiking and camping experience for four or more adolescents or
154 children unrelated to the owner or provider. A program may be
155 established independently or as an adjunct and subsidiary of an
156 adolescent and child residential treatment program established
157 pursuant to s. 394.88.
158 (b) "Program participant" or "participant" means an
159 adolescent or child at least 6 and no more than 18 years of age
160 who enrolls and participates in a program. The term does not
161 include the parent or contracting agent that enrolls the
162 adolescent or child in the program.
163 (3)(a) An adolescent and child outdoor program must be
164 licensed by the Agency for Health Care Administration in
165 accordance with part II of chapter 408. The department, in
166 consultation with the agency and the Agency for Persons with
167 Disabilities, shall establish by rule requirements for
168 licensure, administration, and operation of programs consistent
169 with this section. All local, state, and federal regulations and
170 professional licensing requirements must be met by a program as
171 a condition of licensure by the agency. The agency must review
172 and approve a program's training plan specifying the program's
173 goals and methodologies. The training plan must include
174 provisions governing a participant's conduct and the
175 consequences for his or her conduct while enrolled in the
176 program.
177 (b) A program must provide an educational component

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178 approved by the Department of Education to a participant who is
179 absent from his or her school or educational setting for more
180 than 30 days. Before enrolling a participant, the program
181 supervisor must coordinate with the local school board to
182 provide an educational component as part of the participant's
183 program experience. To offer educational credit to participants,
184 the program must be recognized and approved by the State Board
185 of Education.
186 (4)(a) A program must employ a licensed psychiatrist or a
187 psychologist licensed under chapter 490 as its program
188 supervisor. The program supervisor is responsible for and has
189 authority over the policies and activities of the program. The
190 program supervisor shall coordinate office and support services,
191 supervise the operations of the program, and ensure that all
192 program staff are adequately trained. The program supervisor
193 shall maintain on file at all times enrollment records of all
194 participants and a current list of participants, including each
195 participant's group field activity or expedition and his or her
196 geographic location. The list must be updated every 24 hours.
197 The program supervisor must develop and sign a written plan for
198 each group field activity and expedition. Plans must not expose
199 participants to unreasonable risks.
200 (b) Each group field activity or expedition must have field
201 staff working directly with the participants. A program must
202 have field support staff members who are responsible for the
203 delivery of supplies to the field, mail delivery,
204 communications, and first aid support.
205 (c) Each program must provide its participants access to a
206 multidisciplinary team of licensed health care providers and

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

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207 licensed mental health counselors who have been trained in
208 providing medical services and treatment to adolescents and
209 children and which includes, at a minimum, the following:
210 1. A physician licensed under chapter 458 or chapter 459.
211 2. At least one of the following:
212 a. A psychologist licensed under chapter 490 or chapter
213 491.
214 b. A licensed clinical social worker.
215 c. A mental health counselor licensed under chapter 491.
216 d. A licensed marriage and family therapist.
217 e. A certified school counselor.
218 (d) All program staff, professional and non-professional,
219 and all providers who may be contracted to provide services to
220 participants must undergo a level 2 background screening before
221 engaging in any activity that brings them into contact with a
222 participant. The department may establish by rule further
223 staffing requirements consistent with this section.
224 Section 3. This act shall take effect July 1, 2016.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on Transportation, Tourism, and Economic Development, *Vice Chair*
Banking and Insurance
Criminal Justice
Education Pre-K-12
Ethics and Elections
Fiscal Policy

SENATOR JEFF CLEMENS
27th District

January 20, 2016

Senator René García, Chair
Appropriations Subcommittee on
Health and Human Services
201 The Capitol
404 S. Monroe Street
Tallahassee, FL 32399-1100

Chair García:

I respectfully request that SB 204 – Music Therapists be added to the agenda for the next Appropriations Subcommittee on Health and Human Services meeting.

SB 204 creates a registration process for board-certified music therapists in Florida. This will increase access to qualified music therapy services for Florida residents and limit the potential for harm to the public by ensuring music therapy can only be offered by registered therapists.

Please feel free to contact me with any questions. Thank you, in advance, for your consideration.

Sincerely,

Senator Jeff Clemens
Florida Senate District 27

REPLY TO:
❐ 508 Lake Avenue, Unit C, Lake Worth, Florida 33460 (561) 540-1140 FAX: (561) 540-1143
❐ 226 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5027

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: CS/SB 204

INTRODUCER: Health Policy Committee and Senator Clemens

SUBJECT: Music Therapists

DATE: February 9, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Stovall	HP	**Fav/CS**
2.	Brown	Pigott	AHS	**Favorable**
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 204 creates a new regulated profession, music therapists, in ch. 491, F.S., relating to clinical, counseling, and psychotherapy services. Music therapists will be regulated by the Department of Health (DOH) through a registration process in order to practice music therapy or hold oneself out as a music therapist, with certain exceptions. The bill requires biennial renewal of a music therapist's registration and authorizes the DOH to deny or revoke the registration or renewal for violations of s. 491.017, F.S.

The bill has an indeterminate but likely insignificant fiscal impact.

The bill has an effective date of July 1, 2016.

II. Present Situation:

The Sunrise Act and Sunrise Questionnaire

The Sunrise Act (the act), codified in s. 11.62, F.S., requires the Legislature to consider specific factors in determining whether to regulate a new profession or occupation. The act specifies that it is the intent of the Legislature that:

- No profession or occupation be subject to regulation unless the regulation is necessary to protect the public health, safety, or welfare from significant and discernible harm or damage

and that the state's police power be exercised only to the extent necessary for that purpose; and
- No profession or occupation be regulated in a manner that unnecessarily restricts entry into the practice of the profession or occupation or adversely affects the availability of the services to the public.

Under the act, the Legislature must review all legislation proposing regulation of a previously unregulated profession or occupation and make a determination for regulation based on consideration of the following:
- Whether the unregulated practice of the profession or occupation will substantially harm or endanger the public health, safety, or welfare, and whether the potential for harm is recognizable and not remote;
- Whether the practice of the profession or occupation requires specialized skill or training, and whether that skill or training is readily measurable or quantifiable so that examination or training requirements would reasonably assure initial and continuing professional or occupational ability;
- Whether the regulation will have an unreasonable effect on job creation or job retention in the state or will place unreasonable restrictions on the ability of individuals who seek to practice or who are practicing a given profession or occupation to find employment;
- Whether the public is or can be effectively protected by other means; and
- Whether the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers, will be favorable.

The act requires the proponents of legislation for the regulation of a profession or occupation to provide specific information in writing to the state agency that is proposed to have jurisdiction over the regulation and to the legislative committees of reference.[1] This required information is traditionally compiled in a "Sunrise Questionnaire."

Music Therapists[2]

Currently, music therapists are not regulated in Florida. The primary proponent seeking regulation of music therapists in Florida is the Florida Music Therapy State Task Force (task force). The task force has completed a Sunrise Questionnaire to provide information concerning the proposed regulation of a currently unregulated profession.

"Music therapy" is defined by the task force to mean "the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program." Music therapists serve clinical populations ranging in age from neonates in a hospital's neonatal intensive care unit (NICU) to older adults in hospice care. Music therapy services are provided in a variety of clinical settings, including:
- Psychiatric hospitals;
- Rehabilitative facilities;

[1] See s. 11.62(4)(a)-(m), F.S.
[2] Information in this portion of this Bill Analysis is from the Florida Senate Sunrise Questionnaire completed by the Florida Music Therapy State Task Force (on file with the Senate Committee on Health Policy).

- Medical hospitals;
- Outpatient clinics;
- Day care treatment centers;
- Agencies serving persons with developmental disabilities;
- Community mental health centers;
- Drug and alcohol programs;
- Senior centers;
- Nursing homes;
- Hospice programs;
- Correctional facilities;
- Halfway houses;
- Schools; and
- Private practice.

According to the task force, in some settings, such as certain school districts, the absence of licensure prevents access to music therapy services.

The task force estimates that there are 253 board-certified music therapists, four registered music therapists, and four certified music therapists in Florida.[3]

Music therapy degree programs are offered at approximately 73 colleges and universities in the United States. These programs are accredited by the American Music Therapy Association (AMTA). To become a music therapist, a student must earn a bachelor's degree or higher in music therapy from an AMTA-approved college or university. These programs require academic coursework and 1,200 hours of clinical training, including an approved supervised internship. An internship may be approved by the academic institution or the AMTA. Qualified supervision of clinical training is required and must be coordinated or verified by the academic institution. Internship supervisors must meet minimum requirements outlined by the AMTA Education and Clinical Training Standards.[4]

Currently in Florida, Florida State University (FSU) and the University of Miami (UM) have the only accredited music therapy programs. FSU and UM both offer bachelor's, master's, and doctoral degrees in music therapy. FSU graduates approximately 37 students annually and UM graduates approximately 11 students annually. Additionally, Florida Gulf Coast University is developing a music therapy program and is in the accreditation process.

National Certification of Music Therapists

There are two national organizations that recognize the music therapy profession: the AMTA and the Certification Board for Music Therapists (CBMT). The CBMT is the only organization that

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[3] The number of music therapists in Florida is based on information provided by the Certification Board for Music Therapists and the National Music Therapy Registry.

[4] A music therapy internship supervisor must have a clinical practice in music therapy (either private or institutional) and demonstrate the following: all professional level competencies; effectiveness as a music therapy clinician in at least one area of practice; general understanding of the supervisory needs of internship students, and established skills in supervision. *See* AMTA, *Standards for Education and Clinical Training*, "6.2 Clinical Supervisors," *available at* http://www.musictherapy.org/members/edctstan/ (last visited Jan. 13, 2016).

credentials music therapists nationally. The professional credential for a board-certified music therapist (MT-BC) is granted by the CBMT to individuals who have successfully completed an AMTA-approved academic and clinical training program and have passed a written objective national examination.

Currently, the majority of music therapists hold the MT-BC credential. Other credentials that a music therapist may have are: registered music therapist (RMT), certified music therapist (CMT), or advanced certified music therapist (ACMT). The RMT, CMT, and ACMT credentials were granted prior to 1998 and will expire in 2020.[5]

Regulation of Music Therapists in Other States

Currently eight states regulate music therapists through either licensure or registration.[6] The first state to regulate music therapists was Wisconsin in 1998, which provided a state registry for music therapists through the Wisconsin Department of Regulation and Licensing. This was a title protection act to prohibit the use of the title Wisconsin Music Therapist – Registered (WMTR) unless a music therapist is registered with the state of Wisconsin. Wisconsin does not license state music therapists, and registration is voluntary.[7] Music therapists were first licensed in the states of North Dakota and Nevada in 2011, followed by Georgia in 2012, Rhode Island and Utah in 2014, and Oregon in 2016.[8,9]

Licensure of Health Care Practitioners in Florida Legislature

The DOH is responsible for the licensure of most health care practitioners in the state. In addition to the regulatory authority in specific practice acts for each profession or occupation, ch. 456, F.S., provides the general regulatory provisions for health care professions within the DOH.

Section 456.001, F.S., defines "health care practitioner" as any person licensed under chs.457 (acupuncture); 458 (medicine); 459 (osteopathic medicine); 460 (chiropractic medicine); 461 (podiatric medicine); 462 (naturopathic medicine); 463 (optometry); 464 (nursing); 465 (pharmacy); 466 (dentistry and dental hygiene); 467 (midwifery); 478 (electrology or electrolysis); 480 (massage therapy); 484 (opticianry and hearing aid specialists); 486 (physical therapy); 490 (psychology); 491 (psychotherapy), F.S., or parts III or IV of ch. 483 (clinical laboratory personnel or medical physics), F.S.

Additionally, speech-language pathology and audiology; nursing home administration; occupational therapy; respiratory therapy; dietetics and nutrition practice; athletic trainers; and

[5] American Music Therapy Association, *Therapeutic Music Services At-A-Glance*, Ver. 14.1 (Feb. 2014), *available at*: http://www.musictherapy.org/assets/1/7/TxMusicServicesAtAGlance_15.pdf. , (last visited Jan. 13, 2016).
[6] *State Licensure*, The Certification Board for Music Therapists, *available at*: http://www.cbmt.org/examination/state-licensure/ (last visited Jan. 13, 2016). New York is the eighth state to regulate music therapists and they do so under the title of Licensed Creative Art Therapist.
[7] *See* Wisconsin Chapter for Music Therapy, *Wisconsin Music Therapy Registry* (2015), *available at* http://musictherapywisconsin.org/about-us/wmtr/ (last visited Jan. 13, 2016).
[8] *See* note 6 supra.
[9] New York is the eighth state to regulate music therapists and they do so under the title of Licensed Creative Art Therapist. *See* note 6 supra.

orthotics, prosthetics, and pedorthics regulated under ch. 468, F.S., are considered health care practitioners under s. 456.001, F.S.

III. Effect of Proposed Changes:

The bill creates s. 491.017, F.S., to recognize that music therapy affects the health, safety, and welfare of the public, and that the practice of music therapy should be subject to regulation to protect the public from the practice of music therapy by unregistered persons.

The bill provides the following definitions related to music therapists:
- "Board-certified music therapist" means a person who has completed the education and clinical training requirements established by the American Music Therapy Association and who holds current board certification from the national Certification Board for Music Therapists;
- "Music therapist" means a person registered to practice music therapy pursuant to s. 491.017, F.S.;
- "Music therapy" means the clinical and evidence-based use of music interventions by a board-certified music therapist to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship.

Under the bill, music therapy interventions may include:
- Music improvisation;
- Receptive music listening;
- Song writing;
- Lyric discussion;
- Music and imagery, singing;
- Music performance;
- Learning through music;
- Music combined with other arts;
- Music-assisted relaxation;
- Music-based patient education;
- Electronic music technology;
- Adapted music intervention; and
- Movement to music.

The practice of music therapy does not include the diagnosis or assessment of any physical, mental, or communication disorder.

The bill establishes a registration process and responsibilities for music therapists. A person must be registered as a music therapist to practice musical therapy in this state or to use the title "music therapist," with certain exceptions for a person who does not hold himself or herself out as a music therapist. These exceptions include:
- A person who is licensed, certified, or regulated to practice a profession or occupation in Florida, or personnel supervised by a licensed professional in this state performing work, including the use of music, incidental to the practice of his or her licensed, certified, or regulated profession or occupation;

- A person whose training and national certification attests to the person's preparation and ability to practice his or her certified profession or occupation;
- A student practicing music therapy as a part of an accredited music therapy program; or
- A person practicing music therapy under the supervision of a registered music therapist.

A music therapist may:
- Accept referrals for services from medical, developmental, mental health, or education professionals; family members; clients; caregivers; or other persons authorized to provide client services;
- Collaborate with a client's primary care provider or treatment team before providing services to a client with an identified clinical or developmental need;
- Conduct a music therapy assessment of a client and if treatment is indicated, collect information to determine the appropriateness and type of music therapy services to provide for the client;
- Develop an individualized treatment plan for the client that is based on the results of the music therapy assessment and is consistent with any other developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness, or educational services being provided to the client;
- Evaluate the client's response to music therapy and modify the music therapy treatment plan, as appropriate;
- Develop a plan for determining when music therapy services are no longer needed;
- Minimize barriers to ensure that the client receives music therapy services in the least restrictive environment;
- Collaborate with and educate the client and the client's family members, caregivers, and any other appropriate persons regarding the needs of the client that are being addressed in music therapy and the manner in which the music therapy treatment addresses those needs; and
- Use appropriate knowledge and skills to inform practice to determine appropriate actions in the context of each specific clinical setting.

The bill authorizes the DOH to adopt rules to implement the bill and to establish application, registration, and renewal fees as estimated necessary, not to exceed $50. The DOH may deny or revoke a registration or renewal of registration for violations of s. 491.017, F.S.

The bill provides an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

Under CS/SB 204, music therapists will be required to pay fees associated with registration and renewal, not to exceed $50 each.

B. Private Sector Impact:

Music therapists are required to pay an initial registration fee as well as biennial renewal fees.

C. Government Sector Impact:

The DOH will experience an indeterminate increase in revenues based on music therapist registration application fees and renewal fees. The DOH will also incur an indeterminate increase in workload and costs associated with the regulation of music therapists and educating the public concerning music therapy and licensure.

VI. Technical Deficiencies:

None

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 491.017 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on January 19, 2016:
The CS establishes a title protection act for Music Therapists rather than a full licensure and regulatory structure. Application fees, and registration and renewal fees, are limited to $50 each. Registration as a music therapist is predicated on passing a board certification examination and maintaining that certification.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By the Committee on Health Policy; and Senator Clemens

588-02319-16 2016204c1

1 A bill to be entitled
2 An act relating to music therapists; creating s.
3 491.017, F.S.; providing legislative intent; providing
4 definitions; establishing requirements for
5 registration as a music therapist; providing
6 responsibilities of a music therapist; requiring
7 biennial renewal of registration; prohibiting the
8 practice of music therapy unless the therapist is
9 registered; providing exemptions to registration;
10 authorizing the Department of Health to adopt rules
11 and take disciplinary action against an applicant or
12 registrant who violates the act; providing an
13 effective date.
14
15 Be It Enacted by the Legislature of the State of Florida:
16
17 Section 1. Section 491.017, Florida Statutes, is created to
18 read:
19 491.017 Registration of music therapists.—
20 (1) LEGISLATIVE INTENT.—It is the intent of this section to
21 recognize that music therapy affects the health, safety, and
22 welfare of the public, and that the practice of music therapy
23 should be subject to regulation to protect the public from the
24 practice of music therapy by unregistered persons.
25 (2) DEFINITIONS.—As used in this section, the term:
26 (a) "Board-certified music therapist" means a person who
27 has completed the education and clinical training requirements
28 established by the American Music Therapy Association and who
29 holds current board certification from the national
30 Certification Board for Music Therapists.
31 (b) "Music therapist" means a person registered to practice
32 music therapy pursuant to this section.

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33 (c) "Music therapy" means the clinical and evidence-based
34 use of music interventions by a board-certified music therapist
35 to accomplish individualized goals for people of all ages and
36 ability levels within a therapeutic relationship. The music
37 therapy interventions may include music improvisation, receptive
38 music listening, song writing, lyric discussion, music and
39 imagery, singing, music performance, learning through music,
40 music combined with other arts, music-assisted relaxation,
41 music-based patient education, electronic music technology,
42 adapted music intervention, and movement to music. The practice
43 of music therapy does not include the diagnosis or assessment of
44 any physical, mental, or communication disorder.
45 (3) REGISTRATION.—
46 (a) The department shall register an applicant as a music
47 therapist when the applicant submits to the department:
48 1. A completed application form issued by the department;
49 2. Application and registration fees; and
50 3. Proof of passing the examination for board certification
51 offered by the national Certification Board for Music
52 Therapists, or any successor organization, or proof of being
53 transitioned into board certification, and provides proof that
54 the applicant is currently a board-certified music therapist.
55 (b) A registration issued under this section must be
56 renewed biennially by submitting to the department a renewal fee
57 and proof that the applicant holds an active certificate as a
58 board-certified music therapist.
59 (c) A registrant shall inform the department within 10 days
60 after a change of the registrant's address or a change in the
61 registrant's status as a board-certified music therapist.

62 (4) RESPONSIBILITIES OF A MUSIC THERAPIST.—A music
63 therapist is authorized to:
64 (a) Accept referrals for music therapy services from
65 medical, developmental, mental health, or education
66 professionals; family members; clients; caregivers; or other
67 persons authorized to provide client services.
68 (b) Collaborate with a client's primary care provider to
69 review the client's diagnosis, treatment needs, and treatment
70 plan before providing services to a client with an identified
71 clinical or developmental need or collaborate with the client's
72 treatment team while providing music therapy services to the
73 client.
74 (c) Conduct a music therapy assessment of a client to
75 determine if treatment is indicated and, if treatment is
76 indicated, collect systematic, comprehensive, and accurate
77 information to determine the appropriateness and type of music
78 therapy services to provide for the client.
79 (d) Develop an individualized music therapy treatment plan,
80 including individualized goals, objectives, and specific music
81 therapy approaches or interventions, for the client that is
82 based on the results of the music therapy assessment and is
83 consistent with any other developmental, rehabilitative,
84 habilitative, medical, mental health, preventive, wellness, or
85 educational services being provided to the client.
86 (e) Evaluate the client's response to music therapy and the
87 music therapy treatment plan, documenting change and progress
88 and suggesting modifications, as appropriate.
89 (f) Develop a plan for determining when music therapy
90 services are no longer needed, in collaboration with the client

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91 and the client's physician or other provider of health care or
92 education to the client, family members of the client, and any
93 other appropriate person upon whom the client relies for
94 support.
95 (g) Minimize barriers to ensure that the client receives
96 music therapy services in the least restrictive environment.
97 (h) Collaborate with and educate the client and the
98 client's family members, caregivers, and any other appropriate
99 persons regarding the needs of the client that are being
100 addressed in music therapy and the manner in which the music
101 therapy treatment addresses those needs.
102 (i) Use appropriate knowledge and skills to inform
103 practice, including the use of research, reasoning, and problem-
104 solving skills to determine appropriate actions in the context
105 of each specific clinical setting.
106 (5) PROHIBITED ACTS; EXEMPTIONS.—A person may not practice
107 music therapy or represent himself or herself as being able to
108 practice music therapy in this state unless the person is
109 registered pursuant to this section. This section does not
110 prohibit or restrict the practice, services, or activities of
111 the following:
112 (a) A person licensed, certified, or regulated under the
113 laws of this state in another profession or occupation, or
114 personnel supervised by a licensed professional in this state
115 performing work, including the use of music, incidental to the
116 practice of his or her licensed, certified, or regulated
117 profession or occupation, if that person does not represent
118 himself or herself as a music therapist;
119 (b) A person whose training and national certification

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

120 attests to the person's preparation and ability to practice his
121 or her certified profession or occupation, if that person does
122 not represent himself or herself as a music therapist;
123 (c) Any practice of music therapy as an integral part of a
124 program of study for students enrolled in an accredited music
125 therapy program, if the student does not represent himself or
126 herself as a music therapist; or
127 (d) A person who practices music therapy under the
128 supervision of a registered music therapist, if the person does
129 not represent himself or herself as a music therapist.
130 (6) DEPARTMENT AUTHORITY.—
131 (a) The department is authorized to establish application,
132 registration, and renewal fees estimated necessary to implement
133 the provisions of this section, but each fee may not exceed $50.
134 (b) The department is authorized to adopt rules to
135 implement this section.
136 (c) The department may deny or revoke registration or
137 renewal of registration for violations of this section.
138 Section 2. This act shall take effect July 1, 2016.
139

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

The Florida Senate

Committee Agenda Request

To: Senator Rene Garcia, Chair
Appropriations Subcommittee on Health and Human Services

Subject: Committee Agenda Request

Date: January 29, 2016

I respectfully request that **Senate Bill # 1686**, relating to Telehealth, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Aaron Bean

Senator Aaron Bean
Florida Senate, District 4

File signed original with committee office

S-020 (03/2004)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: CS/SB 1686

INTRODUCER: Health Policy Committee and Senators Bean and Joyner

SUBJECT: Telehealth

DATE: February 9, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Fav/CS**
2.	Brown	Pigott	AHS	**Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1686 creates a Telehealth Task Force within the Agency for Health Care Administration (AHCA), authorizes health care practitioners in Florida to provide telehealth services, and defines telehealth.

The task force will be chaired by the Secretary of the AHCA or his or her designee. The other members of the task force will include the State Surgeon General, and 17 other members, including other health care practitioners, health care providers, telehealth services providers and sellers, and representatives of health care facilities.

The bill requires the task force to compile data and submit a report by June 30, 2017, to the Governor, the President of the Senate, and the Speaker of the House of Representatives, that analyzes:

- Frequency and extent of the use of telehealth nationally and in this state;
- Costs and cost savings associated with using telehealth;
- Types of telehealth services available;
- Extent of available health insurance coverage available for telehealth services; and
- Barriers to implementing the use of, using, or accessing telehealth services.

The bill requires the task force to hold its first meeting by September 1, 2016, and to meet as frequently as necessary to complete its work. The AHCA must support the task force within

existing resources; members of the task force will serve without compensation or per diem reimbursement. The section of law creating the task force sunsets December 1, 2017.

The bill has no direct fiscal impact but could result in cost-savings for the Medicaid program to an indeterminate extent.

The effective date of the bill is July 1, 2016.

II. Present Situation:

The term telehealth is sometimes used interchangeably with telemedicine. Telehealth, however, generally refers to a wider range of health care services that may or may not include clinical services.[1] Telehealth often collectively defines the telecommunications equipment and technology that is used to collect and transmit the data for a telemedicine consultation or evaluation.

The federal Centers for Medicare & Medicaid Services (CMS) defines telehealth as:

> The use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth includes such technologies such as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devises which are used to collect and transmit data for monitoring and interpretation.[2]

Telemedicine is not a separate medical specialty and does not change what constitutes proper medical treatment and services. According to the American Telemedicine Association, services provided through telemedicine include:[3]

- Primary care and specialist referral services that involve a primary care or allied health professional providing consultation with a patient or specialist assisting the primary care physician with a diagnosis;
- Remote patient monitoring;
- Consumer medical and health information that offers consumers specialized health information and online discussion groups for peer-to-peer support; and
- Medical education that provides continuing medical education credits.

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[1] Anita Majerowicz and Susan Tracy, *"Telemedicine: Bridging Gaps in Healthcare Delivery,"* Journal of AHIMA 81, no. 5, (May 2010); 52-53, 56. http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_047324.hcsp?dDocName=bok1_047324 (last visited Jan. 14, 2016).

[2] Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Telemedicine,* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/telemedicine.html (last visited Jan. 14, 2016).

[3] American Telemedicine Association, *What is Telemedicine?* http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.Vpf-P03ot9A (last visited Jan. 14, 2016).

Board of Medicine Rulemaking

Florida's Board of Medicine (board) convened a Telemedicine Workgroup in 2013 to review its rules on telemedicine, which had not been amended since 2003. The 2003 rules focused on standards for the prescribing of medicine via the Internet. On March 12, 2014, the board's new Telemedicine Rule, 64B8-9.0141, became effective for Florida-licensed physicians. The new rule defined telemedicine, established standards of care, prohibited the prescription of controlled substances, permitted the establishment of a doctor-patient relationship via telemedicine, and exempted emergency medical services.[4]

Two months after the initial rule's implementation, the board proposed the development of a rule amendment to address concerns that the prohibition on physicians ordering controlled substances may also preclude physicians from prescribing controlled substances via telemedicine for hospitalized patients. The board indicated such a prohibition was not intended.[5] The amended rule took effect July 22, 2014.

Additional changes followed to clarify medical record requirements and the relationship between consulting or cross-coverage physicians. On December 18, 2015, the board published another proposed rule change to allow controlled substances to be prescribed through telemedicine for the limited treatment of psychiatric disorders.[6] The proposed rule amendment, Rule 64B8-9.0141-Standards for Telemedicine Practice, has been noticed by the Board of Medicine and if requested within 21 days of its first publication date in the Florida Administrative Registrar (FAR), a public hearing on the rule amendment, would be held on the rule and announced at a later date in the FAR. No public hearing notice has yet been published.

Telemedicine in Other States

As of May 2015, 24 states and the District of Columbia have mandated that private insurance plans cover telemedicine services at reimbursement rates equal to an in-person consultation.[7] Such laws require insurance companies and health plans to reimburse providers the same amount for the same visit regardless of whether the visit was conducted face-to-face or via electronic communications.

Forty-eight state Medicaid programs also reimburse for some form of telemedicine via live video.[8] A smaller number of states offer reimbursement for other types of telemedicine services, such as store-and-forward activities;[9] facility fees for hosting either the telemedicine provider,

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[4] Rule 64B15-14.0081, F.A.C., also went into effect March 12, 2014 for osteopathic physicians.

[5] Florida Board of Medicine, *Latest News - Emergency Rule Related to Telemedicine,* http://flboardofmedicine.gov/latest-news/emergency-rule-related-to-telemedicine/ (last visited Jan. 14, 2016).

[6] Vol. 41/244, Fla. Admin. Weekly, Dec. 18, 2015, available at https://www.flrules.org/BigDoc/View_Section.asp?Issue=2011&Section=1 (last visited Feb. 8, 2016).

[7] American Telemedicine Association, *50 State Telemedicine Gaps Analysis: Coverage & Reimbursement*, p. 2, http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis---coverage-and-reimbursement.pdf (last visited Jan. 14, 2016).

[8] Id.

[9] Store and forward technology refers to the electronic transmission of medical information and data such as digital images, documents and pre-recorded images for review by a physician or specialist at a later date, not simultaneously with the patient.

patient, or both; and remote patient monitoring. Florida, Idaho, and Montana only provide reimbursement for physician services.[10]

Hospitals in rural counties have utilized telemedicine to provide specialty care in their emergency rooms and to avoid costly and time-consuming transfers of patients from smaller hospitals to the larger tertiary centers for care.

In a California project, rural hospital emergency rooms received video conference equipment to facilitate the telemedicine consultations. The rural hospital physicians and nurses were linked with pediatric critical care medicine specialists at the University of California, Davis.[11] As a *Futurity* article notes, "while 21 percent of children in the United States live in rural areas, only 3 percent of pediatric critical-care medicine specialists practice in such areas."[12]

Federal Provisions for Telemedicine

Federal laws and regulations address telemedicine from several angles, including prescriptions for controlled substances, hospital emergency room guidelines, and reimbursement rates for the Medicare program.

Prescribing Via the Internet

Federal law specifically prohibits the prescribing of controlled substances via the Internet without an in-person evaluation. Federal regulation 21 CFR §829 specifically states:

> No controlled substance that is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act may be delivered, distributed or dispensed by means of the Internet without a valid prescription.

A valid prescription is further defined under the same regulation as one issued by a practitioner who has conducted an in-person evaluation. The in-person evaluation requires that the patient be in the physical presence of the provider without regard to the presence or conduct of other professionals.[13] However, the Ryan Haight Online Pharmacy Consumer Protection Act,[14] signed into law in October 2008, created an exception for the in-person medical evaluation for telemedicine practitioners. The practitioner is still subject to the requirement that all controlled substances be issued for a legitimate purpose by a practitioner acting in the usual course of professional practice.

The Drug Enforcement Administration (DEA) of the federal Department of Justice issued its own definition of telemedicine in April 2009, as required under the Haight Act.[15] The federal regulatory definition of telemedicine under the DEA includes, but is not limited to, the following elements:

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[10] *Supra* note 7.
[11] Futurity, *In Rural ERs, Kids Get Better Care with Telemedicine,* http://www.futurity.org/in-rural-ers-kids-get-better-care-with-telemedicine/ (last visited Jan. 14, 2016).
[12] Id.
[13] 21 CFR §829(e)(2).
[14] Ryan Haight Online Consumer Protection Act of 2008, Public Law 110-425 (H.R. 6353).
[15] Id., at sec. 3(j).

- The patient and practitioner are located in separate locations;
- Patient and practitioner communicate via a telecommunications system;
- The practitioner must meet other registration requirements for the dispensing of controlled substances via the Internet; and
- Certain practitioners (Department of Veterans Affairs' employees, for example) or practitioners in certain situations (public health emergencies) may be exempted from registration requirements.[16]

Medicare Coverage

Specific telehealth services delivered at designated sites are covered under Medicare. Regulations of federal CMS require both a distant site (location of physician delivering the service via telecommunications) and an originating site (location of the patient).

To qualify for Medicare reimbursement, the Medicare beneficiary must be located at an originating site that meets one of three qualifications. These three qualifications are:

- A rural health professional shortage area (HPSA) that is either outside a metropolitan statistical area (MSA) or in a rural census tract;
- A county outside of an MSA; or
- Participation in a federal telemedicine demonstration project approved by the Secretary of Health and Human Services as of December 31, 2000.[17]

Additionally, federal requirements provide that an originating site must be one of the following location types as further defined in federal law and regulation:

- The office of a physician or practitioner;
- A hospital;
- A critical access hospital (CAH);
- A rural health clinic;
- A federally qualified health center;
- A hospital-based or CAH-based renal dialysis center (including satellite offices);
- A skilled nursing facility; or
- A community mental health center.[18]

Under Medicare, distant site practitioners are limited, subject also to state law, to:

- Physicians;
- Nurse practitioners;
- Physician assistants;
- Nurse-midwives;
- Clinical nurse specialists;
- Certified registered nurse anesthetists;
- Clinical psychologists and clinical social workers; and

[16] 21 CFR §802(54).
[17] Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Telehealth Services- Rural Health Fact Sheet* (Dec. 2014), http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf (last visited Jan. 20, 2016).
[18] *See* 42 U.S.C. sec. 1395(m)(m)(4)(C)(ii).

- Registered dietitians and nutrition professionals.

For 2016, federal CMS added certified registered nurse anesthetists to the list of authorized distant site practitioners who can furnish telehealth services.[19]

For 2015, Medicare added new services under telehealth:
- Annual wellness visits;
- Psychoanalysis;
- Psychotherapy; and
- Prolonged evaluation and management services.[20]

For 2016, Medicare supplemented those services with end-stage renal disease services.[21]

Reimbursement for the distant site is established as “an amount equal to the amount that such physician or practitioner would have been paid under this title had such service been furnished without the use of a telecommunications system.”[22] Federal law also provides for a facility fee for the originating site of $20 through December 31, 2002, and then, by law, the facility fee is subsequently increased each year by the percentage increase in the Medicare Economic Index (MEI). For calendar year 2016, the originating fee for telehealth is 80 percent of the lesser of the actual charge or $25.10.[23]

Telemedicine Services in Florida

University of Miami

The University of Miami (UM) initiated telehealth services in 1973 and claims the first telehealth service in Florida, the first use of nurse practitioners in telemedicine in the nation, and the first telemedicine program in correctional facilities.[24] Today, UM has several initiatives in the area of telehealth, including:
- Tele-dermatology;
- Tele-trauma;
- Humanitarian and disaster response relief;
- School telehealth services; and
- Acute tele-neurology or tele-stroke.

While some of UM’s activities reach its local community, others reach outside of Florida, including providing Haiti earthquake relief and tele-dermatology to cruise line employees.

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[19] Department of Health and Human Services, Centers for Medicare and Medicaid Services, *MLN Matters - News Flash #MM9476* (Dec. 18, 2015), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9476.pdf (last visited Jan. 14, 2016).
[20] Department of Health and Human Services, Centers for Medicare and Medicaid Services, *MLN Matters - News Flash #MM9034* (Dec. 24, 2014), http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9034.pdf (last visited Jan. 20, 2016).
[21] *Supra,* Note 19.
[22] *See* 42 U.S.C. s. 1395(m)(m)(2)(A).
[23] *Supra* note *19*.
[24] University of Miami, Miller School of Medicine, *UM Telehealth - Our History*, http://telehealth.med.miami.edu/about-us/our-history (last visited Jan. 14, 2016).

Telehealth communications are also used for monitoring hospital patients and conducting training exercises.

Florida Medicaid Program

Florida's Medicaid program reimburses only physicians for telemedicine services when there is two-way, real-time interactive communication between a patient and a physician at a distant site.[25] Equipment is also required to meet specific technical safeguards under 45 CFR 164.312, where applicable, which require implementation of procedures for protection of health information, including unique user identifications, automatic log-offs, encryption, authentication of users, and transmission security. Telemedicine services must also comply with all other state and federal laws regarding patient privacy.

For Medicaid, the distant or hub site is where the consulting physician delivering the telemedicine service is located. The spoke site is the location of the Medicaid recipient at the time the service occurs. The spoke site does not receive any reimbursement unless the provider located at the spoke site performs a separate service for the Medicaid recipient on the same day as the telemedicine consultation. The telemedicine referral consultation requires the presence of the referring practitioner and the Medicaid recipient.[26]

Under Medicaid fee-for-service, Medicaid reimbursement for telemedicine services is limited to certain services and settings. The following services are currently covered:[27]

- Behavioral health services, including:
  - Tele-psychiatry services for psychiatric medication management by practitioners licensed under ch. 458 or 459, F.S.; and
  - Tele-behavioral health services for provision of individual and family behavioral health therapy services by qualified practitioners licensed under ch. 490 or 491, F.S.;
  - Dental services provided using video conferencing between a registered dental hygienist employed by and under contract with a Medicaid-enrolled group provider and supervising dentist, including oral prophylaxis, topical fluoride application, and oral hygiene instructions; and
- Physician services, including:
  - Services provided using audio and video equipment that allow for two-way, real-time, interactive communication between the physician and a patient;
  - Consultation services provided via telemedicine;
  - Interpretation of diagnostic testing results through telecommunications and information technology; and
  - Synchronous emergency services provided under parts III and IV of ch. 409, F.S., using an all-inclusive rate.

Medicaid does not reimburse for the following telemedicine services:

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[25] Agency for Health Care Administration, *Practitioner Services Handbook - Telemedicine Services* (April 2014) p. 136, *available at* http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Practitioner%20Services%20Handbook_Adoption.pdf (last visited Jan. 14, 2016).

[26] Id at 137.

[27] Agency for Health Care Administration, *Senate Bill 478 Analysis* (Feb. 4, 2015) p. 3, (on file with the Senate Committee on Health Policy).

- Telephone conversations;
- Video cell phone conversations;
- Email messages;
- Facsimile transmission;
- Telecommunication with recipient at a location other than the spoke; and
- "Store and forward" consultations that are transmitted after the recipient or physician is no longer available.[28]

Medicaid also does not reimburse providers for the costs of any equipment related to telemedicine services.

Coverage of telemedicine services under Medicaid includes specific documentation requirements. The clinical record must include the following information:

- A brief explanation of why the services were not provided face-to-face;
- Documentation of telemedicine services provided, including the results of the assessment; and
- A signed statement from the recipient (parent or guardian, if a child) indicating his or her choice to receive services through telemedicine.[29]

Under the Managed Medical Assistance (MMA) component of Statewide Medicaid Managed Care, managed care plans may use telemedicine for behavioral health, dental services, and physician services.[30] The AHCA may also approve other telemedicine services provided by the managed care plans if approval is sought by those plans under the MMA component.

Child Protection Teams

The child protection team program (CPT) under the Department of Health's Children's Medical Services Network utilizes a telemedicine network to perform child assessments. The CPT is a medically-directed, multi-disciplinary program that works with local sheriff's offices and the Department of Children and Families in cases of child abuse and neglect to supplement investigative activities.[31] The CPT patient is seen at a remote site and a registered nurse assists with the medical exam. A physician or advanced registered nurse practitioner (ARNP) is located at the hub site and has responsibility for directing the exam.[32]

Hub sites are comprehensive medical facilities that include a wide range of medical and interdisciplinary staff, whereas the remote sites tend to be smaller facilities that may lack medical diversity.[33] Twenty-four hub sites throughout the state facilitate these child abuse

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[28] Id.

[29] Id.

[30] Agency for Health Care Administration, *2012-2015 Medicaid Health Plan Model Agreement Attachment II - Exhibit II-A,* p. 63-64 http://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/Attachment_II_Exhibit_II-A_MMA_Model_2014-01-31.pdf , (last visited Jan. 14, 2016).

[31] Florida Dep't of Health, *Child Protection Teams*, http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/child_protection_safety/child_protection_teams.html (last visited Jan. 14, 2016).

[32] Florida Dep't of Health, *Children Protection Team - Telemedicine Network* http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/child_protection_safety/documents/cpt_telemedicine_fact_sheet.pdf (last visited Jan. 14, 2016).

[33] Id.

assessments and the evaluation of suspected cases of child abuse. The University of Florida Child Abuse Protection Team, for example, serves a 12-county area and, for the first six months of 2012, provided over 250 telemedicine examinations with medical community partners.[34]

Compliance with the Health Insurance Portability and Accountability Act (HIPAA)

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information (PHI). Privacy rules were initially issued in 2000 by the federal Department of Health and Human Services and later modified in 2002. These rules address the use and disclosure of an individual's health information and create standards for privacy rights. Additional privacy and security measures were adopted in 2009 with the Health Information Technology for Economic Clinical Health (HITECH) Act.

Only certain entities are subject to HIPAA's provisions. These "covered entities" include:
- Health plans;
- Health care providers;
- Health care clearinghouses; and
- Business associates of the entities listed above.

While not a covered entity as an individual, the patient still maintains his or her privacy and confidentiality rights regardless of the method in which a medical service is delivered. The HITECH Act specifically identified telemedicine as an area for review and consideration, and funding was provided to, in part, strengthen infrastructure and tools to promote telemedicine.[35]

Under the provisions of HIPAA and the HITECH Act, a health care provider or other covered entity participating in telemedicine is required to meet the same technical and physical HIPAA and HITECH requirements as would be required for a physical office visit. These requirements include ensuring that that the equipment and technology are HIPAA compliant.

Discount Medical Plans

Discount medical plans and discount medical plan organizations (DMPOs) are regulated by the Office of Insurance Regulation under part II of ch. 636, F.S. DMPOs offer a variety of health care services to consumers through discount medical plans at a discounted rate. These plans are not health insurance and therefore do not pay for services on behalf of members; instead, the plans offer members access to specific health care products and services at a discounted fee. These health products and services may include, but are not limited to, dental services, emergency services, mental health services, vision care, chiropractic services, and hearing care. Generally, a DMPO has a contract with a provider network under which the individual providers render the medical services at a discount.

[34] Sunshine Arnold and Debra Esernio-Jenssen, *Telemedicine: Reducing Trauma in Evaluating Abuse,* pp. 105-107, http://cdn.intechopen.com/pdfs-wm/41847.pdf (last visited Jan. 14, 2016).
[35] Public Law 111-5, s. 3002(b)(2)(C)(iii) and s. 3011(a)(4).

III. Effect of Proposed Changes:

Section 1 establishes the Telehealth Task Force as a new section of law in s. 408.61, F.S. The task force is created within the AHCA and the AHCA is directed to use existing resources to administer and support its activities.

Under the bill, task force members do not receive any compensation or reimbursement for per diem for travel expenses. Meetings may be held in person, by conference call, or other electronic means. The Secretary of the AHCA or his or her designee serves as the task force chair, and the state Surgeon General or his or her designee also serves, along with 17 other members. The Secretary of the AHCA appoints 10 members:

- Three representatives of hospitals or facilities licensed under chapter 395;
- Three representatives of health insurers that offer coverage of telehealth services;
- Two representatives of organizations that represent health care facilities; and
- Two representatives of entities that create or sell telehealth products.

The State Surgeon General appoints 7 members:

- Five health care practitioners, each of whom practices in a different area of medicine; and
- Two representatives of organizations that represent health care practitioners.

The bill requires the task force to compile data and submit a report by June 30, 2017, to the Governor, the President of the Senate, and the Speaker of the House of Representatives that analyzes:

- Frequency and extent of the use of telehealth nationally and in this state;
- Costs and cost savings associated with using telehealth technology and equipment;
- Types of telehealth services available;
- The extent of available health insurance coverage available for telehealth services, including:
  - A comparative analysis of such coverage to available coverage for in-person services;
  - A description of payment rates for such telehealth services and whether they are below, equal to, or above payment rates for in-person services;
  - Copayment, coinsurance, and deductible amounts; policy year, calendar year, lifetime, or other durational benefit limitations; and maximum benefits for telehealth and in-person services; and
  - Any unique conditions imposed as a prerequisite to obtaining coverage for telehealth services;
- Barriers to implementing the use of, using, or accessing telehealth services; and
- Consideration of opportunities for interstate cooperation in telehealth.

Under the bill, this section of law sunsets effective December 1, 2017.

Section 2 creates s. 456.51, F.S., relating to telehealth, which is applicable to healthcare practitioners generally. A health care practitioner[36] certified under part III of chapter 401,[37] or a person certified under part IV or V of chapter 468[38] who is practicing within the scope of his or her license or certification, may provide telehealth services.

Under the bill, a practitioner or person who provides telehealth services within the scope of his or her license, but is not a physician, will not be considered to be practicing medicine without a license.

"Telehealth" is specifically defined to mean:

> The use of synchronous or asynchronous telecommunications technology by a health care practitioner, a person certified under part III of chapter 401, or a person certified under part IV of chapter 468 to provide medical or other health care services, including, but not limited to, patient assessment, diagnosis, consultation, treatment, or remote monitoring; the transfer of medical or health data; patient and professional health-related education; the delivery of public health services; and health care administration functions.

Section 3 amends the definition of "discount medical plan" under s. 636.202(1), F.S., to provide that "discount medical plan" does not include any telehealth products defined under s. 456.51, F.S.

Section 4 provides that the act is effective July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

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[36] The definition of a "health care practitioner" includes 26 different disciplines: Acupuncture, medical practice, osteopathic medicine, chiropractic medicine, podiatry, naturopathy, optometry, nursing, pharmacy, dentistry, midwifery, speech-language-pathology-audiology, nursing home administration, occupational therapy, respiratory therapy, dietetics and nutrition practice, athletic trainers, orthotics, prosthetics, and pedorthotics, electrolysis, massage, clinical laboratory personnel, medical physicists, dispensing of optical devices and hearing aids, physical therapy, psychological services, and clinical, counseling, and psychotherapy.

[37] Persons certified under chapter 301 are those employed in the emergency medical services field, including emergency medical technicians, paramedics, and registered nurses.

[38] Part IV of Chapter 468 are those individuals certified as radiological personnel, and Part V regulates respiratory therapists.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Under CS/SB 1686, Florida does not currently have a statutory definition for telehealth or telemedicine. Florida TaxWatch has opined in its report, *Moving Telehealth Forward: The High Costs of Paying Later,* that the lack of certainty in Florida around telehealth has led to confusion among providers on billing and payment options.[39] Florida TaxWatch estimated that with more timely access to care through telehealth, a one percent reduction in hospital charges alone could save $1 billion through hospitalization avoidance costs.[40]

The average estimated cost of a telehealth visit ranges from $40 to $50, compared to the average in-person visit of $136 to $176.[41] With an estimated savings of approximately $126 per telehealth visit, the report also showed that the participating vendor was able to resolve a patient's issue approximately 83 percent of the time.[42] When asked where the patient would have gone to receive care, or whether the patient would have received care at all, if not via telehealth, the most likely answer was urgent care (45.8 percent), physician office (30.9 percent), no care at all (12.3 percent), emergency room (5.6 percent), or other clinics (5.4 percent).[43] Other than receiving no care, all of these options would have cost more than the cost of the telehealth visit, ranging from the emergency room ($943 - $1,595) to other clinics ($57 - $83).[44]

C. Government Sector Impact:

The AHCA is required to use existing resources to support activities of the task force.

The Medicaid program may also be impacted with the definition of standard of care for telehealth to the extent that it may differ from the definition currently used by the program. Higher utilization of telehealth services may result in cost savings in other areas of the Medicaid program if the Florida Medicaid program experiences similar results as seen in other state Medicaid programs, such as New York, Texas, and California, where telehealth reimbursement parity is mandated.

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[39] Florida Tax Watch, *Moving Telehealth Forward: The High Costs of Paying Later*, p. 2, (August 2015). www.floridataxwatch.org.
[40] Id at 5.
[41] Dale H. Yamamoto, *Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services*, http://www.connectwithcare.org/wp-content/uploads/2014/12/Medicare-Acute-Care-Telehealth-Feasibility.pdf p. 2, (last visited Jan. 14, 2016).
[42] Id at 5.
[43] Id.
[44] Id at 6.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates the following sections of the Florida Statutes: 408.61 and 456.51.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on January 26, 2016:
The CS makes three modifications to the bill:
- Adds consideration of opportunities for interstate cooperation to the list of items to be reviewed and evaluated by the Telehealth Task Force;
- Includes respiratory therapists to the definition of a telehealth practitioner; and
- Modifies the definition of a "discount medical plan" under s. 636.202, F.S., to specifically exclude telehealth products defined under s. 456.51, F.S.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By the Committee on Health Policy; and Senators Bean and Joyner

588-02606-16 20161686c1

1 A bill to be entitled
2 An act relating to telehealth; creating s. 408.61,
3 F.S.; creating the Telehealth Task Force within the
4 Agency for Health Care Administration; requiring the
5 agency to use existing and available resources to
6 administer and support the task force; providing for
7 the membership of the task force; requiring the task
8 force to compile and analyze certain data and to
9 conduct a comparative analysis of health insurance
10 coverage available for telehealth services and for in-
11 person treatment; providing meeting requirements;
12 requiring the task force to submit a report to the
13 Governor and Legislature by a certain date; providing
14 for the repeal of the section; creating s. 456.51,
15 F.S.; authorizing certain licensed or certified health
16 care professionals to provide telehealth services;
17 defining the term "telehealth"; amending s. 636.202,
18 F.S.; excluding telehealth products from the
19 definition of "discount medical plan"; providing an
20 effective date.
21
22 Be It Enacted by the Legislature of the State of Florida:
23
24 Section 1. Section 408.61, Florida Statutes, is created to
25 read:
26 408.61 Telehealth Task Force.—
27 (1) The Telehealth Task Force is created within the agency.
28 The agency shall use existing and available resources to
29 administer and support the activities of the task force under
30 this section.
31 (2) Members of the task force shall serve without
32 compensation and are not entitled to reimbursement for per diem

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588-02606-16 20161686c1

33 or travel expenses. The task force shall consist of the
34 following 19 members:
35 (a) The Secretary of Health Care Administration or his or
36 her designee, who shall serve as the chair of the task force.
37 (b) The State Surgeon General or his or her designee.
38 (c) Three representatives of hospitals or facilities
39 licensed under chapter 395, three representatives of health
40 insurers that offer coverage of telehealth services, two
41 representatives of organizations that represent health care
42 facilities, and two representatives of entities that create or
43 sell telehealth products, all appointed by the Secretary of
44 Health Care Administration.
45 (d) Five health care practitioners, each of whom practices
46 in a different area of medicine, and two representatives of
47 organizations that represent health care practitioners, all
48 appointed by the State Surgeon General.
49 (3) The task force shall compile and analyze data and
50 information on the following:
51 (a) The frequency and extent of the use of telehealth
52 technology and equipment by health care practitioners and health
53 care facilities nationally and in this state.
54 (b) The costs and cost savings associated with using
55 telehealth technology and equipment.
56 (c) The types of telehealth services available.
57 (d) The extent of available health insurance coverage for
58 telehealth services. The task force shall conduct a comparative
59 analysis of such coverage to available coverage for in-person
60 services. The analysis must include:
61 1. Covered medical or other health care services.

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62 2. A description of payment rates for such telehealth
63 services and whether they are below, equal to, or above payment
64 rates for in-person services.
65 3. Annual and lifetime dollar maximums on coverage for
66 telehealth and in-person services.
67 4. Copayment, coinsurance, and deductible amounts; policy
68 year, calendar year, lifetime, or other durational benefit
69 limitations; and maximum benefits for telehealth and in-person
70 services.
71 5. Any unique conditions imposed as a prerequisite to
72 obtaining coverage for telehealth services.
73 (e) Barriers to implementing the use of, using, or
74 accessing telehealth services.
75 (f) Consideration of opportunities for interstate
76 cooperation in telehealth.
77 (4) The task force shall convene its first meeting by
78 September 1, 2016, and shall meet as often as necessary to
79 fulfill its responsibilities under this section. Meetings may be
80 conducted in person, by teleconference, or by other electronic
81 means.
82 (5) The task force shall submit a report by June 30, 2017,
83 to the Governor, the President of the Senate, and the Speaker of
84 the House of Representatives which includes its findings,
85 conclusions, and recommendations.
86 (6) This section is repealed effective December 1, 2017.
87 Section 2. Section 456.51, Florida Statutes, is created to
88 read:
89 456.51 Telehealth.—
90 (1) A health care practitioner, a person certified under

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91 part III of chapter 401, or a person certified under part IV of
92 chapter 468 who is practicing within the scope of his or her
93 license or certification may provide telehealth services. A
94 practitioner or person who is not a physician, but who provides
95 telehealth services within the scope of his or her license or
96 certification, may not be considered to be practicing medicine
97 without a license.
98 (2) As used in this section, the term “telehealth” means
99 the use of synchronous or asynchronous telecommunications
100 technology by a health care practitioner, a person certified
101 under part III of chapter 401, or a person certified under part
102 IV or V of chapter 468 to provide medical or other health care
103 services, including, but not limited to, patient assessment,
104 diagnosis, consultation, treatment, or remote monitoring; the
105 transfer of medical or health data; patient and professional
106 health-related education; the delivery of public health
107 services; and health care administration functions.
108 Section 3. Subsection (1) of section 636.202, Florida
109 Statutes, is amended to read:
110 636.202 Definitions.—As used in this part, the term:
111 (1) “Discount medical plan” means a business arrangement or
112 contract in which a person, in exchange for fees, dues, charges,
113 or other consideration, provides access for plan members to
114 providers of medical services and the right to receive medical
115 services from those providers at a discount. The term “discount
116 medical plan” does not include any product regulated under
117 chapter 627, chapter 641, or part I of this chapter, or any
118 telehealth product defined under s. 456.51, F.S.
119 Section 4. This act shall take effect July 1, 2016.

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THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Children, Families, and Elder Affairs, *Chair*
Health Policy, *Vice Chair*
Agriculture
Education Pre-K-12
Appropriations Subcommittee on Health and Human Services

SENATOR ELEANOR SOBEL
33rd District

January 27, 2016

Senator Rene Garcia
Chair of the Appropriations Subcommittee on Health and Human Services
310 Senate Office Building
404 South Monroe Street
Tallahassee, Florida 32399

Dear Chair Garcia,

This letter is to request that **SB 7054**, relating to the **Agency for Persons with Disabilities**, be placed on the agenda of the next scheduled meeting of the Appropriations Subcommittee on Health and Human Services.

SB 7054 repeals provisions relating to a program for the prevention and treatment of severe self-injurious behavior, adds client needs that qualify as extraordinary needs which may result in the approval of an increase in a client's allocated funds, requires the Agency for Persons with Disabilities to conduct a certain utilization review, and provides for annual reviews for persons involuntarily committed to residential services.

Thank you for your consideration of this request. Please don't hesitate to contact my office if you have any questions.

With Best Regards,

Eleanor Sobel
State Senator, 33rd District

REPLY TO:
❒ The "Old" Library, First Floor, 2600 Hollywood Blvd., Hollywood, Florida 33020 (954) 924-3693 FAX: (954) 924-3695
❒ 410 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5033

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: PCS/SB 7054 (366342)

INTRODUCER: Appropriations Subcommittee on Health and Human Services; Children, Families, and Elder Affairs Committee

SUBJECT: Agency for Persons with Disabilities

DATE: February 15, 2016 REVISED: ________ ________ ________ ________

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
	Crosier	Hendon		**CF Submitted as Committee Bill**
1.	Brown	Pigott	AHS	**Recommend: Fav/CS**
2.			AP	

I. Summary:

PCS/SB 7054 creates and amends certain statutes to provide the Agency for Persons with Disabilities (APD) with the ability to assign priority to clients on the waiting list for receiving services from the home and community-based services Medicaid waiver; to allow family members of active duty service members to receive waiver services; conduct utilization reviews; to allow contractors to use APD data management systems; to allow annual reviews of persons involuntarily admitted to residential services; and to allow for the use of video and audio monitoring of the comprehensive transitional education program facilities. The bill also allows APD to contract with more than one provider for specialized residential services. Additionally, the bill requires new specialized residential programs to be limited to 15 beds or less.

The bill's fiscal impact is indeterminate.

The bill has an effective date of June 30, 2016, or, if this act fails to become a law until after that date, it will take effect upon becoming a law and operate retroactively to June 30, 2016.

II. Present Situation:

The Agency for Persons with Disabilities (APD) is responsible for providing services to persons with developmental disabilities. A developmental disability is defined as a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.[1]

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[1] *See* s. 393.063(9), F.S.

Individuals who meet Medicaid eligibility requirements, including individuals who have Down syndrome,[2] may choose to receive services in the community through the state's Medicaid home and community-based services (HCBS) waiver for individuals with developmental disabilities administered by the APD or in an intermediate care facility for the developmentally disabled (ICF/DD).

The HCBS waiver, known as iBudget Florida, offers 27 supports and services to assist individuals to live in their community. Such services are not covered under the regular Medicaid program. Examples of HCBS waiver services include residential habilitation, behavioral services, companion, adult day training, employment services, and physical therapy.[3] Services provided through the HCBS waiver enable children and adults to live in the community in their own home, a family home, or in a licensed residential setting, thereby avoiding institutionalization.

While the majority of individuals served by the APD live in the community, a small number live in ICF/DDs, which are defined in s. 393.063(22), F.S., as residential facilities licensed and certified by the Agency for Health Care Administration (AHCA). ICF/DDs are considered institutional placements and provide intermediate nursing care. There are approximately 2,866 private and public ICF/DD beds in Florida.[4]

Because ICF/DDs are considered institutional placements, the federal government requires routine utilization reviews for individuals in ICF/DDs to ensure that individuals are not inappropriately institutionalized. Utilization reviews must be conducted by a group of professionals referred to as the Utilization Review Committee, which must include at least one physician and one individual knowledgeable in the treatment of intellectual disabilities. The APD performs this utilization review function through an interagency agreement with the AHCA.[5]

Home and Community-Based Services Waiver (iBudget Florida)

The iBudget Florida program was developed in response to legislative direction requiring a plan for an individual budgeting approach for improving the management of the HCBS waiver program.[6] iBudget Florida involves the use of an algorithm, or formula, to set individuals' funding allocations for waiver services. The law provides for individuals to receive funding in addition to that allocated through the algorithm under certain conditions, such as when they have a temporary or permanent change in need or an extraordinary need that the algorithm does not

[2] *See* s. 393.0662(1), F.S., provides eligibility for individuals with a diagnosis of Down syndrome.

[3] Agency for Persons with Disabilities, Quarterly Report on Agency Services to Floridians with Developmental Disabilities and Their Costs: First Quarter Fiscal Year 2015-16, November 2015.

[4] *Id.*

[5] *Id.*

[6] Agency for Persons with Disabilities, Report to the Legislature on the Agency's Plan for Implementing Individual Budgeting "iBudget Florida" (February 1 2010), *available at* http://apd.myflorida.com/ibudget/rules-regs.htm (last accessed Dec. 15, 2015).

address.[7] The APD phased-in the implementation of iBudget Florida, which was finalized on July 1, 2013.[8]

However, the iBudget Florida program has been the subject of litigation. In September 2014, in response to a ruling by the 1st District Court of Appeal that that the program's rules were invalid, the APD reset approximately 14,000 individuals' budget allocations to higher amounts.[9] The APD began rulemaking to adopt new rules to replace the invalid ones.[10] The APD, in conjunction with stakeholders, reviewed the algorithm and has filed for the adoption of rules providing a revised algorithm and related funding calculation methods.[11]

iBudget statutes were amended in 2015 to allow additional funding beyond that allocated by the algorithm for transportation to a waiver-funded adult day training program or to employment under certain conditions. However, the 2015 amendment sunsets July 1, 2016.

Waiver Enrollment Prioritization

As of December 14, 2015, 31,665 individuals were enrolled on the iBudget Florida waiver.[12] The majority of waiver enrollees live in a family home with a parent, relative, or guardian. The Legislature appropriated $994,793,906 for Fiscal Year 2015-2016 to provide services through the HCBS waiver program, including federal match of $601,153,957[13]. However, this funding is insufficient to serve all persons seeking waiver services. To enable the APD to remain within legislative appropriations, waiver enrollment is limited. Accordingly, the APD maintains a waiting list for waiver services. Prioritization for the wait list is provided in s. 393.065(5), F.S. Medicaid-eligible persons on the waiting list continue to receive Medicaid services not offered through iBudget Florida.

Waiting list prioritization statutory language has been changed, notwithstanding s. 393.065(5), F.S., in the past two legislative sessions. For example, s. 20 of ch. 2015-222, Laws of Florida, provides that:

- Youth with developmental disabilities who are in extended foster care may be served by both the waiver and the child welfare system;[14] and
- An individual who has been receiving HCBS waiver services in other states may receive Florida HCBS waiver services if his or her parent or guardian is on active military duty and transfers to Florida.[15]

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[7] *See* s. 393.0662, F.S.
[8] *Supra,* note 3.
[9] Agency for Persons with Disabilities, iBudget Florida, http://apd.myflorida.com/ibudget/ (last visited December 15, 2015).
[10] Department of State, Florida Administrative Register, Vol. 40, No. 207, Oct. 23, 2014, pg. 4703-4706.
[11] These rules have been challenged as well. *See* DOAH Case No. 15-005803RP.
[12] E-mail from Caleb Hawkes, Deputy Legislative Affairs Director, Agency for Persons with Disabilities. RE: Requested information for bill analysis for APD agency bill (Dec. 14, 2015). On file with the Senate Committee on Children, Families and Seniors.
[13] *See* Specific Appropriation 251, ch. 2015-232, Laws of Florida.
[14] This provision also specifies the services that APD and the child welfare system must provide such enrollees. Since July 1, 2015, 30 individuals in extended foster care have been enrolled for HCBS waiver services.
[15] This provision has been in effect since July 1, 2014, and since that time, 10 such individuals have been enrolled in the HCBS waiver. *Supra*, note 12.

The provisions of s. 20 of ch. 2015-222, Laws of Florida, sunset on July 1, 2016.

Client Data Management System

In 2015, the Legislature appropriated a total of $2.86 million[16] for Fiscal Year 2015-2016 for the development of a client data management system to provide electronic verification of service delivery to recipients by providers, electronic billings for waiver services, and electronic processing of claims.[17] The APD must also meet federal requirements for administering the iBudget HCBS waiver, such as tracking, measuring, reporting, and providing quality improvement processes for 32 specific program performance measures in order to ensure the program funding can continue. The federal Centers for Medicaid & Medicare Services further requires the state maintain a quality improvement system that includes data collection, data analysis, and reporting. However, the APD currently relies heavily on manual processes and disparate systems to collect, analyze, and report data consistently.

The APD anticipates providers will begin using the system during Fiscal Year 2016-2017. Providers will need standard software and technology in order to log into the system.[18]

Direct Service Provider Staff Training and Professional Development

Under the waiver agreement with the federal government, the APD must coordinate, develop, and provide specialized training for providers and their employees to promote health and well-being of individuals served.[19] These requirements are currently included in the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook. For example, the handbook outlines required basic training and required in-service training and continuing education for direct service providers on topics such as person-centered planning, maintaining health and safety, reporting to the abuse hotline, and first aid. Providers of certain services, such as supported employment or supported living, are required to take additional pre-service certification training. Training is typically offered several ways, such as through the Internet, DVD, and live classroom training.[20]

Involuntary admission to residential services.

Courts have jurisdiction to conduct a hearing and enter an order that a person with a developmental disability requiring involuntary admission to residential services, is provided with care, treatment, habilitation, and rehabilitation services from the APD.[21] When a court receives a petition for such involuntary admission, the APD and an examining committee (comprising at least three disinterested experts in the diagnosis, evaluation, and treatment of persons who have

[16] *See* Specific Appropriation 265 and section 41, ch. 2015-232, Laws of Florida.
[17] *See* Specific Appropriation 265, ch. 2015-232, Laws of Florida.
[18] Agency for Persons with Disabilities, *Agency Analysis of SB 7054* (on file with the Senate Committee on Children, Families, and Elder Affairs.
[19] *Id.*
[20] Rule 59G-13.070, F.A.C. Handbook may be accessed at http://apd.myflorida.com/ibudget/
[21] *See* s. 393.11(1), F.S.

intellectual disabilities) must examine the person and provide a written report for the court. The report must explicitly document the extent to which the person meets the criteria for involuntary admission.[22]

A person charged with a felony and found to be incompetent to proceed due to an intellectual disability is required be committed to the APD. The APD is required to provide appropriate training for the person. The court may order the person into a forensic facility designated by the APD for persons with intellectual disability or autism.

A person who has an intellectual disability must be represented by counsel at all stages of these judicial proceedings, and, if the person is indigent and cannot afford counsel, a public defender must be appointed at least 20 days before a scheduled hearing.[23] The person must be physically present throughout the entire proceeding; however, if the person's attorney believes that the person's presence at the hearing is not in his or her best interest, the requirement may be waived by the court once the court has seen the person and the hearing has commenced.[24]

The court that enters the initial order for involuntary admission to residential services has continuing jurisdiction to enter orders to ensure the person is receiving adequate care, treatment, habilitation, and rehabilitation services.[25] The committing court may order a conditional release of the person based on an approved plan for providing community-based training. If at any time it is determined in a court hearing that the person on conditional release no longer requires court supervision and follow-up care, the court must terminate its jurisdiction and discharge the person.

At any time and without notice, a person involuntarily admitted into residential services, or the person's parent or legal guardian, is entitled to file a petition for a writ of habeas corpus to question the cause, legality, and appropriateness of the involuntary admission.[26]

Comprehensive transitional education program

A private entity known as AdvoServ currently operates Carlton Palms, the only provider of comprehensive transitional education programs (CTEP) in Florida.[27] This program, operating in Lake County, is a group of jointly operating centers and provides educational care, training, treatment, habilitation, and rehabilitation services to persons who have developmental disabilities and who have severe or moderate maladaptive behaviors.[28] All services are to be temporary and delivered in a structured residential setting with the primary goal of incorporating the principle of self-determination in establishing permanent residence not associated with the comprehensive transitional education program.[29]

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[22] *See* s. 393.11(4),(5), F.S.
[23] *See* s .393.11(6), F.S.
[24] *See* s. 393.11(7), F.S.
[25] *See* s. 393.11(11), F.S.
[26] *See* s. 393.11(13), F.S.
[27] *See* AdvoServ: Carlton Palms Educational Center, available at http://www.advoserv.com/programs/florida-program/carlton-palms-education-center/ (last visited Feb. 4, 2016).
[28] *See* s. 393.18, F.S.
[29] *Id.*

Carlton Palms is the CTEP provider for the APD as established in s. 393.18, F.S. As of December 31, 2015, the program served 151 APD clients and 40 out-of-state clients. The total number of residents with maladaptive behaviors being provided with services may not exceed the licensed capacity of 120 residents.[30] AdvoServ holds two licenses for the provision of these services, allowing it to serve up to 240 individuals.

Under s. 25 of ch. 2015-222, Laws of Florida, the Legislature amended s. 393.18, F.S., to provide that, for CTEPs, each residential unit within a CTEP's component centers may not in any instance exceed 15 residents, except that CTEPs authorized to operate residential units with more than 15 residents before July 1, 2015, may continue to operate such units. The 2015 legislation also deleted provisions authorizing the licensure of CTEPs that met certain criteria on July 1, 1989, and other provisions relating to the maximization of federal funds and providing for children needing special behavioral services. These 2015 amendments to s. 393.18, F.S., will sunset on July 1, 2016, under s. 26 of ch. 2015-222, Laws of Florida.

III. Effect of Proposed Changes:

Section 1 amends s. 393.063, F.S., to update current definitions and add new terms.

Section 2 repeals s. 393.0641, F.S., which currently provides a program for the prevention and treatment of clients exhibiting severe self-injurious behavior. The APD currently serves individuals with self-injurious behaviors in the community in licensed homes that are specifically for intensive behavior issues. These services are funded under the iBudget waiver program.

Section 3 amends s. 393.065, F.S., to provide prioritization in the APD's home and community-based waiver relating to individuals with developmental disabilities in extended foster care and allows such individuals to receive both HCBS waiver services and child welfare services. The bill also provides that if an individual meets eligibility requirements, was receiving home and community-based waiver services in another state, and is the son or daughter or ward of an active duty military service member who is transferred to this state, the individual is eligible to receive such services in this state.

Additionally, after individuals formerly on the waiting list are enrolled in the waiver, individuals remaining on the waiting list are not substantially affected by APD action and are not entitled to a hearing under s. 393.125, F.S., or administrative proceedings under chapter 120, F.S.

Section 4 amends s. 393.066, F.S., to require persons or entities under contract with the APD to use APD data management systems for documenting service provision to APD clients. Providers need to have the hardware and software necessary to use these systems, as established by the APD. Such contractors must also ensure that any staff directly serving clients must meet APD requirements for training and professional development.

Section 5 amends s. 393.0662, F.S., to add transportation needs to the list of circumstances that may qualify individuals to receive additional funding beyond that calculated through the algorithm. The bill provides that the APD may grant a funding increase to individuals whose

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[30] *See* s. 393.18(4), Note (4), F.S.

iBudget allocation is insufficient to pay for transportation services to a waiver-funded adult day training program or employment services and who have no other reasonable transportation options.

Section 6 creates s. 393.0679, F.S., to require the APD to conduct utilization reviews in intermediate care facilities for individuals with developmental disabilities (ICF/DDs), both public and private, and requires ICF/DDs to cooperate with these reviews, including requests for information, documentation, and inspection. This will ensure that Florida continues to meet federal requirements for conducting utilization reviews.

Section 7 amends s. 393.11, F.S. to include a person with autism as a person who may require involuntary admission to residential services provided by the APD.

Section 393.11(14), F.S., is created to provide a framework for an annual review of a court's order for involuntary admission to residential services. Reviews are required annually by a qualified evaluator either in the employ of or under contract with the APD. A qualified evaluator may be a psychiatrist licensed under chapter 458 or chapter 459 or a psychologist licensed under chapter 490. The review must consider whether the person continues to meet the criteria for involuntary admission for residential services. If the person is determined to meet the criteria, the court must determine whether the person is in the most appropriate and least restrictive setting. The court must also determine whether the person is receiving adequate care, treatment, habilitation, and rehabilitation in the residential setting. The bill provides for notice requirements of the hearing to the appropriate state's attorney, if applicable, and the person's attorney and guardian or guardian advocate, if one is appointed.

Section 8 reenacts s. 393.067, F.S., to allow the APD to contract with more than one provider for specialized residential services.

Section 9 repeals Section 26 of chapter 2015-222, Laws of Florida.

Section 10 reenacts and amends s. 393.18, F.S., to provide that a CTEP serve individuals who have developmental disabilities, severe maladaptive behaviors, and co-occurring complex medical conditions, or has a dual diagnosis of developmental disability and mental illness. The bill provides that the supervisor of the clinical director of the program licensee must hold a doctoral degree with a primary focus in behavior analysis, be a certified behavior analyst, and have at least one year of experience in providing behavior analysis services for individuals with developmental disabilities.

Additionally, the bill requires a CTEP to include components of intensive treatment and education, intensive training and education, and transition services to avoid regression to more restrictive environments while preparing individuals for independent living. Any educational components of the program, including individual education plans, must be integrated with the local school district to the extent possible. The individual education plans must be developed for each school-aged person and must be integrated with the referring school district.

Beginning July 1, 2016, the APD may approve proposed admission or readmission of individuals into a CTEP for up to two years. The APD may allow an individual to reside in a CTEP for a

longer period of time subject to a clinical review conducted by the APD. To improve resident and staff safety, CTEPs must provide continuous recorded video and audio monitoring in all residential common areas, and those recordings must be maintained for at least 60 days. The programs must operate and maintain video and audio monitoring systems that allow authorized APD staff to monitor program activities in real-time from off-site locations.

The APD is authorized to license a facility that provides residential services for children with developmental disabilities and intensive behavioral problems as defined by the APD and which, as of July 1, 2010, serves children who have been served by the child welfare system and who have an open case in the State Automated Child Welfare Information System. Such a facility must be in compliance with all program criteria and local land use and zoning requirements and may not exceed a capacity of 15 children.

Section 11 amends s. 393.501, F.S., to clarify that rules adopted by the APD regarding CTEPs meet certain criteria.

Section 12 amends s. 383.141, F.S., to correct cross-references.

Section 13 amends s. 1002.385, F.S., to correct cross-references.

Section 14 provides an effective date of June 30, 2016, or if this act fails to become a law until after that date, it shall take effect upon becoming a law and operate retroactively to June 30, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Under PCS/SB 7054, direct care providers may see increased costs to provide data to the new APD client data management system. It is unknown what training and career

development requirements or hardware and software requirements the APD will establish, or the extent to which providers will have to acquire hardware and software to meet those requirements.

C. Government Sector Impact:

The APD may experience increased costs of conducting additional involuntary commitment reviews. This cost is indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections 393.063, 303.065, 393.066, 303.0662, 393.11, 393.18, 393.501, 383.141, and 1002.385.

.

This bill creates section 393.0679 of the Florida Statutes.

This bill repeals the following section 393.0641, of the Florida Statutes and Section 26 of chapter 2015-222, Laws of Florida

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

The proposed CS:

- Reenacts s. 393.067, F.S., to allow the APD to contract with more than one provider for specialized residential services;
- Requires new specialized residential programs to be limited to 15 beds or less;
- Repeals s. 26 of ch. 2015-222, Laws of Florida;
- Allows a qualified evaluator to be either in the employ or under contract with the APD and requires the qualified evaluator may be a psychiatrist licensed under chapter 458 or chapter 459 or a psychologist licensed under chapter 490;
- Provides that if an individual meets eligibility requirements, was receiving home and community-based waiver services in another state, and is the son or daughter or ward of an active duty military service member who is transferred to this state, the individual is eligible to receive such services in this state; and
- Requires individual education plans be developed for each school-aged person in the specialized residential program and also requires that individual education plan for the school-aged person must be integrated with the referring school district.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/15/2016	.	
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	.	

Appropriations Subcommittee on Health and Human Services (Sobel) recommended the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Section 393.063, Florida Statutes, is reordered
6 and amended to read:
7 393.063 Definitions.—For the purposes of this chapter, the
8 term:
9 (2) ~~(1)~~ "Agency" means the Agency for Persons with
10 Disabilities.

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11 (1)~~(2)~~ "Adult day training" means training services that
12 ~~which~~ take place in a nonresidential setting, separate from the
13 home or facility in which the client resides, and~~;~~ are intended
14 to support the participation of clients in daily, meaningful,
15 and valued routines of the community. Such training~~; and~~ may be
16 provided in ~~include~~ work-like settings that do not meet the
17 definition of supported employment.
18 (3) "Algorithm" means the mathematical formula used by the
19 agency to calculate a budget amount for clients using variables
20 that have statistically validated relationships to clients'
21 needs for services provided by the home and community-based
22 Medicaid waiver program.
23 (4) "Allocation methodology" means the process used to
24 determine a client's iBudget by summing the amount generated by
25 the algorithm and, if applicable, any funding authorized by the
26 agency for the client pursuant to s. 393.0662(1)(b).
27 (5)~~(3)~~ "Autism" means a pervasive, neurologically based
28 developmental disability of extended duration which causes
29 severe learning, communication, and behavior disorders with age
30 of onset during infancy or childhood. Individuals with autism
31 exhibit impairment in reciprocal social interaction, impairment
32 in verbal and nonverbal communication and imaginative ability,
33 and a markedly restricted repertoire of activities and
34 interests.
35 (6)~~(4)~~ "Cerebral palsy" means a group of disabling symptoms
36 of extended duration which results from damage to the developing
37 brain that may occur before, during, or after birth and that
38 results in the loss or impairment of control over voluntary
39 muscles. For the purposes of this definition, cerebral palsy

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40 does not include those symptoms or impairments resulting solely
41 from a stroke.
42 (7)~~(5)~~ "Client" means any person determined eligible by the
43 agency for services under this chapter.
44 (8)~~(6)~~ "Client advocate" means a friend or relative of the
45 client, or of the client's immediate family, who advocates for
46 the best interests of the client in any proceedings under this
47 chapter in which the client or his or her family has the right
48 or duty to participate.
49 (9)~~(7)~~ "Comprehensive assessment" means the process used to
50 determine eligibility for services under this chapter.
51 (10)~~(8)~~ "Comprehensive transitional education program"
52 means the program established in s. 393.18.
53 (12)~~(9)~~ "Developmental disability" means a disorder or
54 syndrome that is attributable to intellectual disability,
55 cerebral palsy, autism, spina bifida, Down syndrome, or Prader-
56 Willi syndrome; that manifests before the age of 18; and that
57 constitutes a substantial handicap that can reasonably be
58 expected to continue indefinitely.
59 (11)~~(10)~~ "Developmental disabilities center" means a state-
60 owned and state-operated facility, formerly known as a "Sunland
61 Center," providing for the care, habilitation, and
62 rehabilitation of clients with developmental disabilities.
63 (13)~~(11)~~ "Direct service provider" means a person 18 years
64 of age or older who has direct face-to-face contact with a
65 client while providing services to the client or has access to a
66 client's living areas or to a client's funds or personal
67 property.
68 (14)~~(12)~~ "Domicile" means the place where a client legally

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resides and~~,~~ which ~~place~~ is his or her permanent home. Domicile may be established as provided in s. 222.17. Domicile may not be established in Florida by a minor who has no parent domiciled in Florida, or by a minor who has no legal guardian domiciled in Florida, or by any alien not classified as a resident alien.

(15)~~(13)~~ “Down syndrome” means a disorder caused by the presence of an extra chromosome 21.

(16)~~(14)~~ “Express and informed consent” means consent voluntarily given in writing with sufficient knowledge and comprehension of the subject matter to enable the person giving consent to make a knowing decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

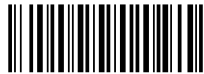
(17)~~(15)~~ “Family care program” means the program established in s. 393.068.

(18)~~(16)~~ “Foster care facility” means a residential facility licensed under this chapter which provides a family living environment including supervision and care necessary to meet the physical, emotional, and social needs of its residents. The capacity of such a facility may not be more than three residents.

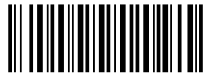
(19)~~(17)~~ “Group home facility” means a residential facility licensed under this chapter which provides a family living environment including supervision and care necessary to meet the physical, emotional, and social needs of its residents. The capacity of such a facility shall be at least 4 but not more than 15 residents.

(20) “Guardian” has the same meaning as in s. 744.102.

(21)~~(18)~~ “Guardian advocate” means a person appointed by a written order of the court to represent a person with

 220012

98 developmental disabilities under s. 393.12.
99 (22) ~~(19)~~ “Habilitation” means the process by which a client
100 is assisted in acquiring and maintaining ~~to acquire and maintain~~
101 those life skills that ~~which~~ enable the client to cope more
102 effectively with the demands of his or her condition and
103 environment and to raise the level of his or her physical,
104 mental, and social efficiency. The term ~~It~~ includes, but is not
105 limited to, programs of formal structured education and
106 treatment.
107 (23) ~~(20)~~ “High-risk child” means, for the purposes of this
108 chapter, a child from 3 to 5 years of age with one or more of
109 the following characteristics:
110 (a) A developmental delay in cognition, language, or
111 physical development.
112 (b) A child surviving a catastrophic infectious or
113 traumatic illness known to be associated with developmental
114 delay, when funds are specifically appropriated.
115 (c) A child with a parent or guardian with developmental
116 disabilities who requires assistance in meeting the child’s
117 developmental needs.
118 (d) A child who has a physical or genetic anomaly
119 associated with developmental disability.
120 (24) ~~(21)~~ “Intellectual disability” means significantly
121 subaverage general intellectual functioning existing
122 concurrently with deficits in adaptive behavior which manifests
123 before the age of 18 and can reasonably be expected to continue
124 indefinitely. For the purposes of this definition, the term:
125 (a) “Adaptive behavior” means the effectiveness or degree
126 with which an individual meets the standards of personal

 220012

127 independence and social responsibility expected of his or her
128 age, cultural group, and community.
129 (b) “Significantly subaverage general intellectual
130 functioning” means performance that is two or more standard
131 deviations from the mean score on a standardized intelligence
132 test specified in the rules of the agency.
133
134 For purposes of the application of the criminal laws and
135 procedural rules of this state to matters relating to pretrial,
136 trial, sentencing, and any matters relating to the imposition
137 and execution of the death penalty, the terms “intellectual
138 disability” or “intellectually disabled” are interchangeable
139 with and have the same meaning as the terms “mental retardation”
140 or “retardation” and “mentally retarded” as defined in this
141 section before July 1, 2013.
142 (25) ~~(22)~~ “Intermediate care facility for the
143 developmentally disabled” ~~or “ICF/DD”~~ means a residential
144 facility licensed and certified under part VIII of chapter 400.
145 (26) ~~(23)~~ “Medical/dental services” means medically
146 necessary services that are provided or ordered for a client by
147 a person licensed under chapter 458, chapter 459, or chapter
148 466. Such services may include, but are not limited to,
149 prescription drugs, specialized therapies, nursing supervision,
150 hospitalization, dietary services, prosthetic devices, surgery,
151 specialized equipment and supplies, adaptive equipment, and
152 other services as required to prevent or alleviate a medical or
153 dental condition.
154 (27) ~~(24)~~ “Personal care services” means individual
155 assistance with or supervision of essential activities of daily

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156 living for self-care, including ambulation, bathing, dressing,
157 eating, grooming, and toileting, and other similar services that
158 are incidental to the care furnished and essential to the
159 health, safety, and welfare of the client if no one else is
160 available to perform those services.
161 (28)~~(25)~~ "Prader-Willi syndrome" means an inherited
162 condition typified by neonatal hypotonia with failure to thrive,
163 hyperphagia or an excessive drive to eat which leads to obesity
164 usually at 18 to 36 months of age, mild to moderate intellectual
165 disability, hypogonadism, short stature, mild facial
166 dysmorphism, and a characteristic neurobehavior.
167 (29)~~(26)~~ "Relative" means an individual who is connected by
168 affinity or consanguinity to the client and who is 18 years of
169 age or older.
170 (30)~~(27)~~ "Resident" means a person who has a developmental
171 disability and resides at a residential facility, whether or not
172 such person is a client of the agency.
173 (31)~~(28)~~ "Residential facility" means a facility providing
174 room and board and personal care for persons who have
175 developmental disabilities.
176 (32)~~(29)~~ "Residential habilitation" means supervision and
177 training with the acquisition, retention, or improvement in
178 skills related to activities of daily living, such as personal
179 hygiene skills, homemaking skills, and the social and adaptive
180 skills necessary to enable the individual to reside in the
181 community.
182 (33)~~(30)~~ "Residential habilitation center" means a
183 community residential facility licensed under this chapter which
184 provides habilitation services. The capacity of such a facility

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185 may not be fewer than nine residents. After October 1, 1989, new
186 residential habilitation centers may not be licensed and the
187 licensed capacity for any existing residential habilitation
188 center may not be increased.
189 (34) ~~(31)~~ "Respite service" means appropriate, short-term,
190 temporary care that is provided to a person who has a
191 developmental disability in order to meet the planned or
192 emergency needs of the person or the family or other direct
193 service provider.
194 (35) ~~(32)~~ "Restraint" means a physical device, method, or
195 drug used to control dangerous behavior.
196 (a) A physical restraint is any manual method or physical
197 or mechanical device, material, or equipment attached or
198 adjacent to an individual's body so that he or she cannot easily
199 remove the restraint and which restricts freedom of movement or
200 normal access to one's body.
201 (b) A drug used as a restraint is a medication used to
202 control the person's behavior or to restrict his or her freedom
203 of movement and is not a standard treatment for the person's
204 medical or psychiatric condition. Physically holding a person
205 during a procedure to forcibly administer psychotropic
206 medication is a physical restraint.
207 (c) Restraint does not include physical devices, such as
208 orthopedically prescribed appliances, surgical dressings and
209 bandages, supportive body bands, or other physical holding
210 necessary for routine physical examinations and tests; for
211 purposes of orthopedic, surgical, or other similar medical
212 treatment; to provide support for the achievement of functional
213 body position or proper balance; or to protect a person from

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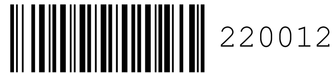
214 falling out of bed.
215 (36)~~(33)~~ “Seclusion” means the involuntary isolation of a
216 person in a room or area from which the person is prevented from
217 leaving. The prevention may be by physical barrier or by a staff
218 member who is acting in a manner, or who is physically situated,
219 so as to prevent the person from leaving the room or area. For
220 the purposes of this chapter, the term does not mean isolation
221 due to the medical condition or symptoms of the person.
222 (37)~~(34)~~ “Self-determination” means an individual’s freedom
223 to exercise the same rights as all other citizens, authority to
224 exercise control over funds needed for one’s own support,
225 including prioritizing these funds when necessary,
226 responsibility for the wise use of public funds, and self-
227 advocacy to speak and advocate for oneself in order to gain
228 independence and ensure that individuals with a developmental
229 disability are treated equally.
230 (38)~~(35)~~ “Specialized therapies” means those treatments or
231 activities prescribed by and provided by an appropriately
232 trained, licensed, or certified professional or staff person and
233 may include, but are not limited to, physical therapy, speech
234 therapy, respiratory therapy, occupational therapy, behavior
235 therapy, physical management services, and related specialized
236 equipment and supplies.
237 (39)~~(36)~~ “Spina bifida” means~~, for purposes of this~~
238 ~~chapter,~~ a person with a medical diagnosis of spina bifida
239 cystica or myelomeningocele.
240 (40)~~(37)~~ “Support coordinator” means a person who is
241 designated by the agency to assist individuals and families in
242 identifying their capacities, needs, and resources, as well as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243 finding and gaining access to necessary supports and services;
244 coordinating the delivery of supports and services; advocating
245 on behalf of the individual and family; maintaining relevant
246 records; and monitoring and evaluating the delivery of supports
247 and services to determine the extent to which they meet the
248 needs and expectations identified by the individual, family, and
249 others who participated in the development of the support plan.
250 (41) ~~(38)~~ "Supported employment" means employment located or
251 provided in an integrated work setting, with earnings paid on a
252 commensurate wage basis, and for which continued support is
253 needed for job maintenance.
254 (42) ~~(39)~~ "Supported living" means a category of
255 individually determined services designed and coordinated in
256 such a manner as to provide assistance to adult clients who
257 require ongoing supports to live as independently as possible in
258 their own homes, to be integrated into the community, and to
259 participate in community life to the fullest extent possible.
260 (43) ~~(40)~~ "Training" means a planned approach to assisting a
261 client to attain or maintain his or her maximum potential and
262 includes services ranging from sensory stimulation to
263 instruction in skills for independent living and employment.
264 (44) ~~(41)~~ "Treatment" means the prevention, amelioration, or
265 cure of a client's physical and mental disabilities or
266 illnesses.
267 Section 2. Section 393.0641, Florida Statutes, is repealed.
268 Section 3. Present subsections (6) and (7) of section
269 393.065, Florida Statutes, are redesignated as subsections (7)
270 and (9), respectively, subsections (3) and (5) and present
271 subsections (6) and (7) of that section are amended, and new

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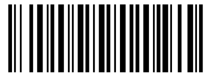
272 subsections (6) and (8) are added to that section, to read:
273 393.065 Application and eligibility determination.—
274 (3) The agency shall notify each applicant, in writing, of
275 its eligibility decision. Any applicant determined by the agency
276 to be ineligible for ~~developmental~~ services has the right to
277 appeal this decision pursuant to ss. 120.569 and 120.57.
278 (5) ~~Except as otherwise directed by law, beginning July 1,~~
279 ~~2010,~~ The agency shall assign and provide priority to clients
280 waiting for waiver services in the following order:
281 (a) Category 1, which includes clients deemed to be in
282 crisis as described in rule, shall be given first priority in
283 moving from the waiting list to the waiver.
284 (b) Category 2, which includes clients on the waiting
285 ~~children on the wait~~ list who are:
286 1. From the child welfare system with an open case in the
287 Department of Children and Families' statewide automated child
288 welfare information system and who are:
289 a. Transitioning out of the child welfare system at the
290 finalization of an adoption, a reunification with a family
291 member, a permanent placement with a relative, or a guardianship
292 with a nonrelative; or
293 b. At least 18 years old, but not yet 22 years old, and who
294 need both waiver services and extended foster care services; or
295 2. At least 18 years old, but not yet 22 years old, and who
296 withdrew consent pursuant to s. 39.6251(5)(c) to remain in
297 extended foster care.
298
299 For clients who are eligible under sub-subparagraph 1.b., the
300 agency shall provide waiver services, including residential

 220012

301 habilitation, and the community-based care lead agency shall
302 fund room and board at the rates established in s. 409.145(4)
303 and provide case management and related services as defined in
304 s. 409.986(3)(e). Such clients may receive both waiver services
305 and services under s. 39.6251 which may not duplicate services
306 available through the Medicaid state plan.
307 (c) Category 3, which includes, but is not required to be
308 limited to, clients:
309 1. Whose caregiver has a documented condition that is
310 expected to render the caregiver unable to provide care within
311 the next 12 months and for whom a caregiver is required but no
312 alternate caregiver is available;
313 2. At substantial risk of incarceration or court commitment
314 without supports;
315 3. Whose documented behaviors or physical needs place them
316 or their caregiver at risk of serious harm and other supports
317 are not currently available to alleviate the situation; or
318 4. Who are identified as ready for discharge within the
319 next year from a state mental health hospital or skilled nursing
320 facility and who require a caregiver but for whom no caregiver
321 is available, or whose caregiver cannot provide the care needed.
322 (d) Category 4, which includes, but is not required to be
323 limited to, clients whose caregivers are 70 years of age or
324 older and for whom a caregiver is required but no alternate
325 caregiver is available.
326 (e) Category 5, which includes, but is not required to be
327 limited to, clients who are expected to graduate within the next
328 12 months from secondary school and need support to obtain a
329 meaningful day activity, ~~or~~ maintain competitive employment, or

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330 to pursue an accredited program of postsecondary education to
331 which they have been accepted.
332 (f) Category 6, which includes clients 21 years of age or
333 older who do not meet the criteria for category 1, category 2,
334 category 3, category 4, or category 5.
335 (g) Category 7, which includes clients younger than 21
336 years of age who do not meet the criteria for category 1,
337 category 2, category 3, or category 4.
338
339 Within categories 3, 4, 5, 6, and 7, the agency shall maintain a
340 waiting ~~wait~~ list of clients placed in the order of the date
341 that the client is determined eligible for waiver services.
342 (6) The agency shall allow an individual who meets the
343 eligibility requirements pursuant to subsection (1) to receive
344 home and community-based services in this state if the
345 individual's parent or legal guardian is an active duty military
346 servicemember and if at the time of the servicemember's transfer
347 to this state, the individual was receiving home and community-
348 based services in another state.
349 (7)~~(6)~~ The client, the client's guardian, or the client's
350 family must ensure that accurate, up-to-date contact information
351 is provided to the agency at all times. Notwithstanding s.
352 393.0651, the agency shall send an annual letter requesting
353 updated information from the client, the client's guardian, or
354 the client's family. The agency shall remove from the waiting
355 ~~wait~~ list any individual who cannot be located using the contact
356 information provided to the agency, fails to meet eligibility
357 requirements, or becomes domiciled outside the state.
358 (8) Agency action that selects individuals to receive

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359 waiver services pursuant to this section does not establish a
360 right to a hearing or an administrative proceeding under chapter
361 120 for individuals remaining on the waiting list.
362 (9) ~~(7)~~ The agency and the Agency for Health Care
363 Administration may adopt rules specifying application
364 procedures, criteria associated with the waiting list ~~wait-list~~
365 categories, procedures for administering the waiting ~~wait~~ list,
366 including tools for prioritizing waiver enrollment within
367 categories, and eligibility criteria as needed to administer
368 this section.
369 Section 4. Subsection (2) of section 393.066, Florida
370 Statutes, is amended to read:
371 393.066 Community services and treatment.—
372 (2) Necessary ~~All~~ services ~~needed~~ shall be purchased,
373 rather than ~~instead of~~ provided directly by the agency, when the
374 purchase of services ~~such arrangement~~ is more cost-efficient
375 than providing them ~~having those services provided~~ directly. All
376 purchased services must be approved by the agency. Persons or
377 entities under contract with the agency to provide services
378 shall use agency data management systems to document service
379 provision to clients. Contracted persons and entities shall meet
380 the minimum hardware and software technical requirements
381 established by the agency for the use of such systems. Such
382 persons or entities shall also meet any requirements established
383 by the agency for training and professional development of staff
384 providing direct services to clients.
385 Section 5. Section 393.0662, Florida Statutes, is amended
386 to read:
387 393.0662 Individual budgets for delivery of home and

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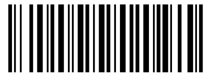
388 community-based services; iBudget system established.—The
389 Legislature finds that improved financial management of the
390 existing home and community-based Medicaid waiver program is
391 necessary to avoid deficits that impede the provision of
392 services to individuals who are on the waiting list for
393 enrollment in the program. The Legislature further finds that
394 clients and their families should have greater flexibility to
395 choose the services that best allow them to live in their
396 community within the limits of an established budget. Therefore,
397 the Legislature intends that the agency, in consultation with
398 the Agency for Health Care Administration, shall manage ~~develop~~
399 ~~and implement a comprehensive redesign of~~ the service delivery
400 system using individual budgets as the basis for allocating the
401 funds appropriated for the home and community-based services
402 Medicaid waiver program among eligible enrolled clients. The
403 service delivery system that uses individual budgets shall be
404 called the iBudget system.
405 (1) The agency shall administer ~~establish~~ an individual
406 budget, referred to as an iBudget, for each individual served by
407 the home and community-based services Medicaid waiver program.
408 The funds appropriated to the agency shall be allocated through
409 the iBudget system to eligible, Medicaid-enrolled clients. For
410 the iBudget system, eligible clients shall include individuals
411 with ~~a diagnosis of Down syndrome or~~ a developmental disability
412 as defined in s. 393.063. The iBudget system shall ~~be designed~~
413 ~~to~~ provide for: enhanced client choice within a specified
414 service package; appropriate assessment strategies; an efficient
415 consumer budgeting and billing process that includes
416 reconciliation and monitoring components; a ~~redefined~~ role for

 220012

417 support coordinators which ~~that~~ avoids potential conflicts of
418 interest; a flexible and streamlined service review process; and
419 a methodology and process that ensures the equitable allocation
420 of available funds ~~to each client~~ based on the client's level of
421 need, as determined by the ~~variables in the allocation~~
422 algorithm.
423 (a) In developing each client's iBudget, the agency shall
424 use the ~~an~~ allocation ~~algorithm and~~ methodology as defined in s.
425 393.063(4). ~~The algorithm shall use variables that have been~~
426 ~~determined by the agency to have a statistically validated~~
427 ~~relationship to the client's level of need for services provided~~
428 ~~through the home and community-based services Medicaid waiver~~
429 ~~program. The algorithm and methodology may consider individual~~
430 ~~characteristics, including, but not limited to, a client's age~~
431 ~~and living situation, information from a formal assessment~~
432 ~~instrument that the agency determines is valid and reliable, and~~
433 ~~information from other assessment processes.~~
434 (b) The allocation methodology shall determine ~~provide the~~
435 ~~algorithm that determines~~ the amount of funds allocated to a
436 client's iBudget.
437 (c) The agency may authorize funding ~~approve an increase in~~
438 ~~the amount of funds allocated, as determined by the algorithm,~~
439 based on a ~~the~~ client having one or more of the following needs
440 that cannot be accommodated within the funding ~~as~~ determined by
441 the algorithm and having no other resources, supports, or
442 services available to meet the need:
443 1. An extraordinary need that would place the health and
444 safety of the client, the client's caregiver, or the public in
445 immediate, serious jeopardy unless the increase is approved.

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However, the presence of an extraordinary need in and of itself does not warrant authorized funding by the agency. An extraordinary need may include, but is not limited to:

a. The loss of or a change in the client’s caregiver arrangement or a documented need based on a medical, behavioral, or psychological assessment;

b.~~a.~~ A documented history of significant, potentially life-threatening behaviors, such as recent attempts at suicide, arson, nonconsensual sexual behavior, or self-injurious behavior requiring medical attention;

c.~~b.~~ A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a nonlicensed person;

d.~~c.~~ A chronic comorbid condition. As used in this subparagraph, the term “comorbid condition” means a medical condition existing simultaneously but independently with another medical condition in a patient; or

e.~~d.~~ A need for total physical assistance with activities such as eating, bathing, toileting, grooming, and personal hygiene.

~~However, the presence of an extraordinary need alone does not warrant an increase in the amount of funds allocated to a client’s iBudget as determined by the algorithm~~.

2. A significant need for one-time or temporary support or services that, if not provided, would place the health and safety of the client, the client’s caregiver, or the public in serious jeopardy~~, unless the increase is approved~~. A significant need may include, but is not limited to, the provision of

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475 environmental modifications, durable medical equipment, services
476 to address the temporary loss of support from a caregiver, or
477 special services or treatment for a serious temporary condition
478 when the service or treatment is expected to ameliorate the
479 underlying condition. As used in this subparagraph, the term
480 “temporary” means a period of fewer than 12 continuous months.
481 However, the presence of such significant need for one-time or
482 temporary supports or services alone does not in and of itself
483 warrant authorized funding by the agency ~~an increase in the~~
484 ~~amount of funds allocated to a client’s iBudget as determined by~~
485 ~~the algorithm~~.
486 3. A significant increase in the need for services after
487 the beginning of the service plan year which ~~that~~ would place
488 the health and safety of the client, the client’s caregiver, or
489 the public in serious jeopardy because of substantial changes in
490 the client’s circumstances, including, but not limited to,
491 permanent or long-term loss or incapacity of a caregiver, loss
492 of services authorized under the state Medicaid plan due to a
493 change in age, or a significant change in medical or functional
494 status which requires the provision of additional services on a
495 permanent or long-term basis that cannot be accommodated within
496 the client’s current iBudget. As used in this subparagraph, the
497 term “long-term” means a period of 12 or more continuous months.
498 However, such significant increase in need for services of a
499 permanent or long-term nature ~~alone~~ does not in and of itself
500 warrant authorized funding by the agency ~~warrant an increase in~~
501 ~~the amount of funds allocated to a client’s iBudget as~~
502 ~~determined by the algorithm~~.
503 4. A significant need for transportation services to a

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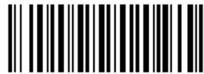
504 waiver-funded adult day training program or to waiver-funded
505 employment services when such need cannot be accommodated within
506 a client’s iBudget as determined by the algorithm without
507 affecting the health and safety of the client, if public
508 transportation is not an option due to the unique needs of the
509 client or other transportation resources are not reasonably
510 available.
511
512 The agency shall reserve portions of the appropriation for the
513 home and community-based services Medicaid waiver program for
514 adjustments required pursuant to this paragraph and may use the
515 services of an independent actuary in determining the amount ~~of~~
516 ~~the portions~~ to be reserved.
517 (d)~~(c) A client’s iBudget shall be the total of the amount~~
518 ~~determined by the algorithm and any additional funding provided~~
519 ~~pursuant to paragraph (b).~~ A client’s annual expenditures for
520 home and community-based ~~services~~ Medicaid waiver services may
521 not exceed the limits of his or her iBudget. The total of all
522 clients’ projected annual iBudget expenditures may not exceed
523 the agency’s appropriation for waiver services.
524 (2) The Agency for Health Care Administration, in
525 consultation with the agency, shall seek federal approval to
526 amend current waivers, request a new waiver, and amend contracts
527 as necessary to manage the iBudget system, to improve services
528 for eligible and enrolled clients, and to improve the delivery
529 of services ~~implement the iBudget system to serve eligible,~~
530 ~~enrolled clients~~ through the home and community-based services
531 Medicaid waiver program and the Consumer-Directed Care Plus
532 Program.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533 ~~(3) The agency shall transition all eligible, enrolled~~
534 ~~clients to the iBudget system. The agency may gradually phase in~~
535 ~~the iBudget system.~~
536 ~~(a) While the agency phases in the iBudget system, the~~
537 ~~agency may continue to serve eligible, enrolled clients under~~
538 ~~the four-tiered waiver system established under s. 393.065 while~~
539 ~~those clients await transitioning to the iBudget system.~~
540 ~~(b) The agency shall design the phase-in process to ensure~~
541 ~~that a client does not experience more than one-half of any~~
542 ~~expected overall increase or decrease to his or her existing~~
543 ~~annualized cost plan during the first year that the client is~~
544 ~~provided an iBudget due solely to the transition to the iBudget~~
545 ~~system.~~
546 (3)~~(4)~~ A client must use all available services authorized
547 under the state Medicaid plan, school-based services, private
548 insurance and other benefits, and any other resources that may
549 be available to the client before using funds from his or her
550 iBudget to pay for support and services.
551 (4)~~(5)~~ The service limitations in s. 393.0661(3)(f)1., 2.,
552 and 3. do not apply to the iBudget system.
553 (5)~~(6)~~ Rates for any or all services established under
554 rules of the Agency for Health Care Administration must ~~shall~~ be
555 designated as the maximum rather than a fixed amount for
556 individuals who receive an iBudget, except for services
557 specifically identified in those rules that the agency
558 determines are not appropriate for negotiation, which may
559 include, but are not limited to, residential habilitation
560 services.
561 (6)~~(7)~~ The agency shall ensure that clients and caregivers

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562 have access to training and education that ~~to~~ inform them about
563 the iBudget system and enhance their ability for self-direction.
564 Such training and education must ~~shall~~ be offered in a variety
565 of formats; ~~and~~ at a minimum, must ~~shall~~ address the policies
566 and processes of the iBudget system and~~;~~ the roles and
567 responsibilities of consumers, caregivers, waiver support
568 coordinators, providers, and the agency; must provide~~;~~
569 information ~~available~~ to help the client make decisions
570 regarding the iBudget system; and must provide examples of
571 support and resources available in the community.
572 (7)~~(8)~~ The agency shall collect data to evaluate the
573 implementation and outcomes of the iBudget system.
574 (8)~~(9)~~ The agency and the Agency for Health Care
575 Administration may adopt rules specifying the allocation
576 algorithm and methodology; criteria and processes for clients to
577 access reserved funds for extraordinary needs, temporarily or
578 permanently changed needs, and one-time needs; and processes and
579 requirements for selection and review of services, development
580 of support and cost plans, and management of the iBudget system
581 as needed to administer this section.
582 Section 6. Section 393.0679, Florida Statutes, is created
583 to read:
584 393.0679 Utilization review.—The agency shall conduct
585 utilization review activities in intermediate care facilities
586 for individuals with developmental disabilities, both public and
587 private, as necessary to meet the requirements of the approved
588 Medicaid state plan and federal law, and such facilities shall
589 comply with any requests for information and documentation made
590 by the agency and permit any agency inspections in connection

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591 with such activities.
592 Section 7. Subsection (1), paragraphs (a) and (b) of
593 subsection (4), paragraphs (b), (e), (f), (g), and (h) of
594 subsection (5), subsection (6), paragraph (d) of subsection (7),
595 subsection (10), and paragraph (b) of subsection (12) of section
596 393.11, Florida Statutes, are amended, and subsection (14) is
597 added to that section, to read:
598 393.11 Involuntary admission to residential services.—
599 (1) JURISDICTION.—If a person has an intellectual
600 disability or autism and requires involuntary admission to
601 residential services provided by the agency, the circuit court
602 of the county in which the person resides has jurisdiction to
603 conduct a hearing and enter an order involuntarily admitting the
604 person in order for the person to receive the care, treatment,
605 habilitation, and rehabilitation that the person needs. For the
606 purpose of identifying intellectual disability or autism,
607 diagnostic capability shall be established by the agency. Except
608 as otherwise specified, the proceedings under this section are
609 governed by the Florida Rules of Civil Procedure.
610 (4) AGENCY PARTICIPATION.—
611 (a) Upon receiving the petition, the court shall
612 immediately order the ~~developmental services program of the~~
613 agency to examine the person being considered for involuntary
614 admission to residential services.
615 (b) Following examination, the agency shall file a written
616 report with the court at least 10 working days before the date
617 of the hearing. The report must be served on the petitioner, the
618 person who has the intellectual disability or autism, and the
619 person's attorney at the time the report is filed with the

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620 court.
621 (5) EXAMINING COMMITTEE.—
622 (b) The court shall appoint at least three disinterested
623 experts who have demonstrated to the court an expertise in the
624 diagnosis, evaluation, and treatment of persons who have
625 intellectual disabilities or autism. The committee must include
626 at least one licensed and qualified physician, one licensed and
627 qualified psychologist, and one qualified professional who, at a
628 minimum, has a master's degree in social work, special
629 education, or vocational rehabilitation counseling, to examine
630 the person and to testify at the hearing on the involuntary
631 admission to residential services.
632 (e) The committee shall prepare a written report for the
633 court. The report must explicitly document the extent that the
634 person meets the criteria for involuntary admission. The report,
635 and expert testimony, must include, but not be limited to:
636 1. The degree of the person's intellectual disability or
637 autism and whether, using diagnostic capabilities established by
638 the agency, the person is eligible for agency services;
639 2. Whether, because of the person's degree of intellectual
640 disability or autism, the person:
641 a. Lacks sufficient capacity to give express and informed
642 consent to a voluntary application for services pursuant to s.
643 393.065 and lacks basic survival and self-care skills to such a
644 degree that close supervision and habilitation in a residential
645 setting are necessary and, if not provided, would result in a
646 threat of substantial harm to the person's well-being; or
647 ~~b. Lacks basic survival and self-care skills to such a~~
648 ~~degree that close supervision and habilitation in a residential~~

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649 ~~setting is necessary and if not provided would result in a real~~
650 ~~and present threat of substantial harm to the person's well-~~
651 ~~being; or~~
652 b.~~c.~~ Is likely to physically injure others if allowed to
653 remain at liberty.
654 3. The purpose to be served by residential care;
655 4. A recommendation on the type of residential placement
656 which would be the most appropriate and least restrictive for
657 the person; and
658 5. The appropriate care, habilitation, and treatment.
659 (f) The committee shall file the report with the court at
660 least 10 working days before the date of the hearing. The report
661 must be served on the petitioner, the person who has the
662 intellectual disability or autism, the person's attorney at the
663 time the report is filed with the court, and the agency.
664 (g) Members of the examining committee shall receive a
665 reasonable fee to be determined by the court. The fees shall be
666 paid from the general revenue fund of the county in which the
667 person who has the intellectual disability or autism resided
668 when the petition was filed.
669 ~~(h) The agency shall develop and prescribe by rule one or~~
670 ~~more standard forms to be used as a guide for members of the~~
671 ~~examining committee.~~
672 (6) COUNSEL; GUARDIAN AD LITEM.—
673 (a) The person who has the intellectual disability or
674 autism must be represented by counsel at all stages of the
675 judicial proceeding. If the person is indigent and cannot afford
676 counsel, the court shall appoint a public defender at least 20
677 working days before the scheduled hearing. The person's counsel

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678 shall have full access to the records of the service provider
679 and the agency. In all cases, the attorney shall represent the
680 rights and legal interests of the person, regardless of who
681 initiates the proceedings or pays the attorney ~~attorney's~~ fee.
682 (b) If the attorney, during the course of his or her
683 representation, reasonably believes that the person who has the
684 intellectual disability or autism cannot adequately act in his
685 or her own interest, the attorney may seek the appointment of a
686 guardian ad litem. A prior finding of incompetency is not
687 required before a guardian ad litem is appointed pursuant to
688 this section.
689 (7) HEARING.—
690 (d) The person who has the intellectual disability or
691 autism must be physically present throughout the entire
692 proceeding. If the person's attorney believes that the person's
693 presence at the hearing is not in his or her best interest, the
694 person's presence may be waived once the court has seen the
695 person and the hearing has commenced.
696 (10) COMPETENCY.—
697 (a) The issue of competency is separate and distinct from a
698 determination of the appropriateness of involuntary admission to
699 residential services due to intellectual disability or autism.
700 (b) The issue of the competency of a person who has an
701 intellectual disability or autism for purposes of assigning
702 guardianship shall be determined in a separate proceeding
703 according to the procedures and requirements of chapter 744. The
704 issue of the competency of a person who has an intellectual
705 disability or autism for purposes of determining whether the
706 person is competent to proceed in a criminal trial shall be

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707 determined in accordance with chapter 916.
708 (12) APPEAL.—
709 (b) The filing of an appeal by the person who has an
710 intellectual disability or autism stays admission of the person
711 into residential care. The stay remains in effect during the
712 pendency of all review proceedings in Florida courts until a
713 mandate issues.
714 (14) REVIEW OF CONTINUED INVOLUNTARY ADMISSION TO
715 RESIDENTIAL SERVICES.—
716 (a) If a person is involuntarily admitted to residential
717 services provided by the agency, the agency shall employ or, if
718 necessary, contract with a qualified evaluator to conduct a
719 review annually, unless otherwise ordered, to determine the
720 appropriateness of the person's continued involuntary admission
721 to residential services based on the criteria in paragraph
722 (8)(b). The review must include an assessment of the most
723 appropriate and least restrictive type of residential placement
724 for the person.
725 (b) A placement resulting from an involuntary admission to
726 residential services must be reviewed by the court at a hearing
727 annually, unless a shorter review period is ordered. The agency
728 shall provide to the court the completed reviews by the
729 qualified evaluator. The review hearing must determine whether
730 the person continues to meet the criteria in paragraph (8)(b)
731 and, if so, whether the person still requires involuntary
732 placement in a residential setting and whether the person is
733 receiving adequate care, treatment, habilitation, and
734 rehabilitation in the residential setting.
735 (c) The agency shall provide a copy of the annual review

736 and reasonable notice of the hearing to the appropriate state’s
737 attorney, if applicable, and the person’s attorney and guardian,
738 or guardian advocate if one is appointed.
739 (d) As used in this subsection, the term “qualified
740 evaluator” means a psychiatrist licensed under chapter 458 or
741 chapter 459, or a psychologist licensed under chapter 490, who
742 has demonstrated to the court an expertise in the diagnosis,
743 evaluation, and treatment of persons with intellectual
744 disabilities.
745 Section 8. For the purpose of incorporating the amendment
746 made by this act to section 393.18, Florida Statutes, in a
747 reference thereto, subsection (15) of section 393.067, Florida
748 Statutes, is reenacted to read:
749 393.067 Facility licensure.—
750 (15) The agency is not required to contract with facilities
751 licensed pursuant to this chapter.
752 Section 9. Section 26 of chapter 2015-222, Laws of Florida,
753 is repealed.
754 Section 10. Section 393.18, Florida Statutes, is reenacted
755 and amended to read:
756 393.18 Comprehensive transitional education program.—A
757 comprehensive transitional education program serves individuals
758 ~~is a group of jointly operating centers or units, the collective~~
759 ~~purpose of which is to provide a sequential series of~~
760 ~~educational care, training, treatment, habilitation, and~~
761 ~~rehabilitation services to persons~~ who have developmental
762 disabilities, ~~and who have~~ severe ~~or moderate~~ maladaptive
763 behaviors, severe maladaptive behaviors and co-occurring complex
764 medical conditions, or a dual diagnosis of developmental

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765 disability and mental illness. ~~However, this section does not~~
766 ~~require such programs to provide services only to persons with~~
767 ~~developmental disabilities. All such~~ Services provided by the
768 program must ~~shall~~ be temporary in nature and delivered in a
769 manner designed to achieve ~~structured residential setting,~~
770 ~~having~~ the primary goal of incorporating the principles
771 ~~principle~~ of self-determination and person-centered planning to
772 transition individuals to the most appropriate, least
773 restrictive community living option of their choice which is not
774 operated as a ~~in establishing permanent residence for persons~~
775 ~~with maladaptive behaviors in facilities that are not associated~~
776 ~~with the~~ comprehensive transitional education program. The
777 supervisor of the clinical director of the program licensee must
778 hold a doctorate degree with a primary focus in behavior
779 analysis from an accredited university, be a certified behavior
780 analyst pursuant to s. 393.17, and have at least 1 year of
781 experience in providing behavior analysis services for
782 individuals with developmental disabilities. The staff must
783 ~~shall~~ include behavior analysts and teachers, as appropriate,
784 who must ~~shall~~ be available to provide services in each
785 component center or unit of the program. A behavior analyst must
786 be certified pursuant to s. 393.17.
787 (1) Comprehensive transitional education programs must
788 ~~shall~~ include ~~a minimum of two component centers or units, one~~
789 ~~of which shall be an intensive treatment and educational center~~
790 ~~or a transitional training and educational center, which~~
791 ~~provides services to persons with maladaptive behaviors in~~ the
792 following components ~~sequential order~~:
793 (a) *Intensive treatment and education* ~~*educational center*~~*.*—

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794 This component provides ~~is a self-contained residential unit~~
795 ~~providing~~ intensive behavioral and educational programming for
796 individuals whose conditions ~~persons with severe maladaptive~~
797 ~~behaviors whose behaviors~~ preclude placement in a less
798 restrictive environment due to the threat of danger or injury to
799 themselves or others. Continuous-shift staff are ~~shall be~~
800 required for this component.
801 (b) *Intensive* ~~*Transitional*~~ *training and education*
802 ~~*educational center.*~~—This component provides ~~is a residential~~
803 ~~unit for persons with moderate maladaptive behaviors providing~~
804 concentrated psychological and educational programming that
805 emphasizes a transition toward a less restrictive environment.
806 Continuous-shift staff are ~~shall be~~ required for this component.
807 (c) ~~*Community*~~ *Transition* ~~*residence*~~*.*—This component provides
808 ~~is a residential center providing~~ educational programs and any
809 support services, training, and care that are needed ~~to assist~~
810 ~~persons with maladaptive behaviors~~ to avoid regression to more
811 restrictive environments while preparing them for more
812 independent living. Continuous-shift staff are ~~shall~~ be required
813 for this component.
814 ~~(d) *Alternative living center.*—This component is a~~
815 ~~residential unit providing an educational and family living~~
816 ~~environment for persons with maladaptive behaviors in a~~
817 ~~moderately unrestricted setting. Residential staff shall be~~
818 ~~required for this component.~~
819 ~~(e) *Independent living education center.*—This component is~~
820 ~~a facility providing a family living environment for persons~~
821 ~~with maladaptive behaviors in a largely unrestricted setting and~~
822 ~~includes education and monitoring that is appropriate to support~~

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823 ~~the development of independent living skills.~~
824 (2) Components of a comprehensive transitional education
825 program are subject to the license issued under s. 393.067 to a
826 comprehensive transitional education program and may be located
827 on a single site or multiple sites as long as such components
828 are located within the same agency region.
829 (3) Comprehensive transitional education programs shall
830 develop individual education plans for each school-aged person
831 with maladaptive behaviors, severe maladaptive behaviors and co-
832 occurring complex medical conditions, or a dual diagnosis of
833 developmental disability and mental illness who receives
834 services from the program. Each individual education plan shall
835 be developed in accordance with the criteria specified in 20
836 U.S.C. ss. 401 et seq., and 34 C.F.R. part 300. Educational
837 components of the program, including individual education plans,
838 must be integrated with the referring school district of each
839 school-aged resident to the extent possible.
840 (4) ~~For comprehensive transitional education programs,~~ The
841 total number of persons in a comprehensive transitional
842 education program ~~residents~~ who are being provided with services
843 may not ~~in any instance~~ exceed ~~the licensed capacity of~~ 120
844 residents, and each residential unit within the component
845 centers of a ~~the~~ program authorized under this section may not
846 ~~in any instance~~ exceed 15 residents. However, a program that was
847 authorized to operate residential units with more than 15
848 residents before July 1, 2015, may continue to operate such
849 units.
850 (5) Beginning July 1, 2016, the agency may approve the
851 proposed admission or readmission of individuals into a

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852 comprehensive transitional education program for up to 2 years
853 subject to a specific review process. The agency may allow an
854 individual to live in this setting for a longer period of time
855 if, after a clinical review is conducted by the agency, it is
856 determined that remaining in the program for a longer period of
857 time is in the best interest of the individual.
858 (6) Comprehensive transitional education programs shall
859 provide continuous recorded video and audio monitoring in all
860 residential common areas. Recordings must be maintained for at
861 least 60 days during which time the agency may review them at
862 any time. At the request of the agency, the comprehensive
863 transitional education program shall retain specified recordings
864 indefinitely throughout the course of an investigation into
865 allegations of potential abuse or neglect.
866 (7) Comprehensive transitional education programs shall
867 operate and maintain a video and audio monitoring system that
868 enables authorized agency staff to monitor program activities
869 and facilities in real time from an off-site location. To the
870 extent possible, such monitoring may be in a manner that
871 precludes detection or knowledge of the monitoring by staff who
872 may be present in monitored areas.
873 (8) Licensure is authorized for a comprehensive
874 transitional education program that, by July 1, 1989:
875 (a) Was in actual operation; or
876 (b) Owned a fee simple interest in real property for which
877 a county or municipal government has approved zoning that allows
878 the placement of a facility operated by the program and has
879 registered an intent with the agency to operate a comprehensive
880 transitional education program. However, nothing prohibits the

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881 assignment of licensure eligibility by such a registrant to
882 another entity at a different site within the state if the
883 entity is in compliance with the criteria of this subsection and
884 local zoning requirements and each residential facility within
885 the component centers or units of the program authorized under
886 this paragraph does not exceed a capacity of 15 persons.
887 (9) Notwithstanding subsection (8), in order to maximize
888 federal revenues and provide for children needing special
889 behavioral services, the agency may authorize the licensure of a
890 facility that:
891 (a) Provides residential services for children who have
892 developmental disabilities and intensive behavioral problems as
893 defined by the agency; and
894 (b) As of July 1, 2010, served children who were served by
895 the child welfare system and who have an open case in the State
896 Automated Child Welfare Information System.
897
898 The facility must be in compliance with all program criteria and
899 local land use and zoning requirements and may not exceed a
900 capacity of 15 children.
901 Section 11. Subsection (2) of section 393.501, Florida
902 Statutes, is amended to read:
903 393.501 Rulemaking.—
904 (2) Such rules must address the number of facilities on a
905 single lot or on adjacent lots, except that there is no
906 restriction on the number of facilities designated as community
907 residential homes located within a planned residential community
908 as those terms are defined in s. 419.001(1). In adopting rules,
909 comprehensive transitional education programs ~~an alternative~~

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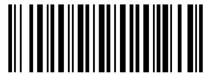
910 ~~living center and an independent living education center~~, as
911 described in s. 393.18, are subject to s. 419.001, except that
912 such program centers are exempt from the 1,000-foot-radius
913 requirement of s. 419.001(2) if:
914 (a) The program centers are located on a site zoned in a
915 manner that permits all the components of a comprehensive
916 transitional education program center to be located on the site;
917 or
918 (b) There are no more than three such program centers
919 within a radius of 1,000 feet.
920 Section 12. Paragraph (b) of subsection (1) of section
921 383.141, Florida Statutes, is amended to read:
922 383.141 Prenatally diagnosed conditions; patient to be
923 provided information; definitions; information clearinghouse;
924 advisory council.—
925 (1) As used in this section, the term:
926 (b) “Developmental disability” includes Down syndrome and
927 other developmental disabilities defined by s. 393.063(12) ~~s.~~
928 ~~393.063(9)~~.
929 Section 13. Paragraph (d) of subsection (2) of section
930 1002.385, Florida Statutes, is amended to read:
931 1002.385 Florida personal learning scholarship accounts.—
932 (2) DEFINITIONS.—As used in this section, the term:
933 (d) “Disability” means, for a 3- or 4-year-old child or for
934 a student in kindergarten to grade 12, autism spectrum disorder,
935 as defined in the Diagnostic and Statistical Manual of Mental
936 Disorders, Fifth Edition, published by the American Psychiatric
937 Association; cerebral palsy, as defined in s. 393.063(6) ~~s.~~
938 ~~393.063(4)~~; Down syndrome, as defined in s. 393.063(15) ~~s.~~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939 ~~393.063(13)~~; an intellectual disability, as defined in s.
940 393.063(24) ~~s. 393.063(21)~~; Prader-Willi syndrome, as defined in
941 s. 393.063(28) ~~s. 393.063(25)~~; or spina bifida, as defined in s.
942 393.063(39) ~~s. 393.063(36)~~; for a student in kindergarten, being
943 a high-risk child, as defined in s. 393.063(23)(a) ~~s.~~
944 ~~393.063(20)(a)~~; muscular dystrophy; and Williams syndrome.
945 Section 14. This act shall take effect June 30, 2016, or,
946 if this act fails to become a law until after that date, it
947 shall take effect upon becoming a law and operate retroactively
948 to June 30, 2016.
949
950 ================= T I T L E A M E N D M E N T ================
951 And the title is amended as follows:
952 Delete everything before the enacting clause
953 and insert:
954 A bill to be entitled
955 An act relating to the Agency for Persons with
956 Disabilities; amending s. 393.063, F.S.; redefining
957 and defining terms; repealing s. 393.0641, F.S.,
958 relating to a program for the prevention and treatment
959 of severe self-injurious behavior; amending s.
960 393.065, F.S.; providing for the assignment of
961 priority to clients waiting for waiver services;
962 requiring the agency to allow an individual to receive
963 specified services if the individual’s parent or legal
964 guardian is an active duty military servicemember,
965 under certain circumstances; requiring the agency to
966 send an annual letter requesting updated information
967 to clients, their guardians, or their families;

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968 providing that certain agency action does not
969 establish a right to a hearing or an administrative
970 proceeding; amending s. 393.066, F.S.; providing for
971 the use of an agency data management system; providing
972 requirements for persons or entities under contract
973 with the agency; amending s. 393.0662, F.S.; revising
974 the allocations methodology that the agency is
975 required to use to develop each client's iBudget;
976 adding client needs that qualify as extraordinary
977 needs, which may result in the approval of an increase
978 in a client's allocated funds; revising duties of the
979 Agency for Health Care Administration relating to the
980 iBudget system; creating s. 393.0679, F.S.; requiring
981 the Agency for Persons with Disabilities to conduct a
982 certain utilization review; requiring specified
983 intermediate care facilities to comply with certain
984 requests and inspections by the agency; amending s.
985 393.11, F.S.; providing for annual reviews for persons
986 involuntarily committed to residential services;
987 requiring the agency to employ or contract with a
988 qualified evaluator; providing requirements for annual
989 reviews; requiring a hearing to be held to consider
990 the results of an annual review; requiring the agency
991 to provide a copy of the review to certain persons;
992 defining a term; reenacting s. 393.067(15), F.S.,
993 relating to contracts between the Agency for Persons
994 with Disabilities and licensed facilities, to
995 incorporate the amendments made to s. 393.18, F.S., in
996 a reference thereto; repealing s. 26 of ch. 2015-222,

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997 Laws of Florida, relating to the abrogation of the
998 scheduled expiration of an amendment to s. 393.18,
999 F.S., and the scheduled reversion of the text of that
1000 section; reenacting and amending s. 393.18, F.S.;
1001 revising the purposes of comprehensive transitional
1002 education programs; providing qualification
1003 requirements for the supervisor of the clinical
1004 director of a specified licensee; revising the
1005 organization and operation of components of a program;
1006 providing for the integration of educational
1007 components with the local school district; authorizing
1008 the agency to approve the admission or readmission of
1009 an individual to a program; providing for video and
1010 audio recording and monitoring of common areas and
1011 program activities and facilities; providing for
1012 licensure of such programs; amending s. 393.501, F.S.;
1013 conforming provisions to changes made by the act;
1014 amending ss. 383.141 and 1002.385, F.S.; conforming
1015 cross references; providing an effective date.

By the Committee on Children, Families, and Elder Affairs

586-02376-16 20167054__

1 A bill to be entitled
2 An act relating to the Agency for Persons with
3 Disabilities; amending s. 393.063, F.S.; revising and
4 defining terms; repealing s. 393.0641, F.S., relating
5 to a program for the prevention and treatment of
6 severe self-injurious behavior; amending s. 393.065,
7 F.S.; providing for the assignment of priority to
8 clients waiting for waiver services; requiring an
9 agency to allow a certain individual to receive such
10 services if the individual's parent or legal guardian
11 is an active-duty military service member; requiring
12 the agency to send an annual letter to clients and
13 their guardians or families; providing that certain
14 agency action does not establish a right to a hearing
15 or an administrative proceeding; amending s. 393.066,
16 F.S.; providing for the use of an agency data
17 management system; providing requirements for persons
18 or entities under contract with the agency; amending
19 s. 393.0662, F.S.; adding client needs that qualify as
20 extraordinary needs, which may result in the approval
21 of an increase in a client's allocated funds; revising
22 duties of the Agency for Health Care Administration
23 relating to the iBudget system; creating s. 393.0679,
24 F.S.; requiring the Agency for Persons with
25 Disabilities to conduct a certain utilization review;
26 requiring certain intermediate care facilities to
27 comply with certain requests and inspections by the
28 agency; amending s. 393.11, F.S.; providing for annual
29 reviews for persons involuntarily committed to
30 residential services; requiring the agency to contract
31 with a qualified evaluator; providing requirements for
32 annual reviews; requiring a hearing to be held to

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33 consider the results of an annual review; requiring
34 the agency to provide a copy of the review to certain
35 persons; defining a term; repealing s. 26 of chapter
36 2015-222, Laws of Florida; abrogating the scheduled
37 expiration of an amendment to s. 393.18, F.S., and the
38 scheduled reversion of the text of that section;
39 reenacting and amending s. 393.18, F.S.; revising the
40 purposes of comprehensive transitional education
41 programs; providing qualification requirements for the
42 clinical director of a comprehensive transitional
43 education program; revising the organization and
44 operation of components of a program; providing for
45 the integration of educational components with the
46 local school district; authorizing the agency to
47 approve the admission or readmission of an individual
48 to a program; providing for video and audio recording
49 and monitoring of common areas and program activities
50 and facilities; providing for licensure of such
51 programs; amending s. 393.501, F.S.; conforming
52 provisions to changes made by the act; amending ss.
53 383.141 and 1002.385, F.S.; conforming cross
54 references; providing an effective date.
55
56 Be It Enacted by the Legislature of the State of Florida:
57
58 Section 1. Section 393.063, Florida Statutes, is amended to
59 read:
60 393.063 Definitions.—For the purposes of this chapter, the
61 term:

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62 (2)~~(1)~~ “Agency” means the Agency for Persons with
63 Disabilities.
64 (1)~~(2)~~ “Adult day training” means training services that
65 ~~which~~ take place in a nonresidential setting, separate from the
66 home or facility in which the client resides, and~~;~~ are intended
67 to support the participation of clients in daily, meaningful,
68 and valued routines of the community. Such training~~; and~~ may be
69 provided in ~~include~~ work-like settings that do not meet the
70 definition of supported employment.
71 (3) “Algorithm” means the mathematical formula developed by
72 the agency based upon statistically valid relationships between
73 the need for services and selected health and social
74 characteristics which is used to calculate a potential amount of
75 financial support through the home and community-based services
76 Medicaid waiver program.
77 (4) “Allocation methodology” means the process for
78 determining the iBudget allocation for an individual which
79 considers:
80 (a) The algorithm amount applicable to an individual based
81 on a formal assessment instrument used by the agency pursuant to
82 s. 393.0661(1)(a); and
83 (b) Any needs identified by the agency during the client
84 review process which cannot be accommodated within the funding
85 determined by the algorithm and are provided for in s.
86 393.0662(1)(b).
87 (5)~~(3)~~ “Autism” means a pervasive, neurologically based
88 developmental disability of extended duration which causes
89 severe learning, communication, and behavior disorders with age
90 of onset during infancy or childhood. Individuals with autism

91 exhibit impairment in reciprocal social interaction, impairment
92 in verbal and nonverbal communication and imaginative ability,
93 and a markedly restricted repertoire of activities and
94 interests.
95 (6)~~(4)~~ “Cerebral palsy” means a group of disabling symptoms
96 of extended duration which results from damage to the developing
97 brain that may occur before, during, or after birth and that
98 results in the loss or impairment of control over voluntary
99 muscles. For the purposes of this definition, cerebral palsy
100 does not include those symptoms or impairments resulting solely
101 from a stroke.
102 (7)~~(5)~~ “Client” means any person determined eligible by the
103 agency for services under this chapter.
104 (8)~~(6)~~ “Client advocate” means a friend or relative of the
105 client, or of the client’s immediate family, who advocates for
106 the best interests of the client in any proceedings under this
107 chapter in which the client or his or her family has the right
108 or duty to participate.
109 (9)~~(7)~~ “Comprehensive assessment” means the process used to
110 determine eligibility for services under this chapter.
111 (10)~~(8)~~ “Comprehensive transitional education program”
112 means the program established in s. 393.18.
113 (12)~~(9)~~ “Developmental disability” means a disorder or
114 syndrome that is attributable to intellectual disability,
115 cerebral palsy, autism, spina bifida, Down syndrome, or Prader-
116 Willi syndrome; that manifests before the age of 18; and that
117 constitutes a substantial handicap that can reasonably be
118 expected to continue indefinitely.
119 (11)~~(10)~~ “Developmental disabilities center” means a state-

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owned and state-operated facility, formerly known as a “Sunland Center,” providing for the care, habilitation, and rehabilitation of clients with developmental disabilities.

(13) ~~(11)~~ “Direct service provider” means a person 18 years of age or older who has direct face-to-face contact with a client while providing services to the client or has access to a client’s living areas or to a client’s funds or personal property.

(14) ~~(12)~~ “Domicile” means the place where a client legally resides and~~,~~ which ~~place~~ is his or her permanent home. Domicile may be established as provided in s. 222.17. Domicile may not be established in Florida by a minor who has no parent domiciled in Florida, or by a minor who has no legal guardian domiciled in Florida, or by any alien not classified as a resident alien.

(15) ~~(13)~~ “Down syndrome” means a disorder caused by the presence of an extra chromosome 21.

(16) ~~(14)~~ “Express and informed consent” means consent voluntarily given in writing with sufficient knowledge and comprehension of the subject matter to enable the person giving consent to make a knowing decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

(17) ~~(15)~~ “Family care program” means the program established in s. 393.068.

(18) ~~(16)~~ “Foster care facility” means a residential facility licensed under this chapter which provides a family living environment including supervision and care necessary to meet the physical, emotional, and social needs of its residents. The capacity of such a facility may not be more than three residents.

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(19) ~~(17)~~ “Group home facility” means a residential facility licensed under this chapter which provides a family living environment including supervision and care necessary to meet the physical, emotional, and social needs of its residents. The capacity of such a facility shall be at least 4 but not more than 15 residents.

(20) “Guardian” has the same meaning as in s. 744.102.

(21) ~~(18)~~ “Guardian advocate” means a person appointed by a written order of the court to represent a person with developmental disabilities under s. 393.12.

(22) ~~(19)~~ “Habilitation” means the process by which a client is assisted in acquiring and maintaining ~~to acquire and maintain~~ those life skills that ~~which~~ enable the client to cope more effectively with the demands of his or her condition and environment and to raise the level of his or her physical, mental, and social efficiency. It includes, but is not limited to, programs of formal structured education and treatment.

(23) ~~(20)~~ “High-risk child” means, for the purposes of this chapter, a child from 3 to 5 years of age with one or more of the following characteristics:

(a) A developmental delay in cognition, language, or physical development.

(b) A child surviving a catastrophic infectious or traumatic illness known to be associated with developmental delay, when funds are specifically appropriated.

(c) A child with a parent or guardian with developmental disabilities who requires assistance in meeting the child’s developmental needs.

(d) A child who has a physical or genetic anomaly

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178 associated with developmental disability.
179 (24) "Initial support plan" means the first support plan
180 that identifies the needs of the individual for supports and
181 services prior to enrollment in the iBudget waiver.
182 (25) ~~(21)~~ "Intellectual disability" means significantly
183 subaverage general intellectual functioning existing
184 concurrently with deficits in adaptive behavior which manifests
185 before the age of 18 and can reasonably be expected to continue
186 indefinitely. For the purposes of this definition, the term:
187 (a) "Adaptive behavior" means the effectiveness or degree
188 with which an individual meets the standards of personal
189 independence and social responsibility expected of his or her
190 age, cultural group, and community.
191 (b) "Significantly subaverage general intellectual
192 functioning" means performance that is two or more standard
193 deviations from the mean score on a standardized intelligence
194 test specified in the rules of the agency.
195
196 For purposes of the application of the criminal laws and
197 procedural rules of this state to matters relating to pretrial,
198 trial, sentencing, and any matters relating to the imposition
199 and execution of the death penalty, the terms "intellectual
200 disability" or "intellectually disabled" are interchangeable
201 with and have the same meaning as the terms "mental retardation"
202 or "retardation" and "mentally retarded" as defined in this
203 section before July 1, 2013.
204 (26) ~~(22)~~ "Intermediate care facility for the
205 developmentally disabled" ~~or "ICF/DD"~~ means a residential
206 facility licensed and certified under part VIII of chapter 400.

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207 (27) ~~(23)~~ "Medical/dental services" means medically
208 necessary services that are provided or ordered for a client by
209 a person licensed under chapter 458, chapter 459, or chapter
210 466. Such services may include, but are not limited to,
211 prescription drugs, specialized therapies, nursing supervision,
212 hospitalization, dietary services, prosthetic devices, surgery,
213 specialized equipment and supplies, adaptive equipment, and
214 other services as required to prevent or alleviate a medical or
215 dental condition.
216 (28) ~~(24)~~ "Personal care services" means individual
217 assistance with or supervision of essential activities of daily
218 living for self-care, including ambulation, bathing, dressing,
219 eating, grooming, and toileting, and other similar services that
220 are incidental to the care furnished and essential to the
221 health, safety, and welfare of the client if no one else is
222 available to perform those services.
223 (29) ~~(25)~~ "Prader-Willi syndrome" means an inherited
224 condition typified by neonatal hypotonia with failure to thrive,
225 hyperphagia or an excessive drive to eat which leads to obesity
226 usually at 18 to 36 months of age, mild to moderate intellectual
227 disability, hypogonadism, short stature, mild facial
228 dysmorphism, and a characteristic neurobehavior.
229 (30) ~~(26)~~ "Relative" means an individual who is connected by
230 affinity or consanguinity to the client and who is 18 years of
231 age or older.
232 (31) ~~(27)~~ "Resident" means a person who has a developmental
233 disability and resides at a residential facility, whether or not
234 such person is a client of the agency.
235 (32) "Resident alien" means a person who is not a citizen

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of the United States but who currently resides in the United States and is classified under Title 8 of the Code of Federal Regulations as either a permanent resident, permanent resident alien, lawful permanent resident, resident alien permit holder, or green card holder.

(33) ~~(28)~~ “Residential facility” means a facility providing room and board and personal care for persons who have developmental disabilities.

(34) ~~(29)~~ “Residential habilitation” means supervision and training with the acquisition, retention, or improvement in skills related to activities of daily living, such as personal hygiene skills, homemaking skills, and the social and adaptive skills necessary to enable the individual to reside in the community.

(35) ~~(30)~~ “Residential habilitation center” means a community residential facility licensed under this chapter which provides habilitation services. The capacity of such a facility may not be fewer than nine residents. After October 1, 1989, new residential habilitation centers may not be licensed and the licensed capacity for any existing residential habilitation center may not be increased.

(36) ~~(31)~~ “Respite service” means appropriate, short-term, temporary care that is provided to a person who has a developmental disability in order to meet the planned or emergency needs of the person or the family or other direct service provider.

(37) ~~(32)~~ “Restraint” means a physical device, method, or drug used to control dangerous behavior.

(a) A physical restraint is any manual method or physical

or mechanical device, material, or equipment attached or adjacent to an individual’s body so that he or she cannot easily remove the restraint and which restricts freedom of movement or normal access to one’s body.

(b) A drug used as a restraint is a medication used to control the person’s behavior or to restrict his or her freedom of movement and is not a standard treatment for the person’s medical or psychiatric condition. Physically holding a person during a procedure to forcibly administer psychotropic medication is a physical restraint.

(c) Restraint does not include physical devices, such as orthopedically prescribed appliances, surgical dressings and bandages, supportive body bands, or other physical holding necessary for routine physical examinations and tests; for purposes of orthopedic, surgical, or other similar medical treatment; to provide support for the achievement of functional body position or proper balance; or to protect a person from falling out of bed.

(38) ~~(33)~~ “Seclusion” means the involuntary isolation of a person in a room or area from which the person is prevented from leaving. The prevention may be by physical barrier or by a staff member who is acting in a manner, or who is physically situated, so as to prevent the person from leaving the room or area. For the purposes of this chapter, the term does not mean isolation due to the medical condition or symptoms of the person.

(39) ~~(34)~~ “Self-determination” means an individual’s freedom to exercise the same rights as all other citizens, authority to exercise control over funds needed for one’s own support, including prioritizing these funds when necessary,

responsibility for the wise use of public funds, and self-advocacy to speak and advocate for oneself in order to gain independence and ensure that individuals with a developmental disability are treated equally.

(40~~(35)~~ "Specialized therapies" means those treatments or activities prescribed by and provided by an appropriately trained, licensed, or certified professional or staff person and may include, but are not limited to, physical therapy, speech therapy, respiratory therapy, occupational therapy, behavior therapy, physical management services, and related specialized equipment and supplies.

(41)~~(36)~~ "Spina bifida" means~~, for purposes of this chapter,~~ a person with a medical diagnosis of spina bifida cystica or myelomeningocele.

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

(43)~~(38)~~ "Supported employment" means employment located or provided in an integrated work setting, with earnings paid on a commensurate wage basis, and for which continued support is needed for job maintenance.

(44)~~(39)~~ "Supported living" means a category of

individually determined services designed and coordinated in such a manner as to provide assistance to adult clients who require ongoing supports to live as independently as possible in their own homes, to be integrated into the community, and to participate in community life to the fullest extent possible.

(45)~~(40)~~ "Training" means a planned approach to assisting a client to attain or maintain his or her maximum potential and includes services ranging from sensory stimulation to instruction in skills for independent living and employment.

(46)~~(41)~~ "Treatment" means the prevention, amelioration, or cure of a client's physical and mental disabilities or illnesses.

Section 2. Section 393.0641, Florida Statutes, is repealed.

Section 3. Subsections (3) and (5) of section 393.065, Florida Statutes, are amended, present subsections (6) and (7) of that section are amended and redesignated as subsections (7) and (9), respectively, and new subsections (6) and (8) are added to that section, to read:

393.065 Application and eligibility determination.—

(3) The agency shall notify each applicant, in writing, of its eligibility decision. Any applicant determined by the agency to be ineligible for ~~developmental~~ services has the right to appeal this decision pursuant to ss. 120.569 and 120.57.

(5) ~~Except as otherwise directed by law, beginning July 1, 2010,~~ The agency shall assign and provide priority to clients waiting for waiver services in the following order:

(a) Category 1, which includes clients deemed to be in crisis as described in rule, shall be given first priority in moving from the waiting list to the waiver.

(b) Category 2, which includes:~~, which includes children~~

1. Individuals on the waiting ~~wait~~ list who are from the child welfare system with an open case in the Department of Children and Families' statewide automated child welfare information system and are:

a. Transitioning out of the child welfare system at the finalization of an adoption, a reunification with family members, a permanent placement with a relative, or a guardianship with a nonrelative; or

b. At least 18 years old, but not yet 22 years old, and need both waiver services and extended foster care services. These individuals may receive both waiver services and services under s. 39.6251 but services may not duplicate services available through the Medicaid state plan.

2. Individuals on the waiting list who are at least 18 years old but not yet 22 years old and who withdrew consent to remain in the extended foster care system pursuant to s. 39.6251(5)(c).

3. Individuals who are at least 18 years old but not yet 22 years old and are eligible under sub-subparagraph 1.b. The agency shall provide waiver services, including residential habilitation, to these individuals. The community-based care lead agency shall fund room and board at the rate established in s. 409.145(4) and provide case management and related services as defined in s. 409.986(3)(e).

(c) Category 3, which includes, but is not required to be limited to, clients:

1. Whose caregiver has a documented condition that is expected to render the caregiver unable to provide care within

the next 12 months and for whom a caregiver is required but no alternate caregiver is available;

2. At substantial risk of incarceration or court commitment without supports;

3. Whose documented behaviors or physical needs place them or their caregiver at risk of serious harm and other supports are not currently available to alleviate the situation; or

4. Who are identified as ready for discharge within the next year from a state mental health hospital or skilled nursing facility and who require a caregiver but for whom no caregiver is available or whose caregiver is unable to provide the care needed.

(d) Category 4, which includes, but is not required to be limited to, clients whose caregivers are 70 years of age or older and for whom a caregiver is required but no alternate caregiver is available.

(e) Category 5, which includes, but is not required to be limited to, clients who are expected to graduate within the next 12 months from secondary school and need support to obtain a meaningful day activity, ~~or~~ maintain competitive employment, or to pursue an accredited program of postsecondary education to which they have been accepted.

(f) Category 6, which includes clients 21 years of age or older who do not meet the criteria for category 1, category 2, category 3, category 4, or category 5.

(g) Category 7, which includes clients younger than 21 years of age who do not meet the criteria for category 1, category 2, category 3, or category 4.

410 Within categories 3, 4, 5, 6, and 7, the agency shall maintain a
411 waiting ~~wait~~ list of clients placed in the order of the date
412 that the client is determined eligible for waiver services.
413 (6) The agency shall allow an individual who meets the
414 eligibility requirements under subsection (1) to receive home
415 and community-based services in this state if the individual's
416 parent or legal guardian is an active-duty military service
417 member and if at the time of the service member's transfer to
418 this state, the individual was receiving home and community-
419 based services in another state.
420 (7)~~(6)~~ The client, the client's guardian, or the client's
421 family must ensure that accurate, up-to-date contact information
422 is provided to the agency at all times. Notwithstanding s.
423 393.0651, the agency shall send an annual letter requesting
424 updated information from the client, the client's guardian, or
425 the client's family. The agency shall remove from the waiting
426 ~~wait~~ list any individual who cannot be located using the contact
427 information provided to the agency, fails to meet eligibility
428 requirements, or becomes domiciled outside the state.
429 (8) Agency action that selects individuals to receive
430 waiver services pursuant to this section does not establish a
431 right to a hearing or an administrative proceeding under chapter
432 120 for individuals remaining on the waiting list.
433 (9)~~(7)~~ The agency and the Agency for Health Care
434 Administration may adopt rules specifying application
435 procedures, criteria associated with the waiting list ~~wait-list~~
436 categories, procedures for administering the waiting ~~wait~~ list,
437 including tools for prioritizing waiver enrollment within
438 categories, and eligibility criteria as needed to administer

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439 this section.
440 Section 4. Subsection (2) of section 393.066, Florida
441 Statutes, is amended to read:
442 393.066 Community services and treatment.—
443 (2) Necessary ~~All~~ services ~~needed~~ shall be purchased,
444 rather than ~~instead of~~ provided directly by the agency, when the
445 purchase of services ~~such arrangement~~ is more cost-efficient
446 than providing them ~~having those services provided~~ directly. All
447 purchased services must be approved by the agency. Persons or
448 entities under contract with the agency to provide services
449 shall use agency data management systems to document service
450 provision to clients. Contracted persons and entities shall meet
451 the minimum hardware and software technical requirements
452 established by the agency for the use of such systems. Such
453 persons or entities shall also meet any requirements established
454 by the agency for training and professional development of staff
455 providing direct services to clients.
456 Section 5. Section 393.0662, Florida Statutes, is amended
457 to read:
458 393.0662 Individual budgets for delivery of home and
459 community-based services; iBudget system established.—The
460 Legislature finds that improved financial management of the
461 existing home and community-based Medicaid waiver program is
462 necessary to avoid deficits that impede the provision of
463 services to individuals who are on the waiting list for
464 enrollment in the program. The Legislature further finds that
465 clients and their families should have greater flexibility to
466 choose the services that best allow them to live in their
467 community within the limits of an established budget. Therefore,

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the Legislature intends that the agency, in consultation with the Agency for Health Care Administration, shall manage ~~develop and implement a comprehensive redesign of~~ the service delivery system using individual budgets as the basis for allocating the funds appropriated for the home and community-based services Medicaid waiver program among eligible enrolled clients. The service delivery system that uses individual budgets shall be called the iBudget system.

(1) The agency shall administer ~~establish~~ an individual budget, referred to as an iBudget, for each individual served by the home and community-based services Medicaid waiver program. The funds appropriated to the agency shall be allocated through the iBudget system to eligible, Medicaid-enrolled clients. For the iBudget system, eligible clients shall include individuals with ~~a diagnosis of Down syndrome or~~ a developmental disability as defined in s. 393.063. The iBudget system shall ~~be designed to~~ provide for: enhanced client choice within a specified service package; appropriate assessment strategies; an efficient consumer budgeting and billing process that includes reconciliation and monitoring components; a ~~redefined~~ role for support coordinators that avoids potential conflicts of interest; a flexible and streamlined service review process; and a methodology and process that ensures the equitable allocation of available funds ~~to each client~~ based on the client's level of need, as determined by the ~~variables in the~~ allocation methodology ~~algorithm~~.

(a) In developing each client's iBudget, the agency shall use the allocation ~~an allocation algorithm and~~ methodology as defined in s. 393.063(4). ~~The algorithm shall use variables that~~

~~have been determined by the agency to have a statistically validated relationship to the client's level of need for services provided through the home and community-based services Medicaid waiver program. The algorithm and methodology may consider individual characteristics, including, but not limited to, a client's age and living situation, information from a formal assessment instrument that the agency determines is valid and reliable, and information from other assessment processes.~~

(b) The allocation methodology shall determine ~~provide the algorithm that determines~~ the amount of funds allocated to a client's iBudget. The agency may approve an increase in the amount of funds allocated, ~~as determined by the algorithm,~~ based on a ~~the~~ client having one or more of the following needs that cannot be accommodated within the funding ~~as~~ determined by the algorithm and having no other resources, supports, or services available to meet the need:

1. An extraordinary need that would place the health and safety of the client, the client's caregiver, or the public in immediate, serious jeopardy unless the increase is approved. However, the presence of an extraordinary need in and of itself does not warrant an increase in the amount of funds allocated to a client's iBudget. An extraordinary need may include, but is not limited to:

a. The client's age and living situation, a change in living situation, the loss of or a change in the client's caregiver arrangement, or a documented need based on a behavioral or psychological assessment;

b.~~a.~~ A documented history of significant, potentially life-threatening behaviors, such as recent attempts at suicide,

arson, nonconsensual sexual behavior, or self-injurious behavior requiring medical attention;

c.~~b.~~ A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a nonlicensed person;

d.~~c.~~ A chronic comorbid condition. As used in this subparagraph, the term “comorbid condition” means a medical condition existing simultaneously but independently with another medical condition in a patient; or

e.~~d.~~ A need for total physical assistance with activities such as eating, bathing, toileting, grooming, and personal hygiene.

~~However, the presence of an extraordinary need alone does not warrant an increase in the amount of funds allocated to a client’s iBudget as determined by the algorithm~~.

2. A significant need for one-time or temporary support or services that, if not provided, would place the health and safety of the client, the client’s caregiver, or the public in serious jeopardy~~, unless the increase is approved~~. A significant need may include, but is not limited to, the provision of environmental modifications, durable medical equipment, services to address the temporary loss of support from a caregiver, or special services or treatment for a serious temporary condition when the service or treatment is expected to ameliorate the underlying condition. As used in this subparagraph, the term “temporary” means a period of fewer than 12 continuous months. However, the presence of such significant need for one-time or temporary supports or services alone does not warrant an

increase in the amount of funds allocated to a client’s iBudget ~~as determined by the algorithm~~.

3. A significant increase in the need for services after the beginning of the service plan year that would place the health and safety of the client, the client’s caregiver, or the public in serious jeopardy because of substantial changes in the client’s circumstances, including, but not limited to, permanent or long-term loss or incapacity of a caregiver, loss of services authorized under the state Medicaid plan due to a change in age, or a significant change in medical or functional status which requires the provision of additional services on a permanent or long-term basis that cannot be accommodated within the client’s current iBudget. As used in this subparagraph, the term “long-term” means a period of 12 or more continuous months. However, such significant increase in need for services of a permanent or long-term nature ~~alone~~ does not in and of itself warrant an increase in the amount of funds allocated to a client’s iBudget ~~as determined by the algorithm~~.

4. A significant need for transportation services to a waiver-funded adult day training program or to waiver-funded employment services when such need cannot be accommodated within a client’s iBudget as determined by the algorithm without affecting the health and safety of the client, if public transportation is not an option due to the unique needs of the client or other transportation resources are not reasonably available.

The agency shall reserve portions of the appropriation for the home and community-based services Medicaid waiver program for

584 adjustments required pursuant to this paragraph and may use the
585 services of an independent actuary in determining the amount ~~of~~
586 ~~the portions~~ to be reserved.
587 (c) ~~A client's iBudget shall be the total of the amount~~
588 ~~determined by the algorithm and any additional funding provided~~
589 ~~pursuant to paragraph (b).~~ A client's annual expenditures for
590 home and community-based ~~services~~ Medicaid waiver services may
591 not exceed the limits of his or her iBudget. The total of all
592 clients' projected annual iBudget expenditures may not exceed
593 the agency's appropriation for waiver services.
594 (2) The Agency for Health Care Administration, in
595 consultation with the agency, shall seek federal approval to
596 amend current waivers, request a new waiver, and amend contracts
597 as necessary to manage the iBudget system, to improve services
598 for eligible and enrolled clients, and to improve the delivery
599 of services ~~implement the iBudget system to serve eligible,~~
600 ~~enrolled clients~~ through the home and community-based services
601 Medicaid waiver program and the Consumer-Directed Care Plus
602 Program to persons with a dual diagnosis of a developmental
603 disability and a mental health diagnosis.
604 ~~(3) The agency shall transition all eligible, enrolled~~
605 ~~clients to the iBudget system. The agency may gradually phase in~~
606 ~~the iBudget system.~~
607 ~~(a) While the agency phases in the iBudget system, the~~
608 ~~agency may continue to serve eligible, enrolled clients under~~
609 ~~the four-tiered waiver system established under s. 393.065 while~~
610 ~~those clients await transitioning to the iBudget system.~~
611 ~~(b) The agency shall design the phase-in process to ensure~~
612 ~~that a client does not experience more than one-half of any~~

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613 ~~expected overall increase or decrease to his or her existing~~
614 ~~annualized cost plan during the first year that the client is~~
615 ~~provided an iBudget due solely to the transition to the iBudget~~
616 ~~system.~~
617 (3)~~(4)~~ A client must use all available services authorized
618 under the state Medicaid plan, school-based services, private
619 insurance and other benefits, and any other resources that may
620 be available to the client before using funds from his or her
621 iBudget to pay for support and services.
622 ~~(5) The service limitations in s. 393.0661(3)(f)1., 2., and~~
623 ~~3. do not apply to the iBudget system.~~
624 (4)~~(6)~~ Rates for any or all services established under
625 rules of the Agency for Health Care Administration must ~~shall~~ be
626 designated as the maximum rather than a fixed amount for
627 individuals who receive an iBudget, except for services
628 specifically identified in those rules that the agency
629 determines are not appropriate for negotiation, which may
630 include, but are not limited to, residential habilitation
631 services.
632 (5)~~(7)~~ The agency shall ensure that clients and caregivers
633 have access to training and education that ~~to~~ inform them about
634 the iBudget system and enhance their ability for self-direction.
635 Such training and education must ~~shall~~ be offered in a variety
636 of formats and, at a minimum, must ~~shall~~ address the policies
637 and processes of the iBudget system and~~;~~ the roles and
638 responsibilities of consumers, caregivers, waiver support
639 coordinators, providers, and the agency, and must provide~~;~~
640 information ~~available~~ to help the client make decisions
641 regarding the iBudget system~~;~~ and examples of support and

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resources available in the community.

(6) ~~(8)~~ The agency shall collect data to evaluate the implementation and outcomes of the iBudget system.

(7) ~~(9)~~ The agency and the Agency for Health Care Administration may adopt rules specifying the allocation algorithm and methodology; criteria and processes for clients to access reserved funds for extraordinary needs, temporarily or permanently changed needs, and one-time needs; and processes and requirements for selection and review of services, development of support and cost plans, and management of the iBudget system as needed to administer this section.

Section 6. Section 393.0679, Florida Statutes, is created to read:

393.0679 Utilization review.—The agency shall conduct utilization review activities in intermediate care facilities for individuals with developmental disabilities, both public and private, as necessary to meet the requirements of the approved Medicaid state plan and federal law, and such facilities shall comply with any requests for information and documentation made by the agency and permit any agency inspections in connection with such activities.

Section 7. Subsection (1), paragraphs (a) and (b) of subsection (4), paragraphs (b), (e), (f), (g), and (h) of subsection (5), subsection (6), paragraph (d) of subsection (7), subsection (10), and paragraph (b) of subsection (12) of section 393.11, Florida Statutes, are amended, and subsection (14) is added to that section, to read:

393.11 Involuntary admission to residential services.—

(1) JURISDICTION.—If a person has an intellectual

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disability or autism and requires involuntary admission to residential services provided by the agency, the circuit court of the county in which the person resides has jurisdiction to conduct a hearing and enter an order involuntarily admitting the person in order for the person to receive the care, treatment, habilitation, and rehabilitation that the person needs. For the purpose of identifying intellectual disability or autism, diagnostic capability shall be established by the agency. Except as otherwise specified, the proceedings under this section are governed by the Florida Rules of Civil Procedure.

(4) AGENCY PARTICIPATION.—

(a) Upon receiving the petition, the court shall immediately order the ~~developmental services program of the~~ agency to examine the person being considered for involuntary admission to residential services.

(b) Following examination, the agency shall file a written report with the court at least 10 working days before the date of the hearing. The report must be served on the petitioner, the person who has the intellectual disability or autism, and the person’s attorney at the time the report is filed with the court.

(5) EXAMINING COMMITTEE.—

(b) The court shall appoint at least three disinterested experts who have demonstrated to the court an expertise in the diagnosis, evaluation, and treatment of persons who have intellectual disabilities or autism. The committee must include at least one licensed and qualified physician, one licensed and qualified psychologist, and one qualified professional who, at a minimum, has a master’s degree in social work, special

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education, or vocational rehabilitation counseling, to examine the person and to testify at the hearing on the involuntary admission to residential services.

(e) The committee shall prepare a written report for the court. The report must explicitly document the extent that the person meets the criteria for involuntary admission. The report, and expert testimony, must include, but not be limited to:

1. The degree of the person's intellectual disability or autism and whether, using diagnostic capabilities established by the agency, the person is eligible for agency services;

2. Whether, because of the person's degree of intellectual disability or autism, the person:

a. Lacks sufficient capacity to give express and informed consent to a voluntary application for services pursuant to s. 393.065 and lacks basic survival and self-care skills to such a degree that close supervision and habilitation in a residential setting is necessary and, if not provided, would result in a threat of substantial harm to the person's well-being; or

~~b. Lacks basic survival and self-care skills to such a degree that close supervision and habilitation in a residential setting is necessary and if not provided would result in a real and present threat of substantial harm to the person's well-being; or~~

b.~~c.~~ Is likely to physically injure others if allowed to remain at liberty.

3. The purpose to be served by residential care;

4. A recommendation on the type of residential placement which would be the most appropriate and least restrictive for the person; and

5. The appropriate care, habilitation, and treatment.

(f) The committee shall file the report with the court at least 10 working days before the date of the hearing. The report must be served on the petitioner, the person who has the intellectual disability or autism, the person's attorney at the time the report is filed with the court, and the agency.

(g) Members of the examining committee shall receive a reasonable fee to be determined by the court. The fees shall be paid from the general revenue fund of the county in which the person who has the intellectual disability or autism resided when the petition was filed.

~~(h) The agency shall develop and prescribe by rule one or more standard forms to be used as a guide for members of the examining committee.~~

(6) COUNSEL; GUARDIAN AD LITEM.—

(a) The person who has the intellectual disability or autism must be represented by counsel at all stages of the judicial proceeding. If the person is indigent and cannot afford counsel, the court shall appoint a public defender at least 20 working days before the scheduled hearing. The person's counsel shall have full access to the records of the service provider and the agency. In all cases, the attorney shall represent the rights and legal interests of the person, regardless of who initiates the proceedings or pays the attorney ~~attorney's~~ fee.

(b) If the attorney, during the course of his or her representation, reasonably believes that the person who has the intellectual disability or autism cannot adequately act in his or her own interest, the attorney may seek the appointment of a guardian ad litem. A prior finding of incompetency is not

758 required before a guardian ad litem is appointed pursuant to
759 this section.
760 (7) HEARING.—
761 (d) The person who has the intellectual disability or
762 autism must be physically present throughout the entire
763 proceeding. If the person's attorney believes that the person's
764 presence at the hearing is not in his or her best interest, the
765 person's presence may be waived once the court has seen the
766 person and the hearing has commenced.
767 (10) COMPETENCY.—
768 (a) The issue of competency is separate and distinct from a
769 determination of the appropriateness of involuntary admission to
770 residential services due to intellectual disability or autism.
771 (b) The issue of the competency of a person who has an
772 intellectual disability or autism for purposes of assigning
773 guardianship shall be determined in a separate proceeding
774 according to the procedures and requirements of chapter 744. The
775 issue of the competency of a person who has an intellectual
776 disability or autism for purposes of determining whether the
777 person is competent to proceed in a criminal trial shall be
778 determined in accordance with chapter 916.
779 (12) APPEAL.—
780 (b) The filing of an appeal by the person who has an
781 intellectual disability or autism stays admission of the person
782 into residential care. The stay remains in effect during the
783 pendency of all review proceedings in Florida courts until a
784 mandate issues.
785 (14) COMMITMENT REVIEW.—
786 (a) For persons involuntarily admitted to residential

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787 services by court order pursuant to this section, such
788 involuntary admission, unless otherwise ordered by the court,
789 must be reviewed annually. Placements resulting from an order
790 for involuntary admission must be part of the review. The agency
791 shall contract with a qualified evaluator to perform such
792 reviews which must be provided to the court upon completion.
793 (b) Upon receipt of an annual review by the court, a
794 hearing must be held to consider the results of the review and
795 to determine whether the person continues to meet the criteria
796 specified in paragraph (8)(b). If the person continues to meet
797 the criteria, the court shall determine whether he or she still
798 requires involuntary admission to a residential setting, whether
799 the person is in the most appropriate and least restrictive
800 setting, and whether the person is receiving adequate care,
801 treatment, habilitation, and rehabilitation in the residential
802 setting.
803 (c) The agency shall provide a copy of the annual review
804 and reasonable notice of the hearing to the appropriate state's
805 attorney, if applicable, and the person's attorney and guardian
806 or guardian advocate, if one is appointed.
807 (d) For purposes of this subsection, the term "qualified
808 evaluator" means a licensed psychologist with expertise in the
809 diagnosis, evaluation, and treatment of persons with
810 intellectual disabilities or autism.
811 Section 8. Section 26 of chapter 2015-222, Laws of Florida,
812 is repealed.
813 Section 9. Section 393.18, Florida Statutes, is reenacted
814 and amended to read:
815 393.18 Comprehensive transitional education program.—A

816 comprehensive transitional education program serves individuals
817 ~~is a group of jointly operating centers or units, the collective~~
818 ~~purpose of which is to provide a sequential series of~~
819 ~~educational care, training, treatment, habilitation, and~~
820 ~~rehabilitation services to persons~~ who have developmental
821 disabilities, ~~and who have~~ severe ~~or moderate~~ maladaptive
822 behaviors, severe maladaptive behaviors and co-occurring complex
823 medical conditions, or a dual diagnosis of developmental
824 disability and mental illness. ~~However, this section does not~~
825 ~~require such programs to provide services only to persons with~~
826 ~~developmental disabilities. All such~~ Services provided by the
827 program must ~~shall~~ be temporary in nature and delivered in a
828 manner designed to achieve ~~structured residential setting,~~
829 ~~having~~ the primary goal of incorporating the principles
830 ~~principle~~ of self-determination and person-centered planning to
831 transition individuals to the most appropriate, least
832 restrictive community living option of their choice which is not
833 operated as a ~~in establishing permanent residence for persons~~
834 ~~with maladaptive behaviors in facilities that are not associated~~
835 ~~with the~~ comprehensive transitional education program. The
836 clinical director of the program must hold a doctorate degree
837 with a primary focus in behavior analysis from an accredited
838 university, be a certified behavior analyst pursuant to s.
839 393.17, and have at least 1 year of experience in providing
840 behavior analysis services for individuals with developmental
841 disabilities. The staff must ~~shall~~ include behavior analysts and
842 teachers, as appropriate, who must ~~shall~~ be available to provide
843 services in each component center or unit of the program. A
844 behavior analyst must be certified pursuant to s. 393.17.

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845 (1) Comprehensive transitional education programs must
846 ~~shall~~ include ~~a minimum of two component centers or units, one~~
847 ~~of which shall be an intensive treatment and educational center~~
848 ~~or a transitional training and educational center, which~~
849 ~~provides services to persons with maladaptive behaviors in~~ the
850 following components ~~sequential order~~:
851 (a) *Intensive treatment and education* ~~*educational center*~~.—
852 This component provides ~~is a self-contained residential unit~~
853 ~~providing~~ intensive behavioral and educational programming for
854 individuals whose conditions ~~persons with severe maladaptive~~
855 ~~behaviors whose behaviors~~ preclude placement in a less
856 restrictive environment due to the threat of danger or injury to
857 themselves or others. Continuous-shift staff are ~~shall be~~
858 required for this component.
859 (b) *Intensive* ~~*Transitional*~~ *training and education*
860 ~~*educational center*~~.—This component provides ~~is a residential~~
861 ~~unit for persons with moderate maladaptive behaviors providing~~
862 concentrated psychological and educational programming that
863 emphasizes a transition toward a less restrictive environment.
864 Continuous-shift staff are ~~shall be~~ required for this component.
865 (c) ~~*Community*~~ *Transition* ~~*residence*~~.—This component provides
866 ~~is a residential center providing~~ educational programs and any
867 support services, training, and care that are needed ~~to assist~~
868 ~~persons with maladaptive behaviors~~ to avoid regression to more
869 restrictive environments while preparing them for more
870 independent living. Continuous-shift staff may ~~shall~~ be required
871 for this component.
872 ~~(d) *Alternative living center*.—This component is a~~
873 ~~residential unit providing an educational and family living~~

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~~environment for persons with maladaptive behaviors in a moderately unrestricted setting. Residential staff shall be required for this component.~~

~~(c) *Independent living education center.*—This component is a facility providing a family living environment for persons with maladaptive behaviors in a largely unrestricted setting and includes education and monitoring that is appropriate to support the development of independent living skills.~~

(2) Components of a comprehensive transitional education program are subject to the license issued under s. 393.067 to a comprehensive transitional education program and may be located on a single site or multiple sites as long as such components are located within the same agency region.

(3) Comprehensive transitional education programs shall develop individual education plans for each person with maladaptive behaviors, severe maladaptive behaviors and co-occurring complex medical conditions, or a dual diagnosis of developmental disability and mental illness who receives services from the program. Each individual education plan shall be developed in accordance with the criteria specified in 20 U.S.C. ss. 401 et seq., and 34 C.F.R. part 300. Educational components of the program, including individual education plans, must be integrated with the local school district to the extent possible.

(4) ~~For comprehensive transitional education programs,~~ The total number of persons in a comprehensive transitional education program ~~residents~~ who are being provided with services may not ~~in any instance~~ exceed ~~the licensed capacity of~~ 120 residents, and each residential unit within the component

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centers of a ~~the~~ program authorized under this section may not ~~in any instance~~ exceed 15 residents. However, a program that was authorized to operate residential units with more than 15 residents before July 1, 2015, may continue to operate such units.

(5) Beginning July 1, 2016, the agency may approve the proposed admission or readmission of individuals into a comprehensive transitional education program for up to 2 years subject to a specific review process. The agency may allow an individual to live in this setting for a longer period of time if, after a clinical review is conducted by the agency, it is determined that remaining in the program for a longer period of time is in the best interest of the individual.

(6) Comprehensive transitional education programs shall provide continuous recorded video and audio monitoring in all residential common areas. Recordings must be maintained for at least 60 days during which time the agency may review them at any time. At the request of the agency, the comprehensive transitional education program shall retain specified recordings indefinitely throughout the course of an investigation into allegations of potential abuse or neglect.

(7) Comprehensive transitional education programs shall operate and maintain a video and audio monitoring system that enables authorized agency staff to monitor program activities and facilities in real time from an off-site location. To the extent possible, such monitoring may be in a manner that precludes detection or knowledge of the monitoring by staff who may be present in monitored areas.

(8) Licensure is authorized for a comprehensive

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transitional education program that, by July 1, 1989:

(a) Was in actual operation; or

(b) Owned a fee simple interest in real property for which a county or municipal government has approved zoning that allows the placement of a facility operated by the program and has registered an intent with the agency to operate a comprehensive transitional education program. However, nothing prohibits the assignment of licensure eligibility by such a registrant to another entity at a different site within the state if the entity is in compliance with the criteria of this subsection and local zoning requirements and each residential facility within the component centers or units of the program authorized under this paragraph does not exceed a capacity of 15 persons.

(9) Notwithstanding subsection (8), in order to maximize federal revenues and provide for children needing special behavioral services, the agency may authorize the licensure of a facility that:

(a) Provides residential services for children who have developmental disabilities and intensive behavioral problems as defined by the agency; and

(b) As of July 1, 2010, served children who were served by the child welfare system and who have an open case in the State Automated Child Welfare Information System.

The facility must be in compliance with all program criteria and local land use and zoning requirements and may not exceed a capacity of 15 children.

Section 10. Subsection (2) of section 393.501, Florida Statutes, is amended to read:

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393.501 Rulemaking.—

(2) Such rules must address the number of facilities on a single lot or on adjacent lots, except that there is no restriction on the number of facilities designated as community residential homes located within a planned residential community as those terms are defined in s. 419.001(1). In adopting rules, comprehensive transitional education programs ~~an alternative living center and an independent living education center~~, as described in s. 393.18, are subject to s. 419.001, except that such program centers are exempt from the 1,000-foot-radius requirement of s. 419.001(2) if:

(a) The program centers are located on a site zoned in a manner that permits all the components of a comprehensive transitional education program center to be located on the site; or

(b) There are no more than three such program centers within a radius of 1,000 feet.

Section 11. Paragraph (b) of subsection (1) of section 383.141, Florida Statutes, is amended to read:

383.141 Prenatally diagnosed conditions; patient to be provided information; definitions; information clearinghouse; advisory council.—

(1) As used in this section, the term:

(b) "Developmental disability" includes Down syndrome and other developmental disabilities defined by s. 393.063(12) ~~s. 393.063(9)~~.

Section 12. Paragraph (d) of subsection (2) of section 1002.385, Florida Statutes, is amended to read:

1002.385 Florida personal learning scholarship accounts.—

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990 (2) DEFINITIONS.—As used in this section, the term:
991 (d) “Disability” means, for a 3- or 4-year-old child or for
992 a student in kindergarten to grade 12, autism spectrum disorder,
993 as defined in the Diagnostic and Statistical Manual of Mental
994 Disorders, Fifth Edition, published by the American Psychiatric
995 Association; cerebral palsy, as defined in s. 393.063(6) ~~s.~~
996 ~~393.063(4)~~; Down syndrome, as defined in s. 393.063(15) ~~s.~~
997 ~~393.063(13)~~; an intellectual disability, as defined in s.
998 393.063(25) ~~s. 393.063(21)~~; Prader-Willi syndrome, as defined in
999 s. 393.063(29) ~~s. 393.063(25)~~; or spina bifida, as defined in s.
1000 393.063(41) ~~s. 393.063(36)~~; for a student in kindergarten, being
1001 a high-risk child, as defined in s. 393.063(23)(a) ~~s.~~
1002 ~~393.063(20)(a)~~; muscular dystrophy; and Williams syndrome.
1003 Section 13. This act shall take effect July 1, 2016.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Children, Families, and Elder Affairs, *Chair*
Health Policy, *Vice Chair*
Agriculture
Education Pre-K-12
Appropriations Subcommittee on Health and Human Services

SENATOR ELEANOR SOBEL
33rd District

January 27, 2016

Senator Rene Garcia
Chair of the Appropriations Subcommittee on Health and Human Services
310 Senate Office Building
404 South Monroe Street
Tallahassee, Florida 32399

Dear Chair Garcia,

This letter is to request that **SB 7054**, relating to the **Agency for Persons with Disabilities**, be placed on the agenda of the next scheduled meeting of the Appropriations Subcommittee on Health and Human Services.

SB 7054 repeals provisions relating to a program for the prevention and treatment of severe self-injurious behavior, adds client needs that qualify as extraordinary needs which may result in the approval of an increase in a client's allocated funds, requires the Agency for Persons with Disabilities to conduct a certain utilization review, and provides for annual reviews for persons involuntarily committed to residential services.

Thank you for your consideration of this request. Please don't hesitate to contact my office if you have any questions.

With Best Regards,

Eleanor Sobel
State Senator, 33rd District

REPLY TO:
❒ The "Old" Library, First Floor, 2600 Hollywood Blvd., Hollywood, Florida 33020 (954) 924-3693 FAX: (954) 924-3695
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ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL: PCS/SB 7056 (939436)

INTRODUCER: Appropriations Subcommittee on Health and Human Services and Health Policy Committee

SUBJECT: Long-term Care Managed Care Prioritization

DATE: February 12, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
	Lloyd	Stovall		**HP Submitted as Committee Bill**
1.	Brown	Pigott	AHS	**Recommend: Fav/CS**
2.			AP	

I. Summary:

PCS/SB 7056 addresses Medicaid's long-term care managed care (LTCMC) program and revises ss. 409.962 and 409.949, F.S., relating to eligibility, enrollment, and prioritization for the program.

The bill requires the Department of Elderly Affairs (DOEA) to maintain a statewide wait list for enrollment for the community-based services portion of LTCMC and to prioritize individuals for potential enrollment using a frailty-based screening tool that generates a priority score. The DOEA must develop the screening tool by rule. The DOEA is also required to make publicly available on its website the specific methodology used to calculate an individual's priority score. The bill requires individuals to be rescreened at least annually or upon notification of a significant change in the individual's circumstances.

When the DOEA Comprehensive Assessment and Review for Long-Term Care Services (CARES) program is notified of available enrollment capacity by the Agency for Health Care Administration (AHCA), a pre-release assessment is conducted of individuals based on the priority scoring process. If capacity is limited for individuals with identical priority scores, the individual with the oldest date of placement on the wait list will receive priority for pre-release assessment.

If found to meet all eligibility criteria, the individual may be enrolled in LTCMC.

An individual may also be terminated from the LTCMC wait list. Once terminated, an individual would be required to initiate a new request for placement on the wait list, and any previous priority consideration would be disregarded.

The bill identifies certain populations that are provided priority enrollment for home and community based services through LTCMC, and which do not have to complete the screening or wait-list process as long as all other program eligibility requirements are met. These populations consist of:

- Individuals who are 18, 19, and 20 years of age who have chronic, debilitating diseases or conditions of one or more physiological or organ systems which generally make the individual dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention;
- Nursing facility residents requesting to transition into the community who have resided in Florida-licensed skilled nursing facility for at least 60 consecutive days; and
- Individuals referred to the DOEA's Adult Protective Services program as high risk and placed in an assisted living facility temporarily funded by the DOEA.

The bill authorizes the DOEA and the AHCA to adopt rules to implement the bill.

Both the DOEA and the AHCA estimate no fiscal impact.

The effective date of the bill July 1, 2016.

II. Present Situation:

Florida Medicaid

The Medicaid program is a partnership between the federal and state governments to provide medical care to low income children and disabled persons. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare & Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the Agency for Health Care Administration (AHCA) and is financed with federal and state funds. The Department of Children and Families (DCF) determines Medicaid eligibility and transmits that information to the AHCA. The AHCA is designated as the single state Medicaid agency and has the lead responsibility for the overall program.[1]

Over 3.9 million Floridians are currently enrolled in Medicaid.[2] The Medicaid program's estimated expenditures for the 2015-2016 fiscal year are $24.7 billion.[3] The current traditional federal share is 60.51 percent with the state paying 39.49 percent for Medicaid enrollees.[4] Florida has the fourth largest Medicaid population in the country.[5]

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[1] *See* s. 409.963, F.S.

[2] Agency for Health Care Administration, *Report of Medicaid Eligibles* (Dec. 31, 2015), on file with the Senate Appropriations Subcommittee on Health and Human Services.

[3] Social Services Estimating Conference, *Medicaid Services Expenditures,* Jan. 7, 2016.

[4] Office of Economic and Demographic Research, *Social Services Estimating Conference - Official FMAP Estimate* (February 2015), http://edr.state.fl.us/Content/conferences/medicaid/fmap.pdf (last viewed Jan. 21, 2016). The SSEC has also created a "real time" FMAP blend" for the Statewide Medicaid Managed Care Program which is 60.43% for SFY 2015-16.

[5] Agency for Health Care Administration, Health and Human Services Appropriations Committee Presentation, *Agency for Health Care Administration - An Overview* (January 22, 2015), slide 9,

Medicaid currently covers:

- 20 percent of Florida's population;
- 27 percent of Florida's children;
- 62.2 percent of Florida's births; and
- 69 percent of Florida's nursing homes days.[6]

The structures of state Medicaid programs vary from state to state, and each state's share of expenditures also varies and is largely determined by the federal government. Federal law and regulations set the minimum amount, scope, and duration of services offered in the program, among other requirements. State Medicaid benefits are provided in statute under s. 409.903, F.S. (Mandatory Payments for Eligible Persons) and s. 409.904, F.S. (Optional Payments for Eligible Persons).

Applicants for Medicaid must be United States citizens or qualified noncitizens, must be Florida residents, and must provide social security numbers for data matching. While self-attestation is permitted for a number of data elements on the application, most components are matched through the Federal Data Services Hub.[7] Applicants must also agree to cooperate with Child Support Enforcement during the application process.[8]

Federal Poverty Guidelines for 2015[9] Annual Income (rounded)				
Family Size	**100%**	**133%**	**150%**	**200%**
1	$11,770	$15,654	$17,655	$23,540
2	$15,930	$21,187	$23,895	$31,860
3	$20,090	$26,720	$30,135	$40,180
4	$24,250	$32,252	$36,375	$48,500

Minimum eligibility coverage thresholds are established in federal law for certain population groups, such as children, as well as minimum benefits and maximum cost sharing. The minimum benefits include items such as physician services, hospital services, home health services, and family planning.[10] States can add benefits, pending federal approval. Florida has added benefits, including prescription drugs, adult dental services, and dialysis.[11] For children under age 21, the benefits must include the Early and Periodic Screening, Diagnostic and Treatment services, which are those health care and diagnostic services and treatment and measures that may be

http://www.flsenate.gov/PublishedContent/Committees/2014-2016/AHS/MeetingRecords/MeetingPacket_2759.pdf (last visited Jan. 21, 2016).

[6] Id at 10.

[7] Florida Dep't of Children and Families, *Family-Related Medicaid Programs Fact Sheet,* p. 3 (January 2015), http://www.dcf.state.fl.us/programs/access/docs/Family-RelatedMedicaidFactSheet.pdf (last visited Jan. 21, 2016).

[8] Id.

[9] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid and CHIP Program Information - 2015 Federal Poverty Level Charts* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf (last visited Jan. 21, 2016).

[10] Section 409.905, F.S.

[11] Section 409.906, F.S.

needed to correct or ameliorate defects or physical and mental illnesses and conditions discovered by screening services, consistent with federal law.[12]

Statewide Medicaid Managed Care

Part IV of ch. 409, F.S., was created in 2011 by ch. 2011-134, L.O.F., and governs the Statewide Medicaid Managed Care program (SMMC). The program, authorized under federal Medicaid waivers, is designed for the AHCA to issue invitations to negotiate[13] and competitively procure contracts with managed care plans in 11 regions of the state to provide comprehensive Medicaid coverage for most of the state's enrollees in the Medicaid program. SMMC has two components: managed medical assistance (MMA) and long-term care managed care (LTCMC).

The LTCMC component began enrolling Medicaid recipients in August 2013 and completed its statewide roll-out in March 2014. The MMA component began enrolling Medicaid recipients in May 2014 and finished its roll-out in August 2014. As of December 2015, 3.19 million Medicaid recipients were enrolled in an SMMC plan while 793,515 were enrolled in Medicaid on a fee-for-service basis.[14]

Long-Term Care Managed Care

LTCMC provides services in two settings: nursing facilities and community settings such as a recipient's home, an assisted living facility, or an adult family care home. Nursing facility services are an entitlement program for eligible enrollees; however, home and community based services are delivered through waivers and are dependent on the availability of annual funding.

Enrollment in the home and community based services portion of LTCMC is managed based on a priority system and wait list. For the 2015-2016 state fiscal year, the state is approved for 50,390 unduplicated recipients in the home and community based services portion of the program.[15]

Eligibility and Enrollment

The AHCA is the single state agency for Medicaid; however through an interagency agreement with the DOEA, the DOEA is Florida's federally mandated pre-admission screening program for nursing home applicants through its Long-Term Care Services (CARES) program, including for LTCMC.[16] The CARES program has 18 field offices across the state which are staffed with

[12] *See* Section 1905 9(r) of the Social Security Act.
[13] An "invitation to negotiate" is a written or electronically posted solicitation for vendors to submit competitive, sealed replies for the purpose of selecting one or more vendors with which to commence negotiations for the procurement of commodities or contractual services. *See* s. 287.012(17), F.S.
[14] The Agency for Health Care Administration, "Florida Statewide Medicaid Monthly Enrollment Report," December 2015, available at http://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Dec. 23, 2015).
[15] Letter from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services to Justin Senior, Deputy Secretary for Medicaid, Agency for Health Care Administration (June 11, 2015), *available at* http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/LTC_Waiver_Amend_Approval_Letter_2015-03-17.pdf (last visited Jan. 21, 2016).
[16] Florida Dep't of Elderly Affairs, *Comprehensive Assessment and Review for Long-Term Care Services (CARES),* http://elderaffairs.state.fl.us/doea/cares.php (last visited Jan. 21, 2016).

physicians, nurses, and other health care professionals who evaluate the level of care an individual may or may not need for waiver services. The frailty-based assessment results in a priority score for an individual, who is then placed on the wait list based on his or her priority score.

To receive nursing facility care, an individual must also be determined to meet the requirements of s. 409.985(3), F.S. This subsection requires:

> The CARES program shall determine if an individual requires nursing facility care and, if the individual requires such care, assign the individual to a level of care as described in s. 409.983(4), F.S. When determining the need for nursing facility care, consideration shall be given to the nature of the services prescribed and which level of nursing or other health care personnel meets the qualifications necessary to provide such services and the availability to and access by the individual of community or alternative resources. For the purposes of the long-term care managed care program, the term "nursing facility care" means the individual:
>
> (a) Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and care required to be performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care professional and requires services that are sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse because of a mental or physical incapacitation by the individual;
>
> (b) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires services on a daily or intermittent basis that are to be performed under the supervision of licensed nursing or other health professionals because the individual is incapacitated mentally or physically; or
>
> (c) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires limited services that are to be performed under the supervision of licensed nursing or other health professionals because the individual is mildly incapacitated mentally or physically.

Individuals are released from the wait list periodically, based on the availability of funding and their priority scores. Before being released, however, individuals must also meet the following eligibility requirements or participate in one of the following waivers, as applicable, to enroll in the program:

- Age 65 years or older and need nursing facility level of care;
- Age 18 years of age or older and are eligible for Medicaid by reason of a disability and need nursing facility level of care;
- Aged and Disabled Adult (A/DA) waiver;

- Consumer Directed Care Plus for individuals in the A/DA waiver;
- Assisted Living waiver;
- Nursing Home Diversion waiver;
- Frail Elder Option; or
- Channeling Services waiver.[17]

Individuals who are enrolled in the following programs may enroll in the LTCMC, but are not required to:

- Developmental Disabilities waiver program;
- Traumatic Brain and Spinal Injury waiver;
- Project AIDS Care waiver;
- Adult Cystic Fibrosis waiver;
- Program of All-Inclusive Care for the Elderly (PACE);
- Familial Dysautonomia waiver; or
- Model waiver.[18]

Individuals, both those who are enrolled in LTCMC and those on the wait list, must be re-screened at least annually or whenever there is a significant change in circumstances, such as change in caregivers or medical condition.[19]

Aging Resource Centers

The Aging Resource Centers (ARCs) provide information to elders and adults who request long-term care services and may make referrals to lead agencies for vulnerable adults in need of other services. Under contract with the DOEA, the ARCs coordinate all initial screenings to determine prioritization for long-term care services, provide choice counseling for nursing facility placements, assist with informal resolution of member grievances with LTCMC plans, and provide enrollment and coverage information to LTCMC enrollees.

The ARCs are also responsible for services funded through these programs:

- Community care for the elderly;
- Home care for the elderly;
- Contracted services;
- Alzheimer's disease initiative; and
- The federal Older American's Act.[20]

The ARCs serve as a "one-stop shop" for all elder services, as elders can receive a single financial determination for all services, including Medicaid, food stamps, and Supplemental

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[17] Agency for Health Care Administration, *A Snapshot of the Florida Medicaid Long-term Care Program,* http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot.pdf (last visited Jan. 21, 2016).

[18] *Id.*

[19] Application for §1915(c) Home and Community-Based Services Waiver (Effective July 1, 2013), pp. 45-46, http://www.fdhc.state.fl.us/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/LTC_1915c_Application.pdf (last visited Jan. 22, 2016).

[20] *See* s. 430.2053(9), F.S.

Security Income.[21] Minimum standards of operation and responsibilities for the ARCs are provided in s. 430.2053, F.S., and in administrative rules under ch. 58B-1, F.A.C.

Delivery System and Benefits

The AHCA conducted a competitive procurement to select LTCMC plans in each of the 11 regions. Contracts were awarded to health maintenance organizations (HMO) and provider service networks (PSN). Six non-specialty plans are currently contracted, including one PSN that is available in all 11 regions and one HMO that is in 10 regions.[22] Recipients receive choice counseling services to assist them in selecting the plan that will best meet their needs.

Each plan under LTCMC is required to provide a minimum level of services. These services include:
- Adult companion care;
- Adult day health care;
- Assisted living;
- Assistive care services;
- Attendant care;
- Behavioral management;
- Care coordination and case management;
- Caregiver training;
- Home accessibility training;
- Home-delivered meals;
- Homemaker;
- Hospice;
- Intermittent and skilled nursing;
- Medical equipment and supplies;
- Medication administration;
- Medicaid management;
- Nursing facility;
- Nutritional assessment/risk reduction;
- Personal care;
- Personal emergency response system;
- Respite care;
- Therapies; and
- Non-emergency transportation.[23]

A LTCMC plan may elect to offer expanded benefits to its enrollees. Some of the approved expanded benefits within LTCMC include:
- Cellular phone service;
- Dental services;
- Emergency financial assistance;

[21] *See* s. 430.2053(9), F.S.
[22] *Supra,* note 19.
[23] *See* s. 409.98, F.S.

- Hearing evaluation;
- Mobile personal emergency response system;
- Non-medical transportation;
- Over-the-counter medication and supplies;
- Support to transition out of a nursing facility;
- Vision services; and
- Wellness grocery discount.[24]

LTCMC enrollees who are not eligible for Medicare receive their medical services through an MMA plan. Some plans participate in both components in the same regions, and a recipient may choose the same managed care plan for both components, but is not required to.

Adult Protective Services

Under the Adult Protective Services program, the DOEA works in conjunction with the DCF and the Aging Network[25] to protect disabled adults or elderly persons from occurrences of abuse, neglect or exploitation. Services provided may include protective supervision and in-home and community-based services.

The DCF operates the Florida Abuse Hotline, to which calls alleging abuse, neglect, or exploitation of vulnerable adults can be made 24 hours a day. DCF's adult protective investigators visit each person who is the subject of a call to the hotline to determine the need for and provision of ongoing protective supervision or the provision of services. If the person is 60 years of age or older and needs home and community-based services, he or she is referred to the Aging Network.

III. Effect of Proposed Changes:

Section 1 adds four definitions to s. 409.963, F.S., relating to long-term care managed care (LTCMC):

- "Authorized representative" means an individual who has the legal authority to make decisions on behalf of a Medicaid recipient or potential Medicaid recipient in matters related to the managed care plan or the screening or eligibility process;
- "Rescreening" means the use of a screening tool to conduct annual screenings or screenings due to a significant change which determine an individual's placement and continuation on the wait list;
- "Screening" means the use of an information collection tool to determine a priority score for placement on the wait list;
- "Significant change" means change in an individual's health status after an accident or illness; an actual or anticipated change in the individual's living situation; a change in the

[24] Agency for Health Care Administration, MMA - Model Contract - Attachment I - Scope of Services (Effective date 11/1/15) p. 5, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Attachment_I-Scope_of_Services_2015-11-01.pdf (last visited Jan. 21, 2016).

[25] Each county's Aging Network consists of the DOEA, the Area Agency on Aging for the Planning and Service Area, and the DOEA's lead agency for the county. *See* the DOEA's "APS Contact List," available at http://elderaffairs.state.fl.us/doea/notices/Dec12/APS Contact List.xlsx (last visited Feb. 11, 2016).

caregiver relationship; loss of or damage to the individual's home, or deterioration of his or her home environment; or loss of the individual's spouse or caregiver.

Section 2 amends s. 409.979, F.S., to clarify the existing eligibility process for the home and community based services through LTCMC. The bill establishes that Medicaid recipients must meet prerequisite criteria for eligibility and be determined eligible by the Long-Term Care Services (CARES) program preadmission screening program at the Department of Elderly Affairs (DOEA) to require nursing facility care as defined in s. 409.985(3), F.S.

The bill clarifies that offers for enrollment in LTCMC will be made subject to the availability of funds and based on wait-list prioritization. Before making any enrollment offers, the Agency for Health Care Administration (AHCA) and the DOEA are required to determine that sufficient funds are available.

The DOEA is directed to maintain a statewide wait list for enrollment into the program for home and community based services through LTCMC. Individuals will be prioritized for enrollment through a frailty-based screening tool that results in a priority score. The priority score is used to determine the release order for individuals from the wait list for potential enrollment. If capacity is limited for individuals with the same priority score, the individual with the oldest date of placement on the wait list receives priority for release.

Aging Resource Center personnel certified by the DOEA are charged with performing the screening or rescreening for each individual requesting enrollment in the home and community based services through LTCMC. The bill requires the DOEA to request that the individual or the individual's authorized representative provide alternate names and their contact information.

To be placed on the wait list, an individual requesting long-term care services, or the individual's authorized representative, must participate in an initial screening or rescreening. A rescreening of the individual must occur annually or upon notification of a significant change in an individual's circumstances.

The DOEA must adopt the screening tool that generates the priority score by rule and make publicly available on its website the specific methodology used to calculate an individual's priority score. When an individual's screening has been completed, the DOEA must inform the individual or the individual's representative that the individual has been placed on the wait list.

If the DOEA is unable to contact the individual or the individual's representative to schedule an initial screening or rescreening, and documents the action steps to do so, a letter must be sent to the last documented address to advise the individual to contact the DOEA within the next 30 calendar days to schedule a screening or rescreening. Failure to conduct a screening or rescreening will result in the individual's termination from the screening process and the wait list.

The bill requires the CARES program to conduct a pre-release assessment of individuals after notification by the AHCA of available capacity in the long-term care managed care program. The DOEA must release individuals from the wait list based on the priority score process and the

prerelease assessment. An individual must be both financially and clinically eligible to enroll in LTCMC.

The bill authorizes the DOEA to terminate an individual on the wait list if the individual:
- Does not have a current priority score due to the individual's action or inaction;
- Requests to be removed from the wait list;
- Does not keep an appointment to complete the rescreening without scheduling another appointment and has not responded to three documented attempts by the DOEA to contact the individual;
- Receives an offer to begin the eligibility determination process for LTCMC; or
- Begins receiving services through LTCMC.

If an individual is removed from the wait list for one of these reasons, and subsequently requests to be placed on the wait list again, the individual is required to initiate a new request for placement on the wait list and any previous placement is disregarded.

The bill provides for priority enrollment for home and community based services through LTCMC for certain individuals. These individuals are not required to complete the screening or wait-list process described above if all other long term care eligibility requirements are met:
- Individuals who are 18, 19, or 20 years of age who have chronic, debilitating diseases or conditions of one or more physiological or organ systems which generally make the individual dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention;
- Nursing facility residents requesting transition into the community who have resided in a Florida-licensed skilled nursing facility for at least 60 consecutive days; and
- Individuals referred by the DOEA's Adult Protective Services program as high risk and placed in an assisted living facility temporarily funded by the DOEA.

The bill provides both the DOEA and the AHCA authority to adopt rules to implement the provisions of this act.

The bill deletes obsolete statutory language.

Section 3 provides that the bill's effective date is July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The Department of Elderly Affairs reports PCS/SB 7056 has no fiscal impact.[26]

The Agency for Health Care Administration reports the bill has no fiscal impact.[27]

VI. Technical Deficiencies:

The bill requires that Aging Resource Center personnel certified by the Department of Elderly Affairs (DOEA) perform the screening for each individual requesting enrollment in long-term care managed care but requires the DOEA to request that the individual or the individual's authorized representative provide "alternate names and their contact information." If this request for alternate names and their contact information is to occur during the screening process, the bill should require Aging Resource Center personnel to make the request.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.962 and 409.979.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

Recommended CS/CS by Appropriations Subcommittee on Health and Human Services on February 11, 2016:
The proposed CS:

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[26] Email from Jo Morris, Legislative Affairs Director, Department of Elderly Affairs (Jan., 22, 2016) (on file with the Senate Committee on Health Policy).
[27] Conversation with Joshua Spagnola, Legislative Affairs Director, Agency for Health Care Administration (Jan. 22, 2016).

- Requires the DOEA to request that individuals seeking enrollment for LTCMC provide alternate names and their contact information;
- Provides that if the DOEA is unable to contact an individual or the individual's authorized representative to schedule an initial screening or rescreening, *and documents the action steps to do so,* the DOEA must send a letter to the last documented address of the individual or the individual's authorized representative, advising that the individual must contact the DOEA within certain parameters to avoid being terminated from the screening process and the wait list, as opposed to the underlying bill which did not include documentation of the DOEA's action steps to contact the individual as a condition for sending the letter;
- Provides that the DOEA *may* terminate an individual from the wait list under certain conditions, as opposed to the requirement in CS/SB 7056 for the DOEA to do so; and
- Provides that individuals referred by the DOEA's Adult Protective Services program as high risk and placed in an assisted living facility temporarily funded by the DOEA, are afforded priority enrollment for LTCMC and do not have to complete the screening or wait-list process if all other eligibility requirements are met.

CS by Health Policy on January 26, 2016:
The Committee Substitute names the Aging Resource Center personnel as the entity to conduct the screenings and rescreenings consistent with their current statutory duties in s. 430.2053, F.S. The CS also reinstates current law with respect to receiving long-term care services through the long-term care managed care (LTCMC) program.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/15/2016	.	
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	.	
	.	

Appropriations Subcommittee on Health and Human Services (Bean) recommended the following:

1 **Senate Amendment (with title amendment)**

2

3 Delete lines 106 - 175

4 and insert:

5 1. Pursuant to s. 430.2053, Aging Resource Center personnel
6 certified by the Department of Elderly Affairs shall perform the
7 screening for each individual requesting enrollment for home and
8 community-based services through the long-term care managed care
9 program. The Department of Elderly Affairs shall request that
10 the individual or the individual's authorized representative

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11 provide alternate names and their contact information.
12 2. The individual requesting the long-term care services,
13 or the individual's authorized representative, must participate
14 in an initial screening or rescreening for placement on the wait
15 list. The screening or rescreening must be completed in its
16 entirety before placement on the wait list.
17 3. Pursuant to s. 430.2053, Aging Resource Center personnel
18 shall administer rescreening annually or upon notification of a
19 significant change in an individual's circumstances.
20 4. The Department of Elderly Affairs shall adopt by rule a
21 screening tool that generates the priority score, and shall make
22 publicly available on its website the specific methodology used
23 to calculate an individual's priority score.
24 (b) Upon completion of the screening or rescreening
25 process, the Department of Elderly Affairs shall notify the
26 individual or the individual's authorized representative that
27 the individual has been placed on the wait list.
28 (c) If the Department of Elderly Affairs is unable to
29 contact the individual or the individual's authorized
30 representative to schedule an initial screening or rescreening,
31 and documents the action steps to do so, it shall send a letter
32 to the last documented address of the individual or the
33 individual's authorized representative. The letter must advise
34 the individual or his or her authorized representative that he
35 or she must contact the Department of Elderly Affairs within 30
36 calendar days after the date of the notice to schedule a
37 screening or rescreening and must notify the individual that
38 failure to complete the screening or rescreening will result in
39 his or her termination from the screening process and the wait

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40 list.
41 (d) After notification by the agency of available capacity,
42 the CARES program shall conduct a prerelease assessment. The
43 Department of Elderly Affairs shall release individuals from the
44 wait list based on the priority scoring process and prerelease
45 assessment results. Upon release, individuals who meet all
46 eligibility criteria may enroll in the long-term care managed
47 care program.
48 (e) The Department of Elderly Affairs may terminate an
49 individual's inclusion on the wait list if the individual:
50 1. Does not have a current priority score due to the
51 individual's action or inaction;
52 2. Requests to be removed from the wait list;
53 3. Does not keep an appointment to complete the rescreening
54 without scheduling another appointment and has not responded to
55 three documented attempts to contact by the Department of
56 Elderly Affairs;
57 4. Receives an offer to begin the eligibility determination
58 process for the long-term care managed care program; or
59 5. Begins receiving services through the long-term care
60 managed care program.
61
62 An individual whose inclusion on the wait list is terminated
63 must initiate a new request for placement on the wait list, and
64 any previous priority considerations must be disregarded.
65 (f) Notwithstanding this subsection, the following
66 individuals are afforded priority enrollment for home and
67 community-based services through the long-term care managed care
68 program and do not have to complete the screening or wait-list

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69 process if all other long-term care managed care program
70 eligibility requirements are met:
71 1. Individuals who are 18, 19, or 20 years of age who have
72 chronic debilitating diseases or conditions of one or more
73 physiological or organ systems which generally make the
74 individual dependent upon 24-hour-per-day medical, nursing, or
75 health supervision or intervention.
76 2. Nursing facility residents requesting to transition into
77 the community who have resided in a Florida-licensed skilled
78 nursing facility for at least 60 consecutive days.
79 3. Individuals referred by the department's adult
80 protective services program as high risk and placed in an
81 assisted living facility temporarily funded by the department.
82
83
84 ================= T I T L E A M E N D M E N T ================
85 And the title is amended as follows:
86 Delete line 23
87 and insert:
88 care program; authorizing the department to terminate
89 an

By the Committee on Health Policy

588-02608-16 20167056__

A bill to be entitled

An act relating to long-term care managed care prioritization; amending s. 409.962, F.S.; defining terms; amending s. 409.979, F.S.; requiring the Department of Elderly Affairs to maintain a statewide wait list for enrollment for home and community-based services through the Medicaid long-term care managed care program; requiring the department to prioritize individuals for potential enrollment using a frailty-based screening tool that provides a priority score; providing for determinations regarding offers of enrollment; requiring screening and certain rescreening by Aging Resource Center personnel of individuals requesting long-term care services from the program; requiring the department to adopt by rule a screening tool; requiring the department to make a specified methodology available on its website; requiring the department to notify applicants if they are placed on the wait list; requiring the department to conduct prerelease assessments upon notification by the agency of available capacity; authorizing certain individuals to enroll in the long-term care managed care program; requiring the department to terminate an individual from the wait list under certain circumstances; providing for priority enrollment for home and community-based services; authorizing the department and the Agency for Health Care Administration to adopt rules; deleting obsolete language; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Present subsections (4) through (13) of section 409.962, Florida Statutes, are redesignated as subsections (5) through and (14), respectively, present subsection (14) of that section is redesignated as subsection (18), and new subsection (4) and subsections (15), (16), and (17) are added to that section, to read:

409.962 Definitions.—As used in this part, except as otherwise specifically provided, the term:

(4) "Authorized representative" means an individual who has the legal authority to make decisions on behalf of a Medicaid recipient or potential Medicaid recipient in matters related to the managed care plan or the screening or eligibility process.

(15) "Rescreening" means the use of a screening tool to conduct annual screenings or screenings due to a significant change which determine an individual's placement and continuation on the wait list.

(16) "Screening" means the use of an information-collection tool to determine a priority score for placement on the wait list.

(17) "Significant change" means change in an individual's health status after an accident or illness; an actual or anticipated change in the individual's living situation; a change in the caregiver relationship; loss of or damage to the individual's home or deterioration of his or her home environment; or loss of the individual's spouse or caregiver.

Section 2. Section 409.979, Florida Statutes, is amended to read:

409.979 Eligibility.—

(1) PREREQUISITE CRITERIA FOR ELIGIBILITY.—Medicaid

recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) preadmission screening program to require nursing facility care as defined in s. 409.985(3).

(2) ENROLLMENT OFFERS.—~~Medicaid recipients who, on the date long-term care managed care plans become available in their region, reside in a nursing home facility or are enrolled in one of the following long-term care Medicaid waiver programs are eligible to participate in the long-term care managed care program for up to 12 months without being reevaluated for their need for nursing facility care as defined in s. 409.985(3):~~

~~(a) The Assisted Living for the Frail Elderly Waiver.~~

~~(b) The Aged and Disabled Adult Waiver.~~

~~(c) The Consumer-Directed Care Plus Program as described in s. 409.221.~~

~~(d) The Program of All-inclusive Care for the Elderly.~~

~~(e) The Channeling Services Waiver for Frail Elders.~~

~~(3)~~ Subject to availability of funds, the Department of Elderly Affairs shall make offers for enrollment to eligible individuals based on a wait-list prioritization ~~and subject to availability of funds~~. Before making enrollment offers, the agency and the Department of Elderly Affairs ~~department~~ shall determine that sufficient funds exist to support additional

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enrollment into plans.

(3) WAIT LIST, RELEASE, AND OFFER PROCESS.—The Department of Elderly Affairs shall maintain a statewide wait list for enrollment for home and community-based services through the long-term care managed care program.

(a) The Department of Elderly Affairs shall prioritize individuals for potential enrollment for home and community-based services through the long-term care managed care program using a frailty-based screening tool that results in a priority score. The priority score is used to set an order for releasing individuals from the wait list for potential enrollment in the long-term care managed care program. If capacity is limited for individuals with identical priority scores, the individual with the oldest date of placement on the wait list shall receive priority for release.

1. Pursuant to s. 430.2053, Aging Resource Center personnel certified by the Department of Elderly Affairs shall perform the screening for each individual requesting enrollment for home and community-based services through the long-term care managed care program.

2. The individual requesting the long-term care services, or the individual’s authorized representative, must participate in an initial screening or rescreening for placement on the wait list. The screening or rescreening must be completed in its entirety before placement on the wait list.

3. Pursuant to s. 430.2053, Aging Resource Center personnel shall administer rescreening annually or upon notification of a significant change in an individual’s circumstances.

4. The Department of Elderly Affairs shall adopt by rule a

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120 screening tool that generates the priority score, and shall make
121 publicly available on its website the specific methodology used
122 to calculate an individual's priority score.
123 (b) Upon completion of the screening or rescreening
124 process, the Department of Elderly Affairs shall notify the
125 individual or the individual's authorized representative that
126 the individual has been placed on the wait list.
127 (c) If the Department of Elderly Affairs is unable to
128 contact the individual or the individual's authorized
129 representative to schedule an initial screening or rescreening,
130 it shall send a letter to the last documented address of the
131 individual or the individual's authorized representative. The
132 letter must advise the individual or his or her authorized
133 representative that he or she must contact the Department of
134 Elderly Affairs within 30 calendar days after the date of the
135 notice to schedule a screening or rescreening and must notify
136 the individual that failure to complete the screening or
137 rescreening will result in his or her termination from the
138 screening process and the wait list.
139 (d) After notification by the agency of available capacity,
140 the CARES program shall conduct a prerelease assessment. The
141 Department of Elderly Affairs shall release individuals from the
142 wait list based on the priority scoring process and prerelease
143 assessment results. Upon release, individuals who also are
144 determined by the department to be financially eligible and by
145 the Department of Elderly Affairs to be clinically eligible may
146 enroll in the long-term care managed care program.
147 (e) The Department of Elderly Affairs shall terminate an
148 individual's inclusion on the wait list if the individual:

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

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149 1. Does not have a current priority score due to the
150 individual's action or inaction;
151 2. Requests to be removed from the wait list;
152 3. Does not keep an appointment to complete the rescreening
153 without scheduling another appointment;
154 4. Receives an offer to begin the eligibility determination
155 process for the long-term care managed care program; or
156 5. Begins receiving services through the long-term care
157 managed care program.
158
159 An individual whose inclusion on the wait list is terminated
160 must initiate a new request for placement on the wait list, and
161 any previous priority considerations must be disregarded.
162 (f) Notwithstanding this subsection, the following
163 individuals are afforded priority enrollment for home and
164 community-based services through the long-term care managed care
165 program and do not have to complete the screening or wait-list
166 process if all other long-term care managed care program
167 eligibility requirements are met:
168 1. Individuals who are 18, 19, or 20 years of age who have
169 chronic debilitating diseases or conditions of one or more
170 physiological or organ systems which generally make the
171 individual dependent upon 24-hour-per-day medical, nursing, or
172 health supervision or intervention.
173 2. Nursing facility residents requesting to transition into
174 the community who have resided in a Florida-licensed skilled
175 nursing facility for at least 60 consecutive days.
176 (g) The Department of Elderly Affairs and the agency may
177 adopt rules to implement this subsection.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

178 Section 3. This act shall take effect July 1, 2016.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

CourtSmart Tag Report

Room: SB 401 **Case:** **Type:**
Caption: Senate Appropriations Subcommittee on Health and Human Services **Judge:**

Started: 2/11/2016 10:03:15 AM
Ends: 2/11/2016 10:51:07 AM Length: 00:47:53

10:03:14 AM Called to order
10:03:34 AM Quorum present
10:03:40 AM Chair Garcia opening remarks
10:03:59 AM TAB 3: SB 1144 (Gaetz)
10:04:22 AM TP bill motion adopted
10:04:27 AM TAB 4: CS/SB 212 (Gaetz)
10:04:34 AM Senator Gaetz
10:05:43 AM Public Testimony
10:05:49 AM Skylar Zander, Deputy State Director, Americans for Prosperity, waives in support
10:05:57 AM Jack McRay, AARP, waives in support
10:05:59 AM Michael Mcdewell, Administrator, Panama City Surgery Center, waives in support
10:06:02 AM Chad Furgason, Group Administrator, FSASC: Surgical Care Affiliates, waives in support
10:06:12 AM Bill Bell, General Counsel, Florida Hospital Association, speaks against.
10:07:33 AM Senator Grimsley Comments
10:08:06 AM CS/SB 212 Favorable
10:08:30 AM TAB 1: SB 1116 (Joyner) not in room yet
10:08:46 AM TAB 5: CS/SB 818 (Latvala) (Presented by Lizbeth Mabry, Legislative Aide)
10:09:27 AM Public Testimony
10:09:33 AM Barbara DeVane, Ms, Florida NOW, waives in support
10:09:49 AM CS/SB 818 Favorable
10:10:17 AM TAB 6: SB 1336 (Latvala) (Presented by Representative Kathleen Peters-House Sponsor)
10:12:29 AM Public Testimony
10:12:33 AM Jill Gran, Policy Director, Florida Alcohol & Drug Abuse Association, waives in support
10:12:37 AM Thad Lowrey, VP Governmental Relation, Operation PAR, waives in support
10:12:42 AM Susan Harbin, Legislative Advocate, Florida Association of Counties, waives in support
10:12:50 AM Chris Floyd, Consultant, Florida Association of Nurse Practitioners, waives in support
10:12:55 AM Georgia McKeoun, President of GA McKeoun & Associates, Phoenix House, waives in support
10:13:03 AM Brian Pitts, Trustee, Justice-2-Jesus
10:15:11 AM Senator Garcia Comments
10:15:32 AM Kathleen Peter close on bill
10:15:50 AM SB 1336 Favorable
10:16:17 AM TAB 9: CS/SB 1686 (Bean)
10:18:17 AM Public Testimony
10:18:22 AM Christian Caballero, President, Telehealth Association of Florida, waives in support
10:18:33 AM Jack McRay, AARP, waives in support
10:18:41 AM Joshua Gabel, Outreach Coordinator, Florida Tax Watch, waives in support
10:18:46 AM Paul Lambert, Florida Chiropractic Association, waives in support
10:19:15 AM Senator Garcia Comments
10:19:28 AM Senator Bean Close
10:20:15 AM CS/SB 1686 Favorable
10:20:44 AM TAB 10: SB 7056 (Bean, Health Policy)
10:21:44 AM 395530
10:22:08 AM Public Testimony
10:22:15 AM Robert Beck, Florida Aging Resource Centers, waives in support
10:22:16 AM Back on the bill as amended
10:22:27 AM Brian Pitts, Trustee, Justice-2-Jesus
10:22:37 AM SB 7056 Favorable
10:23:12 AM TAB 7: SB 998 (Ring) (Presented by Joel Ramos, Legislative Assistant)
10:24:01 AM Public Testimony
10:24:05 AM Brian Pitts, Trustee, Justice-2-Jesus
10:26:54 AM CS/SB 998 Favorable
10:27:35 AM TAB 2: CS/SB 1170 (Detert) (Presented by Charlie Anderson, Legislative Assistant)

10:28:18 AM Amendment for this
10:28:27 AM 1800490
10:28:54 AM Adopted
10:29:00 AM Public Testimony
10:29:10 AM Wences Troncoso, General Counsel, Florida Association of Health Plans, waives in support
10:29:23 AM Brian Pitts, Trustee, Justice-2-Jesus, waives in support
10:29:32 AM Rich Robleto, Deputy Commissioner, Office of Insurance Regulation, waives in support
10:29:46 AM CS/SB 1170 Favorable
10:30:13 AM TAB 1: SB 1116 (Joyner)
10:31:34 AM 611498
10:32:05 AM Adopted
10:32:08 AM Back on the bill as amended
10:32:14 AM Public Testimony
10:32:19 AM Ingrid Delgado, Associate for Social Concerns & Respect Life, Florida Conference of Catholic Bishops, waives against
10:32:27 AM Courtney Gager, Legislative Assistant, Florida Family Action, Legislative Arm of the Florida Family Policy Council, waives against
10:32:39 AM Stephanie Kunkel, Florida Federation of Business & Professional Women, waives in support
10:32:47 AM Barbara DeVane, Ms, Florida NOW, waives in support
10:33:05 AM Brian Pitts, Trustee, Justice-2-Jesus
10:35:35 AM Senator Grimsley Comments
10:36:06 AM Senator Garcia Comments
10:36:31 AM Senator Joyner close on bill
10:38:09 AM SB 1116 Favorable
10:38:44 AM TAB 8: CS/SB 204 (Clemens)
10:39:20 AM Public Testimony
10:39:24 AM Lori Gooding, Assistant Professor of Music Therapy at Florida State University, American Music Therapy Association, FL Music Therapy Task Force & Certification Board for Music Therapists, waives in support
10:39:34 AM Candace McKibben, Director of Faith Outreach Big Bend Hospice & Director of Clinical Services, Big Bend Hospice, FL Hospice & Palliative Care Association, waives in support
10:39:40 AM Maureen Pellito (Michelle)
10:39:45 AM Michelle Pellito, Board Certified Music Therapist, Florida Music Therapy Task Force, speaks in support
10:40:25 AM Caleb Trotter, Attorney, Pacific Legal Foundation, waives against
10:40:31 AM Ron Watson, Lobbyist, Certification Board for Music Therapy, waives in support
10:40:35 AM Brian Pitts, Trustee, Justice-2-Jesus
10:43:06 AM CS/SB 204 Favorable
10:43:31 AM TAB 10: SB 7054 (Sobel)
10:45:53 AM 220012
10:46:07 AM Adopted
10:46:18 AM Back on the bill as amended
10:46:35 AM Senator Sobel Continues Explanation
10:47:31 AM Public Testimony
10:47:36 AM Suzanne Sewel, President/CEO, Florida Association of Rehabilitation Facilities, waives in support
10:47:38 AM Robert Brown, Legislative Affairs Director, Agency for Persons with Disabilities, waives in support
10:47:44 AM Margaret Hooper, Public Policy Coordinator, Florida Developmental Disabilities Council, waives in support
10:48:06 AM SB 7054 Favorable
10:48:52 AM Senator Benacquisto motion to show voting affirmative on CS/SB 818, SB 1336, CS/SB 1686, CS/SB 998, CS/SB 1170, SB 1116
10:49:58 AM Chair Garcia without objection show the motion adopted
10:50:04 AM Senator Bean motion to show voting affirmative on SB 1116, CS/SB 2014
10:50:06 AM Chair Garcia without objection show the motion adopted
10:50:17 AM Senator Abruzzo motion to show voting affirmative on CS/SB 212, CS/SB 818, SB 1336, CS/SB 1686, SB 7056, CS/SB 998, CS/SB 1170, SB 1116, CS/SB 204
10:50:39 AM Chair Garcia without objection show the motion adopted
10:50:40 AM Senator Smith motion to show voting affirmative on CS/SB 212, SB 1336, CS/SB 1686, SB 7056, CS/SB 998, CS/SB 1170
10:50:48 AM Chair Garcia without objection show the motion adopted
10:50:53 AM Meeting Adjourned