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<tr>
<td>Tab 1</td>
<td>SB 1116</td>
<td>Joyner (CO-INTRODUCERS) Grimsley</td>
<td>Long-acting Reversible Contraception Pilot Program</td>
<td>L.91 - 98</td>
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<td>L.275 - 779</td>
<td>02/15 03:01 PM</td>
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<td>Certificates of Need for Health Care-related Projects</td>
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<td>HP, Gaetz</td>
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<td>CS/SB 818</td>
<td>HP, Latvala (CO-INTRODUCERS) Sobel, Abruzzo, Soto</td>
<td>Instruction on Human Trafficking</td>
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<td>SB 1336</td>
<td>Latvala</td>
<td>Behavioral Health Care Services</td>
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<td>Tab 7</td>
<td>CS/SB 998</td>
<td>HP, Ring</td>
<td>Adolescent and Child Treatment Programs</td>
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<td>Tab 8</td>
<td>CS/SB 204</td>
<td>HP, Clemens</td>
<td>Music Therapists</td>
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<td>Tab 9</td>
<td>CS/SB 1686</td>
<td>HP, Bean, Joyner</td>
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<td>Tab 10</td>
<td>SB 7054</td>
<td>CF</td>
<td>Agency for Persons with Disabilities</td>
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<td>Tab 11</td>
<td>SB 7056</td>
<td>HP</td>
<td>Long-term Care Managed Care Prioritization</td>
<td>L.106 - 175</td>
<td>02/15 03:01 PM</td>
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## 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

<table>
<thead>
<tr>
<th>TAB</th>
<th>BILL NO. and INTRODUCER</th>
<th>BILL DESCRIPTION and SENATE COMMITTEE ACTIONS</th>
<th>COMMITTEE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SB 1116 Joyner</td>
<td>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.</td>
<td>Fav/CS Yeas 8 Nays 0</td>
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<td>(Identical H 947)</td>
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<td>HP 01/26/2016 Favorable</td>
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<td>AHS 02/11/2016 Fav/CS</td>
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<tr>
<td>2</td>
<td>CS/SB 1170 Banking and Insurance / Detert</td>
<td>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.</td>
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<td>(Compare CS/H 951)</td>
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<td>3</td>
<td>SB 1144 Gaetz</td>
<td>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.</td>
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<td>BILL DESCRIPTION and SENATE COMMITTEE ACTIONS</td>
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<td>4</td>
<td>CS/SB 212 Health Policy / Gaetz (Compare H 85)</td>
<td>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.</td>
<td>Favorable Yeas 7 Nays 1</td>
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<td>HP 01/19/2016 Fav/CS</td>
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<td>AHS 02/11/2016 Favorable</td>
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<tr>
<td>5</td>
<td>CS/SB 818 Health Policy / Latvala (Compare H 469)</td>
<td>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.</td>
<td>Favorable Yeas 8 Nays 0</td>
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<td>HP 01/26/2016 Fav/CS</td>
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<td>FP</td>
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<tr>
<td>6</td>
<td>SB 1336 Latvala (Compare CS/H 979, CS/H 7097, S 12)</td>
<td>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 &quot;Jennifer Act&quot;; 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.</td>
<td>Favorable Yeas 8 Nays 0</td>
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<td>AP</td>
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<tr>
<td>7</td>
<td>CS/SB 998 Health Policy / Ring</td>
<td>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.</td>
<td>Favorable Yeas 8 Nays 0</td>
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<td>8</td>
<td>CS/SB 204 Health Policy / Clemens (Identical CS/H 571)</td>
<td>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.</td>
<td>Favorable Yeas 8 Nays 0</td>
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<td>CS/SB 1686 Health Policy / Bean / Joyner (Similar H 1353, Compare CS/H 7087)</td>
<td>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.</td>
<td>Favorable Yeas 8 Nays 0</td>
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<td>10</td>
<td>SB 7054 Children, Families, and Elder Affairs (Compare CS/CS/CS/H 919, H 1083, H 4037, CS/H 7003, CS/S 7010)</td>
<td>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.</td>
<td>Fav/CS Yeas 8 Nays 0</td>
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<td>11</td>
<td>SB 7056 Health Policy (Compare H 1335)</td>
<td>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.</td>
<td>Fav/CS Yeas 8 Nays 0</td>
</tr>
</tbody>
</table>

Other Related Meeting Documents
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
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.

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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

2 Id.
4 Id.
5 Id.
8 Id.
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

<table>
<thead>
<tr>
<th>Numbers of Clinic Sites, including Contracted Sites</th>
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<tbody>
<tr>
<td>Hillsborough CHD</td>
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<tr>
<td>Palm Beach CHD</td>
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<tr>
<td>Pinellas CHD</td>
</tr>
</tbody>
</table>

11 Supra, Note 6 at 2.
12 Supra, Note 6 at 1.
In State Fiscal Year 2014-15, the CHDs provided services to 10,806 clients who were using a LARC method.\textsuperscript{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.\textsuperscript{18} The table below illustrates the total number of services in the proposed pilot counties and statewide.

<table>
<thead>
<tr>
<th>County</th>
<th>Age &lt;15-19</th>
<th>Age 20-45+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of Clients with LARCs</td>
<td># of Clients</td>
<td>%</td>
</tr>
<tr>
<td>Hillsborough</td>
<td>52</td>
<td>493</td>
<td>10.55%</td>
</tr>
<tr>
<td>Palm Beach</td>
<td>38</td>
<td>1,529</td>
<td>2.49%</td>
</tr>
<tr>
<td>Pinellas</td>
<td>15</td>
<td>1,714</td>
<td>0.88%</td>
</tr>
<tr>
<td>Statewide</td>
<td>963</td>
<td>24,027</td>
<td>4.01%</td>
</tr>
</tbody>
</table>

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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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;

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\textsuperscript{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.

\textsuperscript{18} Id.

\textsuperscript{19} Id.

\textsuperscript{20} Id.

\textsuperscript{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).

\textsuperscript{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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\(^{26}\) *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.\textsuperscript{27}

\section*{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.

\textsuperscript{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

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

**Senate Amendment (with title amendment)**

Delete lines 91 - 98 and insert:

Section 2. The Department of Health shall implement a long-acting reversible contraception (LARC) pilot program pursuant to this act if specific funding is provided in the General Appropriations Act.

---------------------- TITLE AMENDMENT ----------------------
And the title is amended as follows:

Delete lines 16 - 17

and insert:

such report; directing the department to implement the LARC pilot program if specific funding is provided in the General Appropriations Act; providing legislative findings;
A bill to be entitled
An act relating to a long-acting reversible contraception pilot program; creating s. 381.00515, F.S.; 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 that such contracts include specified provisions; requiring the department to apply for grants for additional funding; requiring the department to submit a report to the Governor and the Legislature; requiring the department to publish the report on its website; specifying requirements for such report; providing an appropriation subject to certain requirements; providing legislative findings; providing an effective date.

WHEREAS, the Legislature finds that unintended pregnancies, especially among young women, carry health risks for mother and baby, and

WHEREAS, the Legislature further finds that programs that provide long-acting reversible contraceptive (LARC) methods, along with other contraceptive methods, contribute to declines in the number of unintended pregnancies and abortions, NOW, THEREFORE,

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

Section 1. Section 381.00515, Florida Statutes, is created to read:
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 department shall publish the report on its website. The report must include, but is not limited to:

(a) An assessment of the operation of the pilot program, including any progress made in reducing the number of unintended pregnancies and subsequent births, especially among teenagers.

(b) An assessment of the effectiveness of the pilot program in increasing the availability of LARC services.

(c) The number and location of family planning providers that participated in the pilot program.

(d) The number of clients served by participating family planning providers.

(e) The number of times LARC services were provided by participating family planning providers.

(f) The average cost per client served.

(g) The demographic characteristics of clients served.

(h) The sources and amounts of funding used for the pilot program.

(i) A description of federal grants the department applied for in order to provide LARC services, including the outcomes of the grant applications.

(j) An analysis of the return on investment for the provision of LARC services with regard to tax dollars saved on health and social services.

(k) A description and analysis of marketing and outreach activities conducted to promote the availability of LARC services.

(l) Recommendations for improving the pilot program.

Section 2. For the 2016-2017 fiscal year, the sum of $75,000 in nonrecurring funds is appropriated from the General Revenue Fund to the Department of Health for the purpose of implementing this act. The department shall distribute the funds equally among the three counties participating in the pilot program. These funds do not supplant or reduce any other appropriation of state funds to family planning providers or to the department for family planning services.

Section 3. The Legislature finds that this act is necessary to protect the public health, safety, and welfare.

Section 4. This act shall take effect July 1, 2016.
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
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. 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 (OIR) that the projected minimum loss ratio for small group and individual policies is 65 percent, 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) 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, 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

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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.
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.\textsuperscript{11}

**Florida Kidcare Program**

The Florida Kidcare Program\textsuperscript{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.\textsuperscript{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.,

\textsuperscript{11} 45 C.F.R. 148.124.
\textsuperscript{12} See \url{http://floridakidcare.org/#eligible} (last visited Jan. 23, 2016).
\textsuperscript{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


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.

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This Senate Bill Analysis does not reflect the intent or official position of the bill’s introducer or the Florida Senate.
Appropriations Subcommittee on Health and Human Services (Richter) recommended the following:

**Senate Amendment (with title amendment)**

1. Delete lines 275 - 779
2. and insert:
3. policies.—Sections 627.6561, 627.65615, 627.65625, and 627.6571 do not apply to:
4. (1) any group insurance policy in relation to its provision of excepted benefits described in s. 627.6513(1)-(14) 627.6561(5)(b).
5. (2) Any group health insurance policy in relation to its
provision of excepted benefits described in s. 627.6561(5)(c), if the benefits:
   (a) Are provided under a separate policy, certificate, or contract of insurance; or
   (b) Are otherwise not an integral part of the policy.
(3) Any group health insurance policy in relation to its provision of excepted benefits described in s. 627.6561(5)(d), if all of the following conditions are met:
   (a) The benefits are provided under a separate policy, certificate, or contract of insurance;
   (b) There is no coordination between the provision of such benefits and any exclusion of benefits under any group policy maintained by the same policyholder; and
   (c) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health policy maintained by the same policyholder.
(4) Any group health policy in relation to its provision of excepted benefits described in s. 627.6561(5)(e), if the benefits are provided under a separate policy, certificate, or contract of insurance.

Section 13. Section 627.6513, Florida Statutes, is amended to read:

627.6513 Scope.—Section 641.312 and the provisions of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, relating to internal grievances, apply to all group health insurance policies issued under this part. This section does not apply to a group health insurance policy that is subject to the Subscriber Assistance Program in
s. 408.7056 or to: the types of benefits or coverages provided under s. 627.6561(5)(b)-(e) issued in any market.

(1) Coverage only for accident insurance, or disability income insurance, or any combination thereof.

(2) Coverage issued as a supplement to liability insurance.

(3) Liability insurance, including general liability insurance and automobile liability insurance.

(4) Workers’ compensation or similar insurance.

(5) Automobile medical payment insurance.

(6) Credit-only insurance.

(7) Coverage for onsite medical clinics, including prepaid health clinics under part II of chapter 641.

(8) Other similar insurance coverage, specified in rules adopted by the commission, under which benefits for medical care are secondary or incidental to other insurance benefits. To the extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(9) Limited scope dental or vision benefits, if offered separately.

(10) Benefits for long-term care, nursing home care, home health care, or community-based care, or any combination thereof, if offered separately.

(11) Other similar, limited benefits, if offered separately, as specified in rules adopted by the commission.

(12) Coverage only for a specified disease or illness, if offered as independent, noncoordinated benefits.

(13) Hospital indemnity or other fixed indemnity insurance, if offered as independent, noncoordinated benefits.
(14) Benefits provided through a Medicare supplemental health insurance policy, as defined under s. 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. chapter 55, and similar supplemental coverage provided to coverage under a group health plan, which are offered as a separate insurance policy and as independent, noncoordinated benefits.

Section 14. Section 627.6561, Florida Statutes, is amended to read:

627.6561 Preexisting conditions.—
(1) As used in this section, the term:
(a) "Enrollment date" means, with respect to an individual covered under a group health policy, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period of such enrollment.
(b) "Late enrollee" means, with respect to coverage under a group health policy, a participant or beneficiary who enrolls under the policy other than during:
1. The first period in which the individual is eligible to enroll under the policy.
2. A special enrollment period, as provided under s. 627.65615.
(c) "Waiting period" means, with respect to a group health policy and an individual who is a potential participant or beneficiary of the policy, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the policy.
(2) Subject to the exceptions specified in subsection (4), an insurer that offers group health insurance coverage may, with
respects to a participant or beneficiary, impose a preexisting condition exclusion only if:

(a) Such exclusion relates to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

(b) Such exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date; and

(c) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, as defined in s. 627.6562(3) subsection (5), applicable to the participant or beneficiary as of the enrollment date.

(3) Genetic information may not be treated as a condition described in paragraph (2)(a) in the absence of a diagnosis of the condition related to such information.

(4)(a) Subject to paragraph (b), an insurer that offers group health insurance coverage may not impose any preexisting condition exclusion in the case of:

1. An individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

2. A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This provision does not apply to coverage before the date of such
adoption or placement for adoption.


(b) Subparagraphs 1. and 2. do not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(5)(a) The term, “creditable coverage,” means, with respect to an individual, coverage of the individual under any of the following:

1. A group health plan, as defined in s. 2791 of the Public Health Service Act.

2. Health insurance coverage consisting of medical care, provided directly, through insurance or reimbursement, or otherwise and including terms and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance contract offered by a health insurance issuer.

3. Part A or part B of Title XVIII of the Social Security Act.

4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under s. 1928.

5. Chapter 55 of Title 10, United States Code.

6. A medical care program of the Indian Health Service or of a tribal organization.

7. The Florida Comprehensive Health Association or another state health benefit risk pool.

8. A health plan offered under chapter 89 of Title 5, United States Code.

9. A public health plan as defined by rules adopted by the
commission. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

10. A health benefit plan under s. 5(e) of the Peace Corps Act (22 U.S.C. s. 2504(e)).

(b) Creditable coverage does not include coverage that consists solely of one or more or any combination thereof of the following excepted benefits:

1. Coverage only for accident, or disability income insurance, or any combination thereof.
2. Coverage issued as a supplement to liability insurance.
3. Liability insurance, including general liability insurance and automobile liability insurance.
4. Workers’ compensation or similar insurance.
5. Automobile medical payment insurance.
6. Credit-only insurance.
7. Coverage for onsite medical clinics, including prepaid health clinics under part II of chapter 641.
8. Other similar insurance coverage, specified in rules adopted by the commission, under which benefits for medical care are secondary or incidental to other insurance benefits. To the extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(c) The following benefits are not subject to the creditable coverage requirements, if offered separately:

1. Limited scope dental or vision benefits.
2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
3. Such other similar, limited benefits as are specified in rules adopted by the commission.

(d) The following benefits are not subject to creditable coverage requirements if offered as independent, noncoordinated benefits:

1. Coverage only for a specified disease or illness.
2. Hospital indemnity or other fixed indemnity insurance.

(e) Benefits provided through a Medicare supplemental health insurance, as defined under s. 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan are not considered creditable coverage if offered as a separate insurance policy.

(6)(a) A period of creditable coverage may not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(b) Any period during which an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage may not be taken into account in determining the 63-day period under paragraph (a) or paragraph (4)(b).

(7)(a) Except as otherwise provided under paragraph (b), an insurer shall count a period of creditable coverage without regard to the specific benefits covered under the period.

(b) An insurer may elect to count, as creditable coverage, coverage of benefits within each of several classes or
categories of benefits specified in rules adopted by the commission rather than as provided under paragraph (a). To the extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services. Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election, an insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(c) In the case of an election with respect to an insurer under paragraph (b), the insurer shall:

1. Prominently state in 10-point type or larger in any disclosure statements concerning the policy, and state to each certificateholder at the time of enrollment under the policy, that the insurer has made such election; and

2. Include in such statements a description of the effect of this election.

(e)(a) Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in this subsection or in such other manner as is specified in rules adopted by the commission. To the extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(b) An insurer that offers group health insurance coverage shall provide the certification described in paragraph (a):

1. At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision or continuation pursuant to s. 627.6692.
2. In the case of an individual becoming covered under a COBRA continuation provision or pursuant to s. 627.6692, at the time the individual ceases to be covered under such a provision.

3. Upon the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in this paragraph.

The certification under subparagraph 1. may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision or continuation pursuant to s. 627.6692.

(c) The certification described in this section is a written certification that must include:

1. The period of creditable coverage of the individual under the policy and the coverage, if any, under such COBRA continuation provision or continuation pursuant to s. 627.6692; and

2. The waiting period, if any, imposed with respect to the individual for any coverage under such policy.

(d) In the case of an election described in subsection (7) by an insurer, if the insurer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual, as provided in this subsection:

1. Upon request of such insurer, the insurer that issued the certification provided by the individual shall promptly disclose to such requesting plan or insurer information on coverage of classes and categories of health benefits available under such insurer’s plan or coverage.

2. Such insurer may charge the requesting insurer for the
reasonable cost of disclosing such information.

(e) The commission shall adopt rules to prevent an insurer’s failure to provide information under this subsection with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(9)(a) Except as provided in paragraph (b), no period before July 1, 1996, shall be taken into account in determining creditable coverage.

(b) The commission shall adopt rules that provide a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for paragraph (a), may be given credit for creditable coverage for such periods through the presentation of documents or other means. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(10) Except as otherwise provided in this subsection, paragraph (8)(b) applies to events that occur on or after July 1, 1996.

(a) In no case is a certification required to be provided under paragraph (8)(b) prior to June 1, 1997.

(b) In the case of an event that occurred on or after July 1, 1996, and before October 1, 1996, a certification is not required to be provided under paragraph (8)(b), unless an individual, with respect to whom the certification is required
to be made, requests such certification in writing.

(11) In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event that occurred before July 1, 1996:

(a) The individual may present other creditable coverage in order to establish the period of creditable coverage.

(b) An insurer is not subject to any penalty or enforcement action with respect to the insurer’s crediting, or not crediting, such coverage if the insurer has sought to comply in good faith with applicable provisions of this section.

(12) For purposes of subsection (9), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement of this section may not be treated as a termination of such collective bargaining agreement.

(13) This section does not apply to any health insurance coverage in relation to its provision of excepted benefits described in paragraph (5)(b).

(14) This section does not apply to any health insurance coverage in relation to its provision of excepted benefits described in paragraphs (5)(c), (d), or (e), if the benefits are provided under a separate policy, certificate, or contract of insurance.

(15) This section applies to health insurance coverage offered, sold, issued, renewed, or in effect on or after July 1, 1997.

Section 15. Subsection (3) of section 627.6562, Florida Statutes, is amended to read:
627.6562 Dependent coverage.—

(3) If, pursuant to subsection (2), a child is provided coverage under the parent’s policy after the end of the calendar year in which the child reaches age 25 and coverage for the child is subsequently terminated, the child is not eligible to be covered under the parent’s policy unless the child was continuously covered by other creditable coverage without a gap in coverage of more than 63 days.

(a) For the purposes of this subsection, the term “creditable coverage” means, with respect to an individual, coverage of the individual under any of the following: has the same meaning as provided in s. 627.6561(5).

1. A group health plan, as defined in s. 2791 of the Public Health Service Act.

2. Health insurance coverage consisting of medical care provided directly through insurance or reimbursement or otherwise, and including terms and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance contract offered by a health insurance issuer.

3. Part A or part B of Title XVIII of the Social Security Act.

4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under s. 1928.

5. Title 10 U.S.C. chapter 55.

6. A medical care program of the Indian Health Service or of a tribal organization.

7. The Florida Comprehensive Health Association or another
state health benefit risk pool.


9. A public health plan as defined by rules adopted by the commission. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

10. A health benefit plan under s. 5(e) of the Peace Corps Act, 22 U.S.C. s. 2504(e).

(b) Creditable coverage does not include coverage that consists of one or more, or any combination thereof, of the following excepted benefits:

1. Coverage only for accident insurance, or disability income insurance, or any combination thereof.

2. Coverage issued as a supplement to liability insurance.

3. Liability insurance, including general liability insurance and automobile liability insurance.

4. Workers’ compensation or similar insurance.

5. Automobile medical payment insurance.

6. Credit-only insurance.

7. Coverage for onsite medical clinics, including prepaid health clinics under part II of chapter 641.

8. Other similar insurance coverage specified in rules adopted by the commission under which benefits for medical care are secondary or incidental to other insurance benefits. To the extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(c) The following benefits are not subject to the creditable coverage requirements, if offered separately:
1. Limited scope dental or vision benefits.
2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
3. Other similar, limited benefits specified in rules adopted by the commission.

(d) The following benefits are not subject to creditable coverage requirements if offered as independent, noncoordinated benefits:

1. Coverage only for a specified disease or illness.
2. Hospital indemnity or other fixed indemnity insurance.

(e) Benefits provided through a Medicare supplemental health insurance policy, as defined under s. 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. chapter 55, and similar supplemental coverage provided to coverage under a group health plan are not considered creditable coverage if offered as a separate insurance policy.

Section 16. Subsection (1) of section 627.65626, Florida Statutes, is amended to read:

627.65626 Insurance rebates for healthy lifestyles.—

(1) Any rate, rating schedule, or rating manual for a health insurance policy that provides creditable coverage as defined in s. 627.6562(3) filed with the office shall provide for an appropriate rebate of premiums paid in the last policy year, contract year, or calendar year when the majority of members of a health plan have enrolled and maintained participation in any health wellness, maintenance, or improvement program offered by the group policyholder and health plan. The rebate may be based upon premiums paid in the last
calendar year or policy year. The group must provide evidence of demonstrative maintenance or improvement of the enrollees’ health status as determined by assessments of agreed-upon health status indicators between the policyholder and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation. The group or health insurer may contract with a third-party administrator to assemble and report the health status required in this subsection between the policyholder and the health insurer. Any rebate provided by the health insurer is presumed to be appropriate unless credible data demonstrates otherwise, or unless the rebate program requires the insured to incur costs to qualify for the rebate which equal or exceed the value of the rebate, but the rebate may not exceed 10 percent of paid premiums.

Section 17. Paragraphs (e) and (l) of subsection (3) and paragraph (d) of subsection (5) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.—
(3) DEFINITIONS.—As used in this section, the term:
(e) “Creditable coverage” has the same meaning as provided ascribed in s. 627.6562(3) 627.6561.
(l) “Late enrollee” means an eligible employee or dependent who, with respect to coverage under a group health policy, is a participant or beneficiary who enrolls under the policy other than during:
1. The first period in which the individual is eligible to enroll under the policy.
2. A special enrollment period, as provided under s.
as defined under s. 627.6561(1)(b).

(5) AVAILABILITY OF COVERAGE.—

(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. 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.

Section 18. Subsection (1) and paragraph (c) of subsection
of section 627.6741, Florida Statutes, are amended to read:

627.6741 Issuance, cancellation, nonrenewal, and replacement.—

(1)(a) An insurer issuing Medicare supplement policies in this state shall offer the opportunity of enrolling in a Medicare supplement policy, without conditioning the issuance or effectiveness of the policy on, and without discriminating in the price of the policy based on, the medical or health status or receipt of health care by the individual:

1. To any individual who is 65 years of age or older, or under 65 years of age and eligible for Medicare by reason of disability or end-stage renal disease, and who resides in this state, upon the request of the individual during the 6-month period beginning with the first month in which the individual has attained 65 years of age and is enrolled in Medicare Part B, or is eligible for Medicare by reason of a disability or end-stage renal disease, and is enrolled in Medicare Part B; or

2. To any individual who is 65 years of age or older, or under 65 years of age and eligible for Medicare by reason of a disability or end-stage renal disease, who is enrolled in Medicare Part B, and who resides in this state, upon the request of the individual during the 2-month period following termination of coverage under a group health insurance policy.

(b) The 6-month period to enroll in a Medicare supplement policy for an individual who is under 65 years of age and is eligible for Medicare by reason of disability or end-stage renal disease and otherwise eligible under subparagraph (a)1. or subparagraph (a)2. and first enrolled in Medicare Part B before October 1, 2009, begins on October 1, 2009.
(c) A company that has offered Medicare supplement policies to individuals under 65 years of age who are eligible for Medicare by reason of disability or end-stage renal disease before October 1, 2009, may, for one time only, effect a rate schedule change that redefines the age bands of the premium classes without activating the period of discontinuance required by s. 627.410(6)(e)2.

(d) As a part of an insurer’s rate filings, before and including the insurer’s first rate filing for a block of policy forms in 2015, notwithstanding the provisions of s. 627.410(6)(e)3., an insurer shall consider the experience of the policies or certificates for the premium classes including individuals under 65 years of age and eligible for Medicare by reason of disability or end-stage renal disease separately from the balance of the block so as not to affect the other premium classes. For filings in such time period only, credibility of that experience shall be as follows: if a block of policy forms has 1,250 or more policies or certificates in force in the age band including ages under 65 years of age, full or 100-percent credibility shall be given to the experience; and if fewer than 250 policies or certificates are in force, no or zero-percent credibility shall be given. Linear interpolation shall be used for in-force amounts between the low and high values. Florida-only experience shall be used if it is 100-percent credible. If Florida-only experience is not 100-percent credible, a combination of Florida-only and nationwide experience shall be used. If Florida-only experience is zero-percent credible, nationwide experience shall be used. The insurer may file its initial rates and any rate adjustment based upon the experience
of these policies or certificates or based upon expected claim experience using experience data of the same company, other companies in the same or other states, or using data publicly available from the Centers for Medicaid and Medicare Services if the insurer’s combined Florida and nationwide experience is not 100-percent credible, separate from the balance of all other Medicare supplement policies.

A Medicare supplement policy issued to an individual under subparagraph (a)1. or subparagraph (a)2. may not exclude benefits based on a preexisting condition if the individual has a continuous period of creditable coverage, as defined in s. 627.6562(3) 627.6561(5), of at least 6 months as of the date of application for coverage.

(2) For both individual and group Medicare supplement policies:

(c) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate or creditable coverage as defined in s. 627.6562(3) 627.6561(5), the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy for similar benefits to the extent such time was spent under the original policy, subject to the requirements of s. 627.6561(6)-{(11)}.

Section 19. Subsection (2) and paragraph (a) of subsection (40) of section 641.31, Florida Statutes, are amended to read:

641.31 Health maintenance contracts.—

(2) The rates charged by any health maintenance
organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. A law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments shall not apply to any health maintenance organization contract that provides coverage as described in s. 641.31071(5)(a)2., offered or delivered to an individual or a group of 51 or more persons. The commission, in accordance with generally accepted actuarial practice as applied to health maintenance organizations, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this subsection.

(40)(a) Any group rate, rating schedule, or rating manual for a health maintenance organization policy, which provides creditable coverage as defined in s. 627.6561(5), filed with the office shall provide for an appropriate rebate of premiums paid in the last policy year, contract year, or calendar year when the majority of members of a health plan are enrolled in and have maintained participation in any health wellness, maintenance, or improvement program offered by the group contract holder. The group must provide evidence of demonstrative maintenance or improvement of his or her health status as determined by assessments of agreed-upon health status indicators between the group and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation. Any rebate provided by the health maintenance organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. A law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments shall not apply to any health maintenance organization contract that provides coverage as described in s. 641.31071(5)(a)2., offered or delivered to an individual or a group of 51 or more persons. The commission, in accordance with generally accepted actuarial practice as applied to health maintenance organizations, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this subsection.
organization is presumed to be appropriate unless credible data
demonstrates otherwise, or unless the rebate program requires
the insured to incur costs to qualify for the rebate which
equals or exceeds the value of the rebate but the rebate may not
exceed 10 percent of paid premiums.

Section 20. Section 641.31071, Florida Statutes, is amended
to read:

641.31071 Preexisting conditions.—
(1) As used in this section, the term:
(a) “Enrollment date” means, with respect to an individual
covered under a group health maintenance organization contract,
the date of enrollment of the individual in the plan or coverage
or, if earlier, the first day of the waiting period of such
enrollment.
(b) “Late enrollee” means, with respect to coverage under a
group health maintenance organization contract, a participant or
beneficiary who enrolls under the contract other than during:
1. The first period in which the individual is eligible to
enroll under the plan.
2. A special enrollment period, as provided under s.
641.31072.
(c) “Waiting period” means, with respect to a group health
maintenance organization contract and an individual who is a
potential participant or beneficiary under the contract, the
period that must pass with respect to the individual before the
individual is eligible to be covered for benefits under the
terms of the contract.
(2) Subject to the exceptions specified in subsection (4),
a health maintenance organization that offers group coverage,
may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(a) Such exclusion relates to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

(b) Such exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date; and

(c) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, as defined in s. 627.6562(3) subsection (5), applicable to the participant or beneficiary as of the enrollment date.

(3) Genetic information shall not be treated as a condition described in paragraph (2)(a) in the absence of a diagnosis of the condition related to such information.

(4)(a) Subject to paragraph (b), a health maintenance organization that offers group coverage may not impose any preexisting condition exclusion in the case of:

1. An individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

2. A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This provision shall not apply to coverage before the date of such
adoption or placement for adoption.


   (b) Subparagraphs (a)1. and 2. do not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

   (5)(a) The term “creditable coverage” means, with respect to an individual, coverage of the individual under any of the following:

   1. A group health plan, as defined in s. 2791 of the Public Health Service Act.

   2. Health insurance coverage consisting of medical care, provided directly, through insurance or reimbursement or otherwise, and including terms and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance contract offered by a health insurance issuer.

   3. Part A or part B of Title XVIII of the Social Security Act.

   4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under s. 1928.

   5. Chapter 55 of Title 10, United States Code.

   6. A medical care program of the Indian Health Service or of a tribal organization.

   7. The Florida Comprehensive Health Association or another state health benefit risk pool.

   8. A health plan offered under chapter 89 of Title 5, United States Code.
9. A public health plan as defined by rule of the commission. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

10. A health benefit plan under s. 5(e) of the Peace Corps Act (22 U.S.C. s. 2504(e)).

(b) Creditable coverage does not include coverage that consists solely of one or more or any combination thereof of the following excepted benefits:

1. Coverage only for accident, or disability income insurance, or any combination thereof.
2. Coverage issued as a supplement to liability insurance.
3. Liability insurance, including general liability insurance and automobile liability insurance.
4. Workers’ compensation or similar insurance.
5. Automobile medical payment insurance.
6. Credit-only insurance.
7. Coverage for onsite medical clinics.
8. Other similar insurance coverage, specified in rules adopted by the commission, under which benefits for medical care are secondary or incidental to other insurance benefits. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(e) The following benefits are not subject to the creditable coverage requirements, if offered separately:

1. Limited scope dental or vision benefits.
2. Benefits or long-term care, nursing home care, home health care, community-based care, or any combination of these.
3. Such other similar, limited benefits as are specified in rules adopted by the commission. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(d) The following benefits are not subject to creditable coverage requirements if offered as independent, noncoordinated benefits:
   1. Coverage only for a specified disease or illness.
   2. Hospital indemnity or other fixed indemnity insurance.

(e) Benefits provided through Medicare supplemental health insurance, as defined under s. 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan are not considered creditable coverage if offered as a separate insurance policy.

(6)(a) A period of creditable coverage may not be counted, with respect to enrollment of an individual under a group health maintenance organization contract, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(b) Any period during which an individual is in a waiting period, or in an affiliation period as defined in subsection (9), for any coverage under a group health maintenance organization contract may not be taken into account in determining the 63-day period under paragraph (a) or paragraph (4)(b).

(7)(a) Except as otherwise provided under paragraph (b), a
A health maintenance organization may elect to count as creditable coverage, coverage of benefits within each of several classes or categories of benefits specified in rules adopted by the commission rather than as provided under paragraph (a). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election, a health maintenance organization shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(c) In the case of an election with respect to a health maintenance organization under paragraph (b), the organization shall:

1. Prominently state in 10-point type or larger in any disclosure statements concerning the contract, and state to each enrollee at the time of enrollment under the contract, that the organization has made such election; and

2. Include in such statements a description of the effect of this election.

(8)(a) Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in this subsection or in such other manner as may be specified in rules adopted by the commission.

(b) A health maintenance organization that offers group coverage shall provide the certification described in paragraph (a) to:

1. At the time an individual ceases to be covered under the
plan or otherwise becomes covered under a COBRA continuation provision or continuation pursuant to s. 627.6692.

2. In the case of an individual becoming covered under a COBRA continuation provision or pursuant to s. 627.6692, at the time the individual ceases to be covered under such a provision.

3. Upon the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in this paragraph.

The certification under subparagraph 1. may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision or continuation pursuant to s. 627.6692.

(e) The certification is a written certification of:

1. The period of creditable coverage of the individual under the contract and the coverage, if any, under such COBRA continuation provision or continuation pursuant to s. 627.6692; and

2. The waiting period, if any, imposed with respect to the individual for any coverage under such contract.

(d) In the case of an election described in subsection (7) by a health maintenance organization, if the organization enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual, as provided by this subsection:

1. Upon request of such health maintenance organization, the insurer or health maintenance organization that issued the certification provided by the individual shall promptly disclose to such requesting organization information on coverage of
classes and categories of health benefits available under such insurer’s or health maintenance organization’s plan or coverage.

2. Such insurer or health maintenance organization may charge the requesting organization for the reasonable cost of disclosing such information.

(e) The commission shall adopt rules to prevent an insurer’s or health maintenance organization’s failure to provide information under this subsection with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health maintenance organization coverage.

(9)(a) A health maintenance organization may provide for an affiliation period with respect to coverage through the organization only if:

1. No preexisting condition exclusion is imposed with respect to coverage through the organization;

2. The period is applied uniformly without regard to any health-status-related factors; and

3. Such period does not exceed 2 months or 3 months in the case of a late enrollee.

(b) For the purposes of this section, the term “affiliation period” means a period that, under the terms of the coverage offered by the health maintenance organization, must expire before the coverage becomes effective. The organization is not required to provide health care services or benefits during such period, and no premium may be charged to the participant or beneficiary for any coverage during the period. Such period begins on the enrollment date and runs concurrently with any waiting period under the plan.
(c) As an alternative to the method authorized by paragraph (a), a health maintenance organization may address adverse selection in a method approved by the office.

(10)(a) Except as provided in paragraph (b), no period before July 1, 1996, shall be taken into account in determining creditable coverage.

(b) The commission shall adopt rules that provide a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for paragraph (a), may be given credit for creditable coverage for such periods through the presentation of documents or other means.

(11) Except as otherwise provided in this subsection, the requirements of paragraph (8)(b) shall apply to events that occur on or after July 1, 1996.

(a) In no case is a certification required to be provided under paragraph (8)(b) prior to June 1, 1997.

(b) In the case of an event that occurs on or after July 1, 1996, and before October 1, 1996, a certification is not required to be provided under paragraph (8)(b), unless an individual, with respect to whom the certification is required to be made, requests such certification in writing.

(12) In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before July 1, 1996:

(a) The individual may present other creditable coverage in order to establish the period of creditable coverage.

(b) A health maintenance organization is not subject to any
penalty or enforcement action with respect to the organization’s
crediting, or not crediting, such coverage if the organization
has sought to comply in good faith with applicable provisions of
this section.

(13) For purposes of subsection (10), any plan amendment
made pursuant to a collective bargaining agreement relating to
the plan which amends the plan solely to conform to any
requirement of this section may not be treated as a termination
of such collective bargaining agreement.

Section 21. Subsections (1), (3), and (4) of section
641.31074, Florida Statutes, are amended to read:

641.31074 Guaranteed renewability of coverage.—
(1) Except as otherwise provided in this section, a health
maintenance organization that issues a group health insurance
contract must renew or continue in force such coverage at the
option of the contract holder.

(3)(a) A health maintenance organization may discontinue
offering a particular contract form for group coverage offered
in the small group market or large group market only if:

1. The health maintenance organization provides notice to
each contract holder provided coverage of this form in such
market, and participants and beneficiaries covered under such
coverage, of such discontinuation at least 90 days prior to the
date of the nonrenewal of such coverage;

2. The health maintenance organization offers to each
contract holder provided coverage of this form in such market
the option to purchase all, or in the case of the large group
market, any other health insurance coverage currently being
offered by the health maintenance organization in such market;
3. In exercising the option to discontinue coverage of this form and in offering the option of coverage under subparagraph 2., the health maintenance organization acts uniformly without regard to the claims experience of those contract holders or any health-status-related factor that relates to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(b)1. In any case in which a health maintenance organization elects to discontinue offering all coverage in the individual market, the small group market, or the large group market, or any combination thereof both, in this state, coverage may be discontinued by the insurer only if:

a. The health maintenance organization provides notice to the office and to each contract holder, and participants and beneficiaries covered under such coverage, of such discontinuation at least 180 days prior to the date of the nonrenewal of such coverage; and

b. All health insurance issued or delivered for issuance in this state in such market is discontinued and coverage under such health insurance coverage in such market is not renewed.

2. In the case of a discontinuation under subparagraph 1. in a market, the health maintenance organization may not provide for the issuance of any health maintenance organization contract coverage in the market in this state during the 5-year period beginning on the date of the discontinuation of the last insurance contract not renewed.

(4) At the time of coverage renewal, a health maintenance organization may modify the coverage for a product offered:
(a) In the large group market; or
(b) In the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, as defined in s. 627.6571(5), such modification is consistent with s. 627.6699 and effective on a uniform basis among group health plans with that product; or
(c) In the individual market if the modification is consistent with the laws of this state and effective on a uniform basis among all individuals with that policy form.

And the title is amended as follows:
Delete lines 29 - 55 and insert:

- types of benefits or coverages; amending s. 627.6561, F.S.; conforming a cross-reference; revising conditions under which an insurer may impose a preexisting condition exclusion; deleting the definition of the term “creditable coverage”; removing certain requirements relating to creditable coverage to conform to changes made by the act; amending s. 627.6562, F.S.; redefining the term “creditable coverage”; providing exceptions and applicability; amending s. 627.65626, F.S.; conforming a cross-reference; amending s. 627.6699, F.S.; redefining terms; deleting a provision that requires a certain health benefit plan to comply with specified preexisting condition provisions; amending s. 627.6741, F.S.; conforming cross-references;
conforming a provision to changes made by the act; amending s. 641.31, F.S.; deleting a provision specifying that a law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments may not apply to a certain health maintenance organization contract; conforming a cross-reference; amending s. 641.31071, F.S.; conforming a cross-reference; deleting the definition of the term “creditable coverage”; removing certain requirements relating to creditable coverage to conform to changes made by the act; amending s. 641.31074; requiring a health maintenance organization that issues a health insurance contract, rather than a group health insurance contract, to renew or continue in force such coverage at the contract holder’s option; revising conditions under which a health maintenance organization may discontinue offering a particular contract form; adding to the conditions under which a health maintenance organization may, at the time of coverage renewal, modify coverage for a product offered; amending s.
By the Committee on Banking and Insurance; and Senator Detert

A bill to be entitled An act relating to health plan regulatory administration; amending s. 408.909, F.S.; redefining the term "health care coverage" or "health flex plan coverage"; amending s. 409.817, F.S.; deleting a provision authorizing group insurance plans to impose a certain preexisting condition exclusion; amending s. 624.123, F.S.; conforming a cross-reference; amending s. 627.402, F.S.; redefining the term "nongrandfathered health plan"; amending s. 627.411, F.S.; deleting a provision relating to a minimum loss ratio standard for specified health insurance coverage; deleting provisions specifying certain incurred claims; amending s. 627.6011, F.S., conforming a cross-reference; amending s. 627.602, F.S.; conforming a cross-reference; amending s. 627.642, F.S.; revising the policies to which certain outline of coverage requirements apply; amending s. 627.6425, F.S.; redefining the term "individual health insurance"; revising applicability; amending s. 627.6487, F.S.; redefining terms; repealing s. 627.64871, F.S., relating to certification of coverage; amending s. 627.6512, F.S.; 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; amending s. 627.6513, F.S.; excluding applicability as to certain types of benefits or coverages; repealing s. 627.6561, F.S., relating to preexisting conditions; amending s. 627.6562, F.S.; redefining the term "creditable coverage"; providing exceptions and applicability;

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

Section 1. Paragraph (d) of subsection (2) of section...
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CODING: Words **stricken** are deletions; words **underlined** are additions.

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CODING: Words **stricken** are deletions; words **underlined** are additions.
Section 6. Section 627.6011, Florida Statutes, is amended to read:

627.6011 Grounds for disapproval.—

(3)(a) For health insurance coverage as described in s. 627.6513(14), the minimum loss ratio standard of incurred claims to earned premium for the form shall be 65 percent.

(b) Incurred claims are claims occurring within a fixed period, whether or not paid during the same period, under the terms of the policy period.

1. Claims include scheduled benefit payments or services provided by a provider or through a provider network for dental, vision, disability, and similar health benefits.

2. Claims do not include state assessments, taxes, company expenses, or any expense incurred by the company for the cost of adjusting and settling a claim, including the review, qualification, oversight, management, or monitoring of a claim or incentives or compensation to providers for other than the provisions of health care services.

3. A company may at its discretion include costs that are demonstrated to reduce claims, such as fraud intervention programs or case management costs, which are identified in each filing, are demonstrated to reduce claims costs, and do not result in increasing the experience period loss ratio by more than 5 percent.

4. For scheduled claim payments, such as disability income or long-term care, the incurred claims shall be the present value of the benefit payments discounted for continuance and interest.

Section 6. Section 627.6011, Florida Statutes, is amended to read:

(CODING: Words underlined are additions; words stricken are deletions.)
(a) It is accompanied by an appropriate outline of coverage; or

(b) An appropriate outline of coverage is completed and delivered to the applicant at the time application is made, and an acknowledgment of receipt or certificate of delivery of such outline is provided to the insurer with the application.

In the case of a direct response, such as a written application to the insurance company from an applicant, the outline of coverage shall accompany the policy when issued.

Section 9. Subsections (1), (6), and (7) of section 627.6425, Florida Statutes, are amended, to read:

627.6425 Renewable of individual coverage.—

(1) Except as otherwise provided in this section, an insurer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual. For the purpose of this section, the term "individual health insurance" means health insurance coverage, as described in s. 624.603 — 627.6561(5)(a)2., offered to an individual in this state, including certificates of coverage offered to individuals in this state as part of a group policy issued to an association outside this state, but the term does not include short-term limited duration insurance or excepted benefits specified in s. 627.6513(1)-(14) — 627.6561(5)(a)2. or, if the benefits are provided under a separate policy, certificate, or contract of insurance, the term does not include excepted benefits specified in s. 627.6561(5)(a), (d), or (e).

(2) The requirements of this section do not apply to any health insurance coverage in relation to its provision of excepted benefits described in s. 627.6561(5)(b) or, if the benefits are provided under a separate policy, certificate, or contract of insurance, the term does not include excepted benefits specified in s. 627.6561(5)(b) and (c). If the benefits are provided under a separate policy, certificate, or contract of insurance, the term does not include excepted benefits specified in s. 627.6561(5)(b), (d), or (e).

(3) For the purposes of this section, the term "eligible individual" means an individual:

(a)1. For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage, as defined in s. 627.6612(3) — 627.6561(5) and (c), is 18 or more months; and

2.a. Whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan, or health insurance coverage offered in connection with any such plan; or
b. Whose most recent prior creditable coverage was under an
individual plan issued in this state by a health insurer or
health maintenance organization, which coverage is terminated
due to the insurer or health maintenance organization becoming
insolvent or discontinuing the offering of all individual
coverage in the State of Florida, or due to the insured no
longer living in the service area in the State of Florida of the
insurer or health maintenance organization that provides
coverage through a network plan in the State of Florida;
(d) Who, having been offered the option of continuation
or person other than the individual; and

1. A group health plan, as defined in s. 2791 of the Public
Health Service Act;
2. A conversion policy or contract issued by an authorized
insurer or health maintenance organization under s. 627.6675 or
s. 641.3921, respectively, offered to an individual who is no
longer eligible for coverage under either an insured or self-
insured employer plan;
3. Part A or part B of Title XVIII of the Social Security
Act; or
4. A state plan under Title XIX of such act, or any
successor program, and does not have other health insurance
coverage;
(c) With respect to whom the most recent coverage within
the coverage period described in paragraph (a) was not
terminated based on a factor described in s. 627.6571(2)(a) or
(b), relating to nonpayment of premiums or fraud, unless such
nonpayment of premiums or fraud was due to acts of an employer
or person other than the individual;
(d) Who, having been offered the option of continuation

Section 11. Section 627.64871, Florida Statutes, is
repealed.

Section 12. Section 627.6512, Florida Statutes, is amended
to read:

627.6512 Exemption of certain group health insurance
policies.—Sections 627.6512, 627.65615, 627.65625, and 627.6571
do not apply to
(1) any group insurance policy in relation to its provision
of excepted benefits described in ss. 627.6513(1)-(14) and
627.6513(15)-(16).
(2) Any group health insurance policy in relation to the
provision of excepted benefits described in ss. 627.6513(1)(a) or
if the benefits are
(a) are provided under a separate policy, certificate, or
contract of insurance; or
(b) are otherwise not an integral part of the policy.
(3) Any group health insurance policy in relation to the
provision of excepted benefits described in ss. 627.6513(1)(b)
if all of the following conditions are met:
(a) The benefits are provided under a separate policy,
certificate, or contract of insurance;
(b) There is no coordination between the provision of such
benefits and any exclusion of benefits under any group policy
maintained by the same policyholder; and

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health clinics under part II of chapter 641. 321
(8) Other similar insurance coverage, specified in rules
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627.6562 Dependent coverage.— 350
(3) If, pursuant to subsection (2), a child is provided
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coverage under the parent’s policy after the end of the calendar year in which the child reaches age 25 and coverage for the child is subsequently terminated, the child is not eligible to be covered under the parent’s policy unless the child was continuously covered by other creditable coverage without a gap in coverage of more than 63 days.

(a) For the purposes of this subsection, the term “creditable coverage” means, with respect to an individual, coverage of the individual under any of the following:

1. A group health plan, as defined in s. 2791 of the Public Health Service Act.

2. Health insurance coverage consisting of medical care provided directly through insurance or reimbursement or otherwise, and including terms and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance contract offered by a health insurance issuer.

3. Part A or part B of Title XVIII of the Social Security Act.

4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under s. 1928.

5. 10 U.S.C. chapter 55.

6. A medical care program of the Indian Health Service or of a tribal organization.

7. The Florida Comprehensive Health Association or another state health benefit risk pool.


9. A public health plan as defined by rules adopted by the commission. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

10. A health benefit plan under s. 5(e) of the Peace Corps Act, 22 U.S.C. s. 2504(e).

(b) Creditable coverage does not include coverage that consists of one or more, or any combination thereof, of the following excepted benefits:

1. Coverage only for accident insurance or disability income insurance, or any combination thereof.

2. Coverage issued as a supplement to liability insurance.

3. Liability insurance, including general liability insurance and automobile liability insurance.

4. Workers’ compensation or similar insurance.

5. Automobile medical payment insurance.

6. Credit-only insurance.

7. Coverage for onsite medical clinics, including prepaid health clinics under part II of chapter 641.

8. Other similar insurance coverage specified in rules adopted by the commission under which benefits for medical care are secondary or incidental to other insurance benefits. To the extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(c) The following benefits are not subject to the creditable coverage requirements, if offered separately:

1. Limited scope dental or vision benefits.

2. Benefits for long-term care, nursing home care, home health care, or another state health benefit risk pool.
group must provide evidence of

- Coverage only for a specified disease or illness.
- Hospital indemnity or other fixed indemnity insurance.
- Benefits provided through a Medicare supplemental health insurance policy, as defined under s. 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. chapter 55, and similar supplemental coverage provided to coverage under a group health plan are not considered creditable coverage if offered as a separate insurance policy.

Section 16. Subsection (1) of section 627.65626, Florida Statutes, is amended to read:

627.65626 Insurance rebates for healthy lifestyles.—
(1) Any rate, rating schedule, or rating manual for a health insurance policy that provides creditable coverage as defined in s. 627.65626(3) filed with the office shall provide for an appropriate rebate of premiums paid in the last policy year, contract year, or calendar year when the majority of members of a health plan have enrolled and maintained participation in any health wellness, maintenance, or improvement program offered by the group policyholder and health plan. The rebate may be based upon premiums paid in the last calendar year or policy year. The group must provide evidence of

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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.—

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) 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...

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3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or
renewal date, unless the composition of the group changes or benefits are changed. However, a small employer carrier may modify the rate one time within the 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers covered under the policy:
   a. The carrier discloses to the employer in a clear and conspicuous manner the date of the first renewal and the fact that the premium may increase on or after that date.
   b. The insurer demonstrates to the office that efficiencies in administration are achieved and reflected in the rates charged to small employers covered under the policy.

4. A carrier may issue a group health insurance policy to a small employer health alliance or other group association with rates that reflect a premium credit for expense savings attributable to administrative activities being performed by the alliance or group association if such expense savings are specifically documented in the insurer’s rate filing and are approved by the office. Any such credit may not be based on different morbidity assumptions or on any other factor related to the health status or claims experience of any person covered under the policy. This subparagraph does not exempt an alliance or group association from licensure for activities that require licensure under the insurance code. A carrier issuing a group health insurance policy to a small employer health alliance or other group association shall allow any properly licensed and

5. Any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents. For a small employer’s policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier’s approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer’s renewal premium, up to 10 percent annually, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 4 percent for the current policy term, the carrier shall limit the application of such adjustments only to minus adjustments. For any subsequent policy term, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 4 percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer’s premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier’s experience.
and are subject to office review and approval.

6. A small employer carrier rating methodology may include separate rating categories for one dependent child, for two dependent children, and for three or more dependent children for family coverage of employees having a spouse and dependent children or employees having dependent children only. A small employer carrier may have fewer, but not greater, numbers of categories for dependent children than those specified in this subparagraph.

7. Small employer carriers may not use a composite rating methodology to rate a small employer with fewer than 10 employees. For the purposes of this subparagraph, the term “composite rating methodology” means a rating methodology that averages the impact of the rating factors for age and gender in the premiums charged to all of the employees of a small employer.

8. A carrier may separate the experience of small employer groups with fewer than 2 eligible employees from the experience of small employer groups with 2-50 eligible employees for purposes of determining an alternative modified community rating.

a. If a carrier separates the experience of small employer groups, the rate to be charged to small employer groups of fewer than 2 eligible employees may not exceed 150 percent of the rate determined for small employer groups of 2-50 eligible employees. However, the carrier may charge excess losses of the experience pool consisting of small employer groups with less than 2 eligible employees to the experience pool consisting of small employer groups with 2-50 eligible employees so that all losses are allocated and the 150-percent rate limit on the experience pool consisting of small employer groups with less than 2 eligible employees is maintained.

b. Notwithstanding s. 627.411(1), the rate to be charged to a small employer group of fewer than 2 eligible employees, insured as of July 1, 2002, may be up to 125 percent of the rate determined for small employer groups of 2-50 eligible employees for the first annual renewal and 150 percent for subsequent annual renewals.

9. A carrier shall separate the experience of grandfathered health plans from nongrandfathered health plans for determining rates.

Section 18. Subsection (1) and paragraph (c) of subsection (2) of section 627.6741, Florida Statutes, are amended to read:

(1)(a) An insurer issuing Medicare supplement policies in this state shall offer the opportunity of enrolling in a Medicare supplement policy, without conditioning the issuance or effectiveness of the policy on, and without discriminating in the price of the policy based on, the medical or health status or receipt of health care by the individual:

1. To any individual who is 65 years of age or older, or under 65 years of age and eligible for Medicare by reason of disability or end-stage renal disease, and who resides in this state, upon the request of the individual during the 6-month period beginning with the first month in which the individual has attained 65 years of age and is enrolled in Medicare Part B, or is eligible for Medicare by reason of a disability or end-
stage renal disease, and is enrolled in Medicare Part B, or
2. To any individual who is 65 years of age or older, or
under 65 years of age and eligible for Medicare by reason of a
disability or end-stage renal disease, who is enrolled in
Medicare Part B, and who resides in this state, upon the request
of the individual during the 2-month period following
termination of coverage under a group health insurance policy.
(b) The 6-month period to enroll in a Medicare supplement
policy for an individual who is under 65 years of age and is
eligible for Medicare by reason of disability or end-stage renal
disease and otherwise eligible under subparagraph (a)1. or
subparagraph (a)2. and first enrolled in Medicare Part B before
October 1, 2009, begins on October 1, 2009.
(c) A company that has offered Medicare supplement policies
to individuals under 65 years of age who are eligible for
Medicare by reason of disability or end-stage renal disease
before October 1, 2009, may, for one time only, effect a rate
schedule change that redefines the age bands of the premium
classes without activating the period of discontinuance required
by s. 627.410(6)(e)2.
(d) As a part of an insurer’s rate filings, before and
including the insurer’s first rate filing for a block of policy
forms in 2015, notwithstanding the provisions of s.
627.410(6)(e)3., an insurer shall consider the experience of the
policies or certificates for the premium classes including
individuals under 65 years of age and eligible for Medicare by
reason of disability or end-stage renal disease separately from
the balance of the block so as not to affect the other premium
classes. For filings in such time period only, credibility of
that experience shall be as follows: if a block of policy forms
has 1,250 or more policies or certificates in force in the age
band including ages under 65 years of age, full or 100-percent
credibility shall be given to the experience; and if fewer than
250 policies or certificates are in force, no or zero-percent
credibility shall be given. Linear interpolation shall be used
for in-force amounts between the low and high values. Florida-
only experience shall be used if it is 100-percent credible. If
Florida-only experience is not 100-percent credible, a
combination of Florida-only and nationwide experience shall be
used. If Florida-only experience is zero-percent credible,
nationwide experience shall be used. The insurer may file its
initial rates and any rate adjustment based upon the experience
of these policies or certificates or based upon expected claim
experience using experience data of the same company, other
companies in the same or other states, or using data publicly
available from the Centers for Medicaid and Medicare Services if
the insurer’s combined Florida and nationwide experience is not
100-percent credible, separate from the balance of all other
Medicare supplement policies.
A Medicare supplement policy issued to an individual under
subparagraph (a)1. or subparagraph (a)2. may not exclude
benefits based on a preexisting condition if the individual has
a continuous period of creditable coverage, as defined in s.
627.6562(3) , of at least 6 months as of the date
of application for coverage.
(2) For both individual and group Medicare supplement
policies:

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(c) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate or creditable coverage as defined in ss. 627.6562(3) and 627.6561(4), the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy for similar benefits to the extent such time was spent under the original policy, subject to the requirements of ss. 627.6561(6) and 627.6561(7).

Section 19. Paragraphs (f) and (h) of subsection (1) of section 641.185, Florida Statutes, are amended to read:

641.185 Health maintenance organization subscriber protections.—

(I) With respect to the provisions of this part and part III, the principles expressed in the following statements shall serve as standards to be followed by the commission, the office, the department, and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

(f) A health maintenance organization subscriber should receive the flexibility to transfer to another Florida health maintenance organization, regardless of health status, pursuant to ss. 641.228, 641.3104, 641.3107(1), 641.3111, 641.3921, and 627.505.

(h) A health maintenance organization that issues a group health contract must provide coverage for preexisting conditions pursuant to ss. 641.31071, guarantee renewability of coverage pursuant to ss. 641.31074, provide notice of
enrolled in and have maintained participation in any health wellness, maintenance, or improvement program offered by the group contract holder. The group must provide evidence of demonstrative maintenance or improvement of his or her health status as determined by assessments of agreed-upon health status indicators between the group and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation. Any rebate provided by the health maintenance organization is presumed to be appropriate unless credible data demonstrates otherwise, or unless the rebate program requires the insured to incur costs to qualify for the rebate which equals or exceeds the value of the rebate but the rebate may not exceed 10 percent of paid premiums.

Section 21. Section 641.31071, Florida Statutes, is repealed.

Section 22. Subsection (4) of section 641.3111, Florida Statutes, is amended to read:

641.3111 Extension of benefits.—
(4) Except as provided in subsection (1), no subscriber is entitled to an extension of benefits if the termination of the contract by the health maintenance organization is based upon any event referred to in ss. 641.3922(7)(a), (b), or (c).

Section 23. Section 641.312, Florida Statutes, is amended to read:

641.312 Scope.—The Office of Insurance Regulation may adopt rules to administer the provisions of the National Association of Insurance Commissioners’ Uniform Health Carrier External Review Model Act, issued by the National Association of Insurance Commissioners and dated April 2010. This section does not apply to a health maintenance contract that is subject to the Subscriber Assistance Program under s. 408.7056 or to the types of benefits or coverages provided under ss. 627.6513(1)–627.6561(5)(b)–(e) issued in any market.

Section 24. This act shall take effect July 1, 2016.
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. 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. Applications for CON review must be submitted by the specified deadline for the particular batch cycle. The AHCA must review the application within 15 days of the filing deadline and, if necessary, request additional information for an incomplete application. The applicant then has 21 days to complete the application or it is deemed withdrawn from consideration.

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. The AHCA must then publish the decision, within 14 days, in the Florida Administrative Register. 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.

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. 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.

**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, 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;

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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, 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 beds15 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, 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;\(^\text{17}\)
• 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:\(^\text{18}\)
  o Has experienced an annual net out-migration of at least 600 open heart surgery cases for three consecutive years; and
  o 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.

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\(^{17}\) 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.\(^\text{19}\) 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.\(^\text{20}\)

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.\(^\text{21}\)

\(^{19}\) 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.
Senate Appropriations Subcommittee on Health and Human Services (Richter) recommended the following:

**Senate Amendment (with title amendment)**

Delete everything after the enacting clause and insert:

Section 1. Present paragraphs (a) through (t) of subsection (3) of section 408.036, Florida Statutes, are redesignated as paragraphs (c) through (v), respectively, new paragraphs (a) and (b) are added to that subsection, present subsections (4) and (5) of that section are redesignated as subsections (5) and (6), respectively, and a new subsection (4) is added to that section,
Projects subject to review; exemptions.—

(3) EXEMPTIONS.—Upon request, the following projects are subject to exemption from the provisions of subsection (1):

(a) Except for projects described in paragraphs (b) and (c), any project conditioned upon a significant, active, and continuing commitment to improved access to care for uninsured and low-income residents of the applicable service district. Such commitment is demonstrated by compliance with the following conditions and requirements which the project applicant must accept in a signed agreement with the agency:

1. The project licensee must contribute, once the project is operational and at the end of each of the first four calendar quarters of the project’s operations, an amount equal to 1.5 percent of the gross revenues earned by the exempt project. Contributions shall be made to the agency and deposited in the Public Medical Assistance Trust Fund.

2.a. Beginning in the fifth calendar quarter of the exempt project’s operations, the licensee must provide charity care in an amount equal to twice the applicable district average among licensed providers of similar services. For purposes of this section, the term “charity care” means 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 valuation of charity care must be based on Medicaid reimbursement rates.

b. Alternatively, if the licensee provides less charity care than is required by sub-subparagraph a., the licensee must
donate:

(I) Pursuant to a written agreement with a charity care provider in the service district, payments for charity care provided to residents of the service district in total amounts equal to or greater than the difference between the value of the charity care provided in sub-subparagraph a. and the applicable district average among licensed providers of similar services; or

(II) Payments to Florida Health Choices for health care coverage financial assistance in total amounts equal to or greater than the difference between the value of the charity care provided in sub-subparagraph a. and the applicable district average among licensed providers of similar services. The payments for financial assistance must be made in increments sufficient to purchase silver-level health care coverage for an individual for at least 1 year. The individual receiving this assistance must have been uninsured during the previous 12 months. The licensee and Florida Health Choices shall cooperate to identify individuals from the service district who are qualified to receive the available assistance.

c. The agreement between the agency and the applicant for an exemption must require the licensee to submit reports and data necessary to monitor compliance with the charity care threshold.

(b) Any project to construct or establish a new skilled nursing facility or increase the licensed bed capacity of an existing skilled nursing facility conditioned on a significant, active, and continuing commitment by the facility to improved access to Medicaid long-term care services. Such commitment is
demonstrated by an applicant by compliance with a signed agreement between the applicant and the agency which, upon the project becoming operational, requires the project licensee to contribute an amount equal to the state share of one-fourth of the cost of enrolling a person in the long-term care waiver program established pursuant to Part IV of Chapter 409 times twice the number of new beds included in the project. The contribution shall be paid by the project licensee to the agency at the end of each calendar quarter that the project is operational and deposited in the Public Medical Assistance Trust Fund. The agreement between the agency and the applicant must require the licensee to submit reports and data necessary to monitor compliance with the charity care threshold.

(4) PENALTIES.—A facility licensed based on the exemption established in subsection (3)(a)-(b) is subject to the following penalties for noncompliance with its specific commitment to improve access to care for uninsured and low-income persons in the service district:

(a) For the first quarter in which the value of services, donations, and financial assistance falls below the specified threshold, the fine is equal to twice the amount of the shortfall. The fine is doubled in each subsequent quarter of noncompliance up to a maximum of four quarters.

(b) Following a fifth quarter of noncompliance, the exempt license shall be suspended until the licensee implements a corrective action plan that the agency has approved.

(c) Failure by the facility to maintain compliance following the implementation of a corrective action plan shall result in revocation of the exempt license.
Section 2. This act shall take effect July 1, 2016.

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled An act relating to certificates of need for health care-related projects; amending s. 408.036, F.S.; providing an exemption from certificate of need review for certain health care-related projects; specifying conditions and requirements for the exemption; requiring that project applicants enter into an agreement with the Agency for Health Care Administration as a condition of eligibility for the exemption; requiring specified monetary contributions; providing penalties for failure to comply with the terms of the agreement; providing an effective date.
Appropriations Subcommittee on Health and Human Services (Richter) recommended the following:

Senate Amendment to Amendment (223842)

Delete lines 15 - 16
and insert:

(a) Except for projects described in paragraph (b), any project conditioned upon a significant, active, and
By Senator Gaetz

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CODING: Words **stricken** are deletions; words __underlined__ are additions.

A bill to be entitled
An act relating to certificates of need for health care-related projects; amending s. 408.036, F.S.; 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; providing an effective date.

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

Section 1. Present paragraphs (a) through (t) of subsection (3) of section 408.036, Florida Statutes, are redesignated as paragraphs (b) through (u), respectively, a new paragraph (a) is added to that subsection, present subsections (4) and (5) of that section are redesignated as subsections (5) and (6), respectively, and a new subsection (4) is added to that section, to read:

408.036 Projects subject to review; exemptions.—
(3) EXEMPTIONS.—Upon request, the following projects are subject to exemption from the provisions of subsection (1):
(a) Any project conditioned upon a significant, active, and continuing commitment to improved access to care for uninsured and low-income residents of the applicable service district, such commitment is demonstrated by compliance with the following conditions and requirements which the project applicant must accept in a signed agreement with the agency:
1. The project licensee must contribute, once the project is operational and at the end of each of the first four calendar quarters of the project’s operations, an amount equal to 1.5 percent of the gross revenues earned by the exempt project. Contributions shall be made to the agency and deposited in the Public Medical Assistance Trust Fund.
2.a. Beginning in the fifth calendar quarter of the exempt project’s operations, the licensee must provide charity care in an amount equal to or greater than the applicable district average among licensed providers of similar services. For purposes of this section, the term “charity care” means 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 valuation of charity care must be based on Medicaid reimbursement rates.
   b. Alternatively, if the licensee provides less charity care than is required by sub-subparagraph a., the licensee must donate:
   (I) Pursuant to a written agreement with a charity care provider in the service district, payments for charity care provided to residents of the service district in total amounts equal to or greater than the difference between the value of the charity care provided in sub-subparagraph a. and the applicable district average among licensed providers of similar services;
   or
   (II) Payments to Florida Health Choices for health care coverage financial assistance in total amounts equal to or greater than the difference between the value of the charity care provided in sub-subparagraph a. and the applicable district average among licensed providers of similar services;
average among licensed providers of similar services. The payments for financial assistance must be made in increments sufficient to purchase silver-level health care coverage for an individual for at least 1 year. The individual receiving this assistance must have been uninsured during the previous 12 months. The licensee and Florida Health Choices shall cooperate to identify individuals from the service district who are qualified to receive the available assistance.

c. The agreement between the agency and the applicant for an exemption must require the licensee to submit reports and data necessary to monitor compliance with the charity care threshold.

(4) PENALTIES.—A facility licensed based on the exemption established in subsection (3)(a) is subject to the following penalties for noncompliance with its specific commitment to improve access to care for uninsured and low-income persons in the service district:

(a) For the first quarter in which the value of services, donations, and financial assistance falls below the specified threshold, the fine is equal to twice the amount of the shortfall. The fine is doubled in each subsequent quarter of noncompliance up to a maximum of four quarters.

(b) Following a fifth quarter of noncompliance, the exempt license shall be suspended until the licensee implements a corrective action plan that the agency has approved.

(c) Failure by the facility to maintain compliance following the implementation of a corrective action plan shall result in revocation of the exempt license.

Section 2. This act shall take effect July 1, 2016.
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
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 freestanding 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

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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.


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

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\(^8\) 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.\(^{15}\)

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\(^{11}\) 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.\(^\text{16}\)

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.\(^\text{17}\) 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.

\(^\text{16}\) 42 C.F.R. §416.2
\(^\text{17}\) 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.

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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

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 (11) 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)[11] A hospital licensed as of June 1, 2004, shall be exempt from subsection (9) subsection (11) 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 (11) subsection (11). Unless the hospital is otherwise exempt under subsection (9) subsection (11) subsection (11), the agency shall deny or revoke the license of a hospital that violates any of the criteria set forth in that subsection.

(11)[12] The agency may adopt rules implementing the licensure requirements set forth in subsection (9) subsection (11) subsection (11). Within 14 days after rendering its decision on a license

CODING: Words _______ are deletions; words _______ are additions.
application or revocation, the agency shall publish its proposed
decision in the Florida Administrative Register. Within 21 days
after publication of the agency’s decision, any authorized
person may file a request for an administrative hearing. In
administrative proceedings challenging the approval, denial, or
revocation of a license pursuant to subsection (9) of subsection
(8), the hearing must be based on the facts and law existing at
the time of the agency’s proposed agency action. Existing
hospitals may initiate or intervene in an administrative hearing
to approve, deny, or revoke licensure under subsection (9)
subsection (8) based upon a showing that an established program
will be substantially affected by the issuance or renewal of a
license to a hospital within the same district or service area.

Section 3. This act shall take effect July 1, 2016.
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

Cc: Scarlet Pigott, Staff Director; Robin Jackson, Administrative Assistant
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

¹ See s. 741.28, F.S.
² See s. 787.06(2)(d), F.S.
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 relicensure 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.

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\(^7\) See The Department of Health, *Continuing Education – CE*, [http://www.floridahealth.gov/licensing-and-regulation/ce.html](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.

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.

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This Senate Bill Analysis does not reflect the intent or official position of the bill’s introducer or the Florida Senate.
A bill to be entitled An act relating to instruction on human trafficking;
amending s. 456.031, F.S.; providing that certain
licensing boards must require specified licensees to
come a specified continuing education course that
includes a section on human trafficking as a condition
of relicensure or recertification; providing
requirements and procedures related to the course;
providing an effective date.

Be It Enacted by the Legislature of the State of Florida:
Section 1. Section 456.031, Florida Statutes, is amended to
read:
456.031 Requirement for instruction on domestic violence
and human trafficking.—
(1)(a) The appropriate board shall require each person
licensed or certified under chapter 456, chapter 459, part I of
chapter 464, chapter 466, chapter 467, chapter 490, or chapter
491 to complete a 2-hour continuing education course, approved
by the board, on domestic violence, as defined in s. 741.28, and
human trafficking, as defined in s. 787.06(2), as part of
every third biennial relicensure or recertification.
1. The domestic violence section of the course must be
consist of data and information on the number of patients in
that professional’s practice who are likely to be victims of
domestic violence and 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 such patients with information on, or how to

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

2. The human trafficking section of the course must consist of
information related to human trafficking, such as labor and sex, and the extent of human trafficking; factors
that place a person at greater risk for being a victim of human
trafficking; management of medical records of patients who are
human trafficking victims; patient safety and security; 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 United States Department of Homeland
Security; validated assessment tools for identifying human
trafficking victims and 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.

(b) Each such licensee or certificateholder shall submit
confirmation of having completed the continuing education such
course, on a form provided by the board, when submitting fees
for every third biennial relicensure or recertification renewal.
(c) The board may approve additional equivalent courses
that may be used to satisfy the requirements of paragraph (a).
Each licensing board that requires a licensee to complete a
continuing education course pursuant to this subsection may
include the hour required for completion of the course in the
total hours of continuing education required by law for the such
profession, unless the continuing education requirements for the
such profession consist of fewer than 30 hours of continuing
education biennially.

(d) Any person holding two or more licenses subject to the
provisions of this subsection shall be permitted to show proof
of completion of having taken one board-approved course on
domestic violence and human trafficking, for purposes of
relicensure or recertification for additional licenses.

(e) Failure to comply with the requirements of this
subsection shall constitute grounds for disciplinary action
under each respective practice act and under s. 456.072(1)(k).
In addition to discipline by the board, the licensee shall be
required to complete the board-approved such course under this
subsection.

(2) Each board may adopt rules to carry out the provisions
of this section.

Section 2. This act shall take effect July 1, 2016.
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 (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.

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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. Unemployment rates for persons with mental disorders are high relative to the overall population. People with severe mental illness have exceptionally high rates of unemployment, between 60 percent and 100 percent. Mental illness increases a person’s risk of homelessness in America threefold. 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. 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.

According to the National Alliance on Mental Illness (NAMI), approximately 50 percent of individuals with severe mental health disorders are affected by substance abuse. NAMI also estimates that 29 percent of all people diagnosed as mentally ill abuse alcohol or other drugs. 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.

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. 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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4 Id.
5 Id.
6 Id.
7 Id.
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.\(^\text{12}\)

**Baker Act**

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.\(^\text{13}\) 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.\(^\text{14}\)

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.\(^\text{15}\)

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


\(^\text{13}\) Chapter 71-131, Laws of Fla.; The Baker Act is contained in ch. 394, F.S.

\(^\text{14}\) Section 397.6795, F.S.

\(^\text{15}\) Section 394.462(1)(f) and (g), F.S.
available bed.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{20} If the person does not consent, the law enforcement officer may transport the person without using unreasonable force.\textsuperscript{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.\textsuperscript{22}

The Baker Act provides that a person cannot be held in a receiving facility for involuntary examination for more than 72 hours.\textsuperscript{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

\textsuperscript{16} Section 397.6772(1), F.S.
\textsuperscript{17} Section 394.459(1), F.S.
\textsuperscript{18} Section 397.675, F.S.
\textsuperscript{19} Section 397.677, F.S.
\textsuperscript{20} Section 397.6771, F.S.
\textsuperscript{21} Section 397.6772(1), F.S.
\textsuperscript{22} Section 397.6773(1) and (2), F.S.
\textsuperscript{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 394.465(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.
their own basic needs. If left untreated, acute episodes may spiral out of control before the person meets commitment criteria.

The Uniform Law Commission 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. A key failure of the HCDA is that it does not empower patients to form self-binding arrangements for care. 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. 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. 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. 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.

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

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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 subspecialties 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.


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.
A bill to be entitled

An act relating to behavioral health care services; amending s. 394.453, F.S.; revising legislative intent and providing legislative findings for the Florida Mental Health Act; amending ss. 394.66 and 397.305, F.S.; revising legislative intent with respect to mental health and substance abuse treatment services; amending ss. 394.9082, F.S.; requiring behavioral health managing entities to coordinate service delivery plans with their respective counties or circuits; providing responsibilities of county governments for designation of receiving facilities for the examination and assessment of persons with mental health or substance use disorders; authorizing the Department of Children and Families to monitor and enforce compliance with ch. 394, F.S., relating to mental health; requiring managing entities to coordinate the development of a certain local plan; requiring managing entities to provide certain technical assistance; requiring managing entities to develop and implement transportation plans; requiring local law enforcement agencies, local governments, and certain providers to review and approve transportation plans; providing departmental authority for final approval of such plans; amending s. 397.675, F.S.; revising criteria for involuntary admission for assessment, stabilization, and treatment of persons with substance use or mental health disorders; amending s. 397.6793, F.S.; specifying professionals authorized to execute a certificate for emergency admission; providing criteria for emergency admission; amending s. 397.681, F.S.; prohibiting a court from

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field of medical practice. 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; 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) It is the intent of the Legislature:
(a) 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 part.
(b) To ensure that local systems of acute care services use a common protocol and apply consistent practice standards that provide for nondiscriminatory and equitable access to the level and duration of care based on the specific needs and preferences of the persons served.
(c) 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.
(d) To authorize and direct the Department of Children and Families to evaluate, research, plan, and recommend to the Governor and the Legislature programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, behavioral, and substance use disorders and the conditions that encompass biological, genetic, psychological, cultural, and social factors; and are subspecialties within the family of medical practice. 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; 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) It is the intent of the Legislature:
(a) 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 part.
(b) To ensure that local systems of acute care services use a common protocol and apply consistent practice standards that provide for nondiscriminatory and equitable access to the level and duration of care based on the specific needs and preferences of the persons served.
(c) 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.
(d) To authorize and direct the Department of Children and Families to evaluate, research, plan, and recommend to the Governor and the Legislature programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, behavioral, and substance use disorders and the conditions that encompass biological, genetic, psychological, cultural, and social factors; and are subspecialties within the family of medical practice. 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; 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.
It is the policy of this state that the use of restraint and seclusion on clients is justified only as an emergency safety measure to be used in response to imminent danger to the client or others. It is, therefore, the intent of the Legislature to achieve an ongoing reduction in the use of restraint and seclusion in programs and facilities serving persons with mental illness.

Section 2. Subsection (2) of section 394.66, Florida Statutes, is amended to read:

394.66 Legislative intent with respect to substance abuse and mental health services.—It is the intent of the Legislature to:

(2) 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 subspecialties within the field of medical practice. 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, 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 to persons with mental illness and substance abuse impairment as diseases that are responsive to medical and psychological interventions and management that integrate treatment, rehabilitative, and support services to achieve recovery.

Section 3. Subsections (4) through (12) of section 394.9082, Florida Statutes, are renumbered as subsections (6)
A managing entity shall coordinate the development of a local plan that:

1. Includes the county or circuit.

2. Establishes the specifications and minimum standards for access to care available in each community and specifies the roles, processes, and responsibilities of community intervention programs for the diversion of persons from acute care placements.

3. Specifies the method by which local hospitals, ambulatory centers, designated receiving facilities, and acute care inpatient and detoxification providers will coordinate activities to assess, examine, triage, intake, and process persons presented on an involuntary basis.

4. Includes a local transportation plan as provided in s. 394.462.

5. Provides an option to procure nonmedical transportation contracts for the transportation of patients between facilities.

(c) A managing entity shall provide technical assistance to counties or circuits for the development, receipt, and approval of such plans and incorporate the community resources designated in such plans when conducting the needs assessment and coordinating the resources within its assigned region.

5. TRANSPORTATION PLANS.—

(a) Each managing entity shall develop, in consultation with local law enforcement agencies, county officials, and local acute care providers, a transportation plan for each county or circuit within its assigned region. At a minimum, the plan must address the following:

1. The designated public or private substance abuse receiving facility or residential detoxification facility to be used by local law enforcement agencies as their primary receiving facility.
264. 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, 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) 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) 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) It is the purpose of this chapter to provide for a comprehensive continuum of accessible and quality substance abuse services, acute care placements, and attendance at involuntary court proceedings and resulting commitments.
It is the intent of the Legislature to establish services for individuals with co-occurring substance abuse and mental disorders.

(10) 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) 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) 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) 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
Section 5. Section 397.675, Florida Statutes, is amended to read:

397.675 Criteria for involuntary admissions, including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and alternative involuntary assessment for minors, for purposes of assessment and stabilization, and for involuntary treatment.—A person meets the criteria for involuntary admission if there is good faith reason to believe the person has a substance use or co-occurring mental health disorder and, because of this condition, has refused or is unable to determine whether examination is necessary. The refusal of services is insufficient evidence of an inability to determine whether an examination is necessary unless, without care or treatment, the person is substance abuse impaired and, because of such impairment:

(1) The person is likely to neglect or refuse care for himself or herself to the extent that the neglect or refusal poses a real and present threat of substantial harm to his or her well-being;

(2) The person is at risk of the deterioration of his or her physical or mental health and this condition may not be avoided despite assistance from willing family members, friends, or other services; or

(3) There is a substantial likelihood that the person will cause serious bodily harm to himself or herself or others, as shown by the person’s recent behavior, has lost the power of self-control with respect to substance use, and either

(2)(a) Has inflicted, or threatened or attempted to

Section 6. Section 397.6793, Florida Statutes, is amended to read:

397.6793 Professional Physician certificate for emergency admission.—

(1) A physician, 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 licensed clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 5 days and finds that the person appears to meet the criteria for emergency admission and stating the observations upon which that conclusion is based. The professional physician’s certificate must include the name of the person to be admitted, the relationship between the person and the professional executing the certificate, the relationship between the applicant and the professional executing the certificate, and any relationship between the professional
executing the certificate and the licensed service provider, and a statement that the person has been examined and assessed within 5 days of the application date, and must include factual allegations with respect to the need for emergency admission, including:

(a) The reason for the physician’s belief that the person is substance abuse impaired; and

(b) The reason for the physician’s belief that because of such impairment the person has lost the power of self-control with respect to substance abuse; and either

(c) The reason for the belief that, without care or treatment:

1. The person is likely to neglect or refuse to care for himself or herself to the extent that the neglect or refusal poses a real and present threat of substantial harm to his or her well-being;

2. The person is at risk of the deterioration of his or her physical or mental health and that this condition may not be avoided despite assistance from willing family members, friends, or other services; or

3. There is a substantial likelihood that the person will cause serious bodily harm to himself or herself or others, as shown by the person’s recent behavior, the physician believes that the person has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted; or

4. The reason the physician believes that the person’s refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the person is incapable of appreciating his or her need for care and of making a rational decision regarding his or her need for care.

(2) The professional physician’s certificate must recommend the least restrictive type of service that is appropriate for the person. The certificate must be signed by the professional physician. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer shall take the person named in the certificate into custody and deliver him or her to the nearest facility selected by the county for emergency admission.

(3) A signed copy of the professional physician’s certificate shall accompany the person, and shall be made a part of the person’s clinical record, together with a signed copy of the application. The application and professional physician’s certificate authorize the involuntary admission of the person pursuant to, and subject to the provisions of ss. 397.679-397.6797.

(4) The professional physician’s certificate must indicate whether the person requires transportation assistance for delivery for emergency admission and specify, pursuant to s. 397.6795, the type of transportation assistance necessary. Section 7. Subsection (1) of section 397.681, Florida Statutes, is amended to read:

397.681 Involuntary petitions; general provisions; court jurisdiction and right to counsel.--

(1) JURISDICTION.—The courts have jurisdiction of involuntary assessment and stabilization petitions and involuntary treatment petitions for substance abuse impaired persons, and such petitions must be filed with the clerk of the court in the county where the person is located. The court may...
Court determination.—At the hearing initiated in section 397.6818, Florida Statutes, to read:

(1) If the person upon whose behalf the petition is being filed is an adult, a petition for involuntary assessment and stabilization may be filed by the respondent’s spouse or guardian, any relative, a private practitioner, the director of a licensed service provider or the director’s designee, or any adult willing to provide testimony that he or she has personally observed the actions of that person and believes that person to be a threat to himself or herself or others. The court shall have personal knowledge of the respondent’s substance abuse impairment.

Section 9. Subsection (4) is added to section 397.6818, Florida Statutes, to read:

397.6818 Court determination.—At the hearing initiated in accordance with s. 397.6811(1), the court shall hear all relevant testimony. The respondent must be present unless the court has reason to believe that his or her presence is likely to be injurious to him or her, in which event the court shall appoint a guardian advocate to represent the respondent. The respondent has the right to examination by a court-appointed qualified professional. After hearing all the evidence, the court shall determine whether there is a reasonable basis to believe the respondent meets the involuntary admission criteria of s. 397.675.

(4) The order is valid only until executed or, if not executed, for the period specified in the order. If no time limit is specified in the order, the order is valid for 7 days after the date the order is signed.

Section 10. Subsection (1) of section 397.697, Florida Statutes, is amended to read:

397.697 Court determination; effect of court order for involuntary substance abuse treatment.—

(1) When the court finds that the conditions for involuntary substance abuse treatment have been proved by clear and convincing evidence, it may order the respondent to undergo involuntary treatment by a licensed service provider for a period not to exceed 90 days. If the court finds it necessary, it may direct the sheriff to take the respondent into custody and deliver him or her to the licensed service provider specified in the court order, or to the nearest appropriate licensed service provider, for involuntary treatment. When the conditions justifying involuntary treatment no longer exist, the individual must be released as provided in s. 397.6971.
conditions justifying involuntary treatment are expected to exist after 90 days of treatment, a renewal of the involuntary treatment order may be requested pursuant to s. 397.6975 before the end of the 90-day involuntary treatment 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 the end of the 90-day involuntary treatment period, or before 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 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 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
Section 16. Part V of chapter 765, Florida Statutes, is amended to read:

(a) A mental health or substance abuse treatment advance has been broken or the individual is involuntarily committed to a mental health care or substance abuse treatment facility. The Legislature further recognizes the following:

1. The Legislature recognizes that an individual with mental illness has the ability to control decisions relating to his or her own mental health care or substance abuse treatment. The Legislature also makes the following findings:

(a) Substance abuse and some mental illnesses cause individuals to fluctuate between capacity and incapacity.

(b) During periods when an individual’s capacity is unclear, the individual may be unable to provide informed consent necessary to access needed treatment.

(c) Early treatment may prevent an individual from becoming so ill that involuntary treatment is necessary.

(d) Individuals with substance abuse impairment or mental illness need an established procedure to express their instructions and preferences for treatment and provide advance consent to or refusal of treatment. This procedure should be less expensive and less restrictive than guardianship.

2. The Legislature further recognizes the following:

(a) A mental health or substance abuse treatment advance
(b) For a mental health or substance abuse treatment advance directive to be an effective tool, individuals must be able to choose how they want their directives to be applied during periods when they are incompetent to consent to treatment.

(c) There must be a clear process so that treatment providers can abide by an individual’s treatment choices.

Section 19. Section 765.503, Florida Statutes, is created to read:

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

1. “Adult” means any individual who has attained the age of majority or is an emancipated minor.

2. “Capacity” means that an adult has not been found to be incapacitated pursuant to s. 394.463.

3. “Health care facility” means a hospital, nursing home, hospice, home health agency, or health maintenance organization licensed in this state, or any facility subject to part I of chapter 394.

4. “Incapacity” or “incompetent” means one or more of the following conditions when present in an adult:

(a) An inability to understand the nature, character, and anticipated results of proposed treatment or alternatives or the recognized serious possible risks, complications, and anticipated benefits of treatments and alternatives, including nontreatment.

(b) An inability to physically or mentally communicate a willful and knowing decision about mental health care or

(c) An inability to communicate his or her understanding or treatment decisions.

(d) Criteria exist for an involuntary examination pursuant to s. 394.463.

(5) “Informed consent” means consent voluntarily given by a person after a sufficient explanation and disclosure of the subject matter involved to enable that person to have a general understanding of the treatment or procedure and the medically acceptable alternatives, including the substantial risks and hazards inherent in the proposed treatment or procedures or nontreatment, and to make knowing mental health care or substance abuse treatment decisions without coercion or undue influence.

(6) “Interested person” means any person who may reasonably be expected to be affected by the outcome of the particular proceeding involved, including anyone interested in the welfare of an incapacitated person.

(7) “Mental health or substance abuse treatment advance directive” means a written document in which the principal makes a declaration of instructions or preferences or appoints a surrogate to make decisions on behalf of the principal regarding the principal’s mental health or substance abuse treatment, or both.

(8) “Mental health professional” means a psychiatrist, psychologist, psychiatric nurse, or social worker, and such other mental health professionals licensed pursuant to chapter 458, chapter 459, chapter 464, chapter 490, or chapter 491.

(9) “Principal” means a competent adult who executes a

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mental health or substance abuse treatment advance directive and
on whose behalf mental health care or substance abuse treatment
decisions are to be made.

(10) “Service provider” means a mental health receiving
facility, a facility licensed under chapter 397, a treatment
facility, an entity under contract with the department to
provide mental health or substance abuse services, a community
mental health center or clinic, a psychologist, a clinical
social worker, a marriage and family therapist, a mental health
counselor, a physician, a psychiatrist, an advanced registered
nurse practitioner, or a psychiatric nurse.

(11) “Surrogate” means any competent adult expressly
designated by a principal to make mental health care or
substance abuse treatment decisions on behalf of the principal
as set forth in the principal’s mental health or substance abuse
treatment advance directive created pursuant to this part.

Section 20. Section 765.504, Florida Statutes, is created
to read:

765.504 Mental health or substance abuse treatment advance
directive; execution; allowable provisions.—

(1) An adult with capacity may execute a mental health or
substance abuse treatment advance directive.

(2) A directive executed in accordance with this section is
presumed to be valid. The inability to honor one or more
provisions of a directive does not affect the validity of the
remaining provisions.

(3) A directive may include any provision relating to
mental health or substance abuse treatment or the care of the
principal for whom the directive is executed. Without

CODING: Words strike-through are deletions; words underlined are additions.
(d) Be witnessed by two adults, each of whom must declare that he or she personally knows the principal and was present when the principal dated and signed the directive, and that the principal did not appear to be incapacitated or acting under fraud, undue influence, or duress. The person designated as the surrogate may not act as a witness to the execution of a document designating the mental health care or substance abuse treatment surrogate. At least one person who acts as a witness may not be the principal’s spouse or his or her blood relative.

(2) A directive is valid upon execution, but all or part of the directive may take effect at a later date as designated by the principal in the directive.

(3) A directive may be revoked, in whole or in part, pursuant to s. 765.506 or expire under its own terms.

(4) A directive does not or may not:

(a) Create an entitlement to mental health, substance abuse, or medical treatment or supersede a determination of medical necessity.

(b) Obligate any health care provider, professional person, or health care facility to pay the costs associated with the treatment requested.

(c) Obligate a health care provider, professional person, or health care facility to be responsible for the nontreatment or personal care of the principal or the principal’s personal affairs outside the scope of services the facility normally provides.

(d) Replace or supersede any will or testamentary document or supersede the application of intestate succession.

Section 22. Section 765.506, Florida Statutes, is created to read:

765.506 Revocation; waiver.—

(1) A principal with capacity may, by written statement of the principal or at the principal’s direction in the principal’s presence, revoke a directive in whole or in part.

(2) The principal shall provide a copy of his or her written statement of revocation to his or her agent, if any, and to each health care provider, professional person, or health care facility that received a copy of the directive from the principal.

(3) The written statement of revocation is effective as to a health care provider, professional person, or health care facility upon the individual’s or entity’s receipt of the statement. The professional person, health care provider, or health care facility, or persons acting under their direction, shall make the statement of revocation part of the principal’s medical record.

(4) A directive also may:

(a) Be revoked, in whole or in part, expressly or to the extent of any inconsistency, by a subsequent directive; or

(b) Be superseded or revoked by a court order, including any order entered in a criminal matter. The principal’s family, a health care facility, an attending physician, or any other interested person who may be directly affected by a surrogate’s decision relating to the principal’s health care may seek expedited judicial intervention pursuant to rule 5.900 of the Florida Probate Rules, if that person believes:

1. The surrogate’s decision is not in accord with the
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CODING: Words [____] are deletions; words [____] are additions.

Section 765.507, Florida Statutes, is created to read:

765.507 Immunity from liability; weight of proof; presumption.—

1. The advance directive is ambiguous, or the principal has changed his or her mind after execution of the advance directive.

2. The surrogate was improperly designated or appointed, or the designation of the surrogate is no longer effective or has been revoked.

3. The surrogate has failed to discharge duties, or incapacity or illness renders the surrogate incapable of discharging duties;

4. The surrogate has abused his or her power or authority; or

5. The surrogate has exceeded his or her authority.

6. The principal has sufficient capacity to make his or her own health care decisions.

(5) A directive that would have otherwise expired but is effective because the principal is incapacitated remains effective until the principal is no longer incapacitated, unless the principal elected in the directive to be able to revoke while incapacitated and has revoked the directive.

(6) When a principal with capacity consents to treatment that differs from, or refuses treatment consented to in, his or her directive, the consent or refusal constitutes a waiver of a particular provision of the directive and does not constitute a revocation of that provision or the directive unless the principal also expressly revokes the provision or directive.

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(1) A health care facility, 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, and may not be deemed to have engaged in unprofessional conduct, as a result of carrying out a mental health care or substance abuse treatment decision made in accordance with this part. The surrogate who makes a mental health care or substance abuse treatment decision on a principal’s behalf, pursuant to this part, is not subject to criminal prosecution or civil liability for such action.

(2) This section does not apply if it is shown by a preponderance of the evidence that the person authorizing or carrying out a mental health care or substance abuse treatment decision did not exercise reasonable care or, in good faith, comply with this part.

Section 24. Section 765.508, Florida Statutes, is created to read:

765.508 Recognition of mental health or substance abuse treatment advance directive executed in another state.—A mental health or substance abuse treatment advance directive executed in another state in compliance with the laws of that state is validly executed for the purposes of this part.

Section 25. Section 765.509, Florida Statutes, is created to read:

765.509 Dissemination of information.—

(1) A service provider shall give information relating to mental health or substance abuse treatment advance directives to its patients and assist competent and willing patients in completing mental health or substance abuse treatment advance 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) 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 of chapter 765, or chapter 873, without notification of and approval by the next of kin.

Section 27. Subsection (29) of section 408.820, Florida Statutes, is amended to read:

408.820 Applicability.—The provisions of this part apply to the provisions 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 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 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...
pursuant to part VI of this chapter.

(6) "Health care decision" means:

(d) The decision to make an anatomical gift pursuant to

part VI of this chapter.

Section 30. Section 765.203, Florida Statutes, is amended
to read:

765.203 Suggested form of designation.—A written
designation of a health care surrogate executed pursuant to this
chapter may, but need not be, in the following form:

DESIGNATION OF HEALTH CARE SURROGATE

I, ...(name)..., designate as my health care surrogate under s.
765.202, Florida Statutes:

Name: ...(name of health care surrogate)...
Address: ...(address)...
Phone: ...(telephone)...

If my health care surrogate is not willing, able, or reasonably
available to perform his or her duties, I designate as my
alternate health care surrogate:

Name: ...(name of alternate health care surrogate)...
Address: ...(address)...
Phone: ...(telephone)...

INSTRUCTIONS FOR HEALTH CARE

I authorize my health care surrogate to:

...(Initial here)... Receive any of my health information,
whether oral or recorded in any form or medium, that:

1. Is created or received by a health care provider, health
care facility, health plan, public health authority, employer,
life insurer, school or university, or health care
clearinghouse; and

2. Relates to my past, present, or future physical or
mental health or condition; the provision of health care to me;
or the past, present, or future payment for the provision of
health care to me.

I further authorize my health care surrogate to:

...(Initial here) Make all health care decisions for me, which means he or she has the authority to:

1. Provide informed consent, refusal of consent, or
withdrawal of consent to any and all of my health care,
including life-prolonging procedures.

2. Apply on my behalf for private, public, government, or
veterans' benefits to defray the cost of health care.

3. Access my health information reasonably necessary for
the health care surrogate to make decisions involving my health
care and to apply for benefits for me.

4. Decide to make an anatomical gift pursuant to part VI
of chapter 765, Florida Statutes.

...(Initial here) Specific instructions and
restrictions: ......................................................

......................................................

......................................................

CODING: Words stricken are deletions; words underlined are additions.
While I have decisionmaking capacity, my wishes are controlling and my physicians and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation. To the extent I am capable of understanding, my health care surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.

This health care surrogate designation is not affected by my subsequent incapacity except as provided in chapter 765, Florida statutes.

Pursuant to section 765.104, Florida statutes, I understand that I may, at any time while I retain my capacity, revoke or amend this designation by:

(1) Signing a written and dated instrument which expresses my intent to amend or revoke this designation;
(2) Physically destroying this designation through my own action or by that of another person in my presence and under my direction;
(3) Verbally expressing my intention to amend or revoke this designation; or
(4) Signing a new designation that is materially different from this designation.

My health care surrogate’s authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I initial either or both of the following boxes:

- If I initial this box [....], my health care surrogate’s authority to receive my health information takes effect immediately.
- If I initial this box [....], my health care surrogate’s authority to make health care decisions for me takes effect immediately. Pursuant to section 765.204(3), Florida statutes, any instructions or health care decisions I make, either verbally or in writing, while I possess capacity shall supersede any instructions or health care decisions made by my surrogate that are in material conflict with those made by me.

Signatures: Sign and date the form here:

...(date)... ...(sign your name)...
...(address)... ...(print your name)...
...(city)... ...(state)...

Signatures of witnesses:

First witness Second witness
...(print name)...
...(print name)...
...(address)...
...(address)...
...(city)...
...(city)...
...(state)...
...(state)...
...(signature of witness)...
...(signature of witness)...
...(date)...
...(date)...

Section 31. This act shall take effect July 1, 2016.
To: Senator Rene García  
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.

Senator Jeremy Ring  
Florida Senate, District 29
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

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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

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\(^8\) 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, and comprehensive transitional education programs that serve APD clients.

Wilderness Camps

The DCF regulates wilderness camps as residential child-caring agencies. 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 from several regulations applicable to residential programs, these programs are currently subject to existing regulation.

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, and rehabilitation or habilitation 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 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 engagement.

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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 ceased 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.


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. 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.

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. 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:

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25 Section 394.67(15)(b), F.S.
26 Section 394.67(24)(d), F.S.
• 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.  

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.  

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.

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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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.
The purpose of an adolescent and child residential treatment program is to offer room and board and to provide, or arrange for the provision of, specialized treatment, specialized therapies as defined in s. 393.063, and services for rehabilitation or habilitation as defined in s. 393.063, for adolescents and children with emotional, psychological, developmental, or behavioral problems or disorders, or substance abuse problems. In an adolescent and child residential treatment program, adolescents and children are assisted in acquiring the social and behavioral skills necessary for a healthy adjustment to school, family life, and community.

(2) As used in this section, the term:
(a) "Adolescent and child residential treatment program" or "program" means a privately owned and operated 24-hour group living environment for four or more adolescents or children unrelated to the owner or provider.
(b) "Program resident" or "resident" means an adolescent or child at least 6 and no more than 18 years of age who enrolls and participates in a program.

(3) An adolescent and child residential treatment program must be licensed by the Agency for Health Care Administration in accordance with this section.

Section 1. Section 394.88, Florida Statutes, is created to read:
394.88 Adolescent and child residential treatment programs.—
(1) The purpose of an adolescent and child residential treatment program is to offer room and board and to provide, or arrange for the provision of, specialized treatment, specialized therapies as defined in s. 393.063, and services for rehabilitation or habilitation as defined in s. 393.063, for adolescents and children with emotional, psychological, developmental, or behavioral problems or disorders, or substance abuse problems. In an adolescent and child residential treatment program, adolescents and children are assisted in acquiring the social and behavioral skills necessary for a healthy adjustment to school, family life, and community.
accordance with part II of chapter 408. The department, in consultation with the agency and the Agency for Persons with Disabilities, shall establish by rule requirements for licensure, administration, and operation of programs and program facilities consistent with this section.

(4)(a) A program must employ a licensed psychiatrist or a psychologist licensed under chapter 490 as the director of the program. The director is responsible for the operation of the program, the program facility, and the day-to-day supervision of program residents. The director or a member of program staff appointed by the director as his or her substitute must be present at the program facility at all times. The director shall maintain on site a current list of all program residents.

(b) Program staff must include, in addition to the director, physicians licensed under chapter 458 or chapter 459, psychologists licensed under chapter 490 or chapter 491, mental health counselors licensed under chapter 491, or advanced registered nurse practitioners licensed under part 1 of chapter 464 and certified under s. 464.012 who have been trained in providing medical services and treatment to adolescents and children to serve as professional program staff providing treatment to residents. Such professional program staff must be specifically trained in providing medical services and treatment to adolescents and children diagnosed with mental health and substance abuse problems and to residents with disabilities if the program serves these populations. A program must have a minimum of two such professional staff members on duty at all times and must maintain a professional staff-to-resident ratio of no less than 1 to 4 during awake hours. All program staff, professional and non-professional, and all providers who may be contracted to provide services to residents must undergo a level 2 background screening before engaging in any activity that brings them into contact with a resident. The department may establish by rule further staffing requirements to ensure resident safety and service delivery consistent with this section.

(5) A program must ensure that a treatment plan exists for each resident. The treatment plan must be reviewed and signed at the time a resident enrolls and periodically after enrollment, as provided in the treatment plan, by the director of the program and the resident’s parent or legal guardian. The department may establish by rule further requirements relating to the treatment and care of residents consistent with this section.

(6) A program must maintain written documentation of compliance with the following local requirements, as applicable:

(a) Zoning ordinances.
(b) Business license requirements.
(c) Building codes.
(d) Firesafety codes and standards.
(e) Health codes.
(f) Approval from appropriate governmental agencies for new program services or increased consumer capacity.

A program facility that provides services to residents with disabilities must be located where schools, churches, recreation facilities, and other community facilities are available. The department may establish by rule further requirements relating
Section 2. Section 394.89, Florida Statutes, is created to read:

394.89 Adolescent and child outdoor programs.—

(1) The purpose of an adolescent and child outdoor program is to offer wilderness hiking and camping experiences through program field group activities and expeditions as a form of rehabilitation and treatment for adolescents or children with emotional, psychological, developmental, or behavioral problems or disorders, or substance abuse problems. In an adolescent and child outdoor program, adolescents and children are assisted in acquiring the social and behavioral skills necessary for a healthy adjustment to school, family life, and community.

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

(a) “Adolescent and child outdoor program” or “program” means a privately owned and operated 24-hour group wilderness hiking and camping experience for four or more adolescents or children unrelated to the owner or provider. A program may be established independently or as an adjunct and subsidiary of an adolescent and child residential treatment program established pursuant to s. 394.88.

(b) “Program participant” or “participant” means an adolescent or child at least 6 and no more than 18 years of age who enrolls and participates in a program. The term does not include the parent or contracting agent that enrolls the adolescent or child in the program.

(3)(a) An adolescent and child outdoor program must be licensed by the Agency for Health Care Administration in accordance with part II of chapter 408. The department, in consultation with the agency and the Agency for Persons with Disabilities, shall establish by rule requirements for licensure, administration, and operation of programs consistent with this section. All local, state, and federal regulations and professional licensing requirements must be met by a program as a condition of licensure by the agency. The agency must review and approve a program’s training plan specifying the program’s goals and methodologies. The training plan must include provisions governing a participant’s conduct and the consequences for his or her conduct while enrolled in the program.

(b) A program must provide an educational component...
approved by the Department of Education to a participant who is absent from his or her school or educational setting for more than 30 days. Before enrolling a participant, the program supervisor must coordinate with the local school board to provide an educational component as part of the participant’s program experience. To offer educational credit to participants, the program must be recognized and approved by the State Board of Education.

(4)(a) A program must employ a licensed psychiatrist or a psychologist licensed under chapter 490 as its program supervisor. The program supervisor is responsible for and has authority over the policies and activities of the program. The program supervisor shall coordinate office and support services, supervise the operations of the program, and ensure that all program staff are adequately trained. The program supervisor shall maintain on file at all times enrollment records of all participants and a current list of participants, including each participant’s group field activity or expedition and his or her geographic location. The list must be updated every 24 hours. The program supervisor must develop and sign a written plan for each group field activity and expedition. Plans must not expose participants to unreasonable risks.

(b) Each group field activity or expedition must have field staff working directly with the participants. A program must have field support staff members who are responsible for the delivery of supplies to the field, mail delivery, communications, and first aid support.

(c) Each program must provide its participants access to a multidisciplinary team of licensed health care providers and

1. A physician licensed under chapter 458 or chapter 459.
2. At least one of the following:
   a. A psychologist licensed under chapter 490 or chapter 491.
   b. A licensed clinical social worker.
   c. A mental health counselor licensed under chapter 491.
   d. A licensed marriage and family therapist.
   e. A certified school counselor.

(d) All program staff, professional and non-professional, and all providers who may be contracted to provide services to participants must undergo a level 2 background screening before engaging in any activity that brings them into contact with a participant. The department may establish by rule further staffing requirements consistent with this section.

Section 3. This act shall take effect July 1, 2016.
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
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. This required information is traditionally compiled in a "Sunrise Questionnaire.”

**Music Therapists**

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;

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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

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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.
By the Committee on Health Policy; and Senator Clemens

588-02319-16

A bill to be entitled An act relating to music therapists; creating s. 491.017, F.S.; providing legislative intent; providing definitions; establishing requirements for registration as a music therapist; providing responsibilities of a music therapist; requiring biennial renewal of registration; prohibiting the practice of music therapy unless the therapist is registered; providing exemptions to registration; authorizing the Department of Health to adopt rules and take disciplinary action against an applicant or registrant who violates the act; providing an effective date.

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

Section 1. Section 491.017, Florida Statutes, is created to read:

491.017 Registration of music therapists.—

(1) LEGISLATIVE INTENT.—It is the intent of this section 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.

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

(a) "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.

(b) "Music therapist" means a person registered to practice music therapy pursuant to this section.

(c) "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. The 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.

(3) REGISTRATION.—

(a) The department shall register an applicant as a music therapist when the applicant submits to the department:

1. A completed application form issued by the department;

2. Application and registration fees; and

3. Proof of passing the examination for board certification offered by the national Certification Board for Music Therapists, or any successor organization, or proof of being transitioned into board certification, and provides proof that the applicant is currently a board-certified music therapist.

(b) A registration issued under this section must be renewed biennially by submitting to the department a renewal fee and proof that the applicant holds an active certificate as a board-certified music therapist.

(c) A registrant shall inform the department within 10 days after a change of the registrant’s address or a change in the registrant’s status as a board-certified music therapist.
(4) RESPONSIBILITIES OF A MUSIC THERAPIST.—A music therapist is authorized to:

(a) Accept referrals for music therapy services from medical, developmental, mental health, or education professionals; family members; clients; caregivers; or other persons authorized to provide client services.

(b) Collaborate with a client’s primary care provider to review the client’s diagnosis, treatment needs, and treatment plan before providing services to a client with an identified clinical or developmental need or collaborate with the client’s treatment team while providing music therapy services to the client.

(c) Conduct a music therapy assessment of a client to determine if treatment is indicated and, if treatment is indicated, collect systematic, comprehensive, and accurate information to determine the appropriateness and type of music therapy services to provide for the client.

(d) Develop an individualized music therapy treatment plan, including individualized goals, objectives, and specific music therapy approaches or interventions, for the client that is consistent with any other developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness, or educational services being provided to the client.

(e) Evaluate the client’s response to music therapy and the music therapy treatment plan, documenting change and progress and suggesting modifications, as appropriate.

(f) Develop a plan for determining when music therapy services are no longer needed, in collaboration with the client.

and the client’s physician or other provider of health care or education to the client, family members of the client, and any other appropriate person upon whom the client relies for support.

(g) Minimize barriers to ensure that the client receives music therapy services in the least restrictive environment.

(h) 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.

(i) Use appropriate knowledge and skills to inform practice, including the use of research, reasoning, and problem-solving skills to determine appropriate actions in the context of each specific clinical setting.

(5) PROHIBITED ACTS; EXEMPTIONS.—A person may not practice music therapy or represent himself or herself as being able to practice music therapy in this state unless the person is registered pursuant to this section. This section does not prohibit or restrict the practice, services, or activities of the following:

(a) A person licensed, certified, or regulated under the laws of this state in another profession or occupation, 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, if that person does not represent himself or herself as a music therapist;

(b) A person whose training and national certification are deletions; words underlined are additions.
attests to the person’s preparation and ability to practice his or her certified profession or occupation, if that person does not represent himself or herself as a music therapist;

(c) Any practice of music therapy as an integral part of a program of study for students enrolled in an accredited music therapy program, if the student does not represent himself or herself as a music therapist; or

(d) A person who practices music therapy under the supervision of a registered music therapist, if the person does not represent himself or herself as a music therapist.

(6) DEPARTMENT AUTHORITY.—

(a) The department is authorized to establish application, registration, and renewal fees estimated necessary to implement the provisions of this section, but each fee may not exceed $50.

(b) The department is authorized to adopt rules to implement this section.

(c) The department may deny or revoke registration or renewal of registration for violations of this section.

Section 2. This act shall take effect July 1, 2016.
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.

Senator Aaron Bean  
Florida Senate, District 4
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. 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 devices which are used to collect and transmit data for monitoring and interpretation.

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:

- 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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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,
patient, or both; and remote patient monitoring. Florida, Idaho, and Montana only provide reimbursement for physician services.\textsuperscript{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.\textsuperscript{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.”\textsuperscript{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.\textsuperscript{13} However, the Ryan Haight Online Pharmacy Consumer Protection Act,\textsuperscript{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.\textsuperscript{15} The federal regulatory definition of telemedicine under the DEA includes, but is not limited to, the following elements:

\textsuperscript{10} Supra note 7.
\textsuperscript{12} Id.
\textsuperscript{13} 21 CFR §829(e)(2).
\textsuperscript{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.\(^\text{16}\)

**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.\(^\text{17}\)

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.\(^\text{18}\)

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

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\(^{16}\) 21 CFR §802(54).
• 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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\(^{21}\) *Supra*, Note 19.

\(^{22}\) See 42 U.S.C. s. 1395(m)(m)(2)(A).

\(^{23}\) *Supra* note 19.

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. 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.

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

- **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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26 Id at 137.
• 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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.

\textbf{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 medially-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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{33} Twenty-four hub sites throughout the state facilitate these child abuse

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.

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.

\(^{36}\) 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.

\(^ {40}\) Id at 5.
\(^ {42}\) 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.
Florida Senate - 2016

CS for SB 1686

By the Committee on Health Policy; and Senators Bean and Joyner

A bill to be entitled

An act relating to telehealth; creating s. 408.61, F.S.; 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; providing for the membership of the task force; requiring the task force to compile and analyze certain data and to conduct a comparative analysis of health insurance coverage available for telehealth services and for in-person treatment; providing meeting requirements; requiring the task force to submit a report to the Governor and Legislature by a certain date; providing for the repeal of the section; creating s. 456.51, F.S.; authorizing certain licensed or certified health care professionals to provide telehealth services; defining the term “telehealth”; amending s. 636.202, F.S.; excluding telehealth products from the definition of “discount medical plan”; providing an effective date.

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

Section 1. Section 408.61, Florida Statutes, is created to read:

408.61 Telehealth Task Force.—

(1) The Telehealth Task Force is created within the agency. The agency shall use existing and available resources to administer and support the activities of the task force under this section.

(2) Members of the task force shall serve without compensation and are not entitled to reimbursement for per diem or travel expenses. The task force shall consist of the following 19 members:

(a) The Secretary of Health Care Administration or his or her designee, who shall serve as the chair of the task force.

(b) The State Surgeon General or his or her designee.

(c) 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, all appointed by the Secretary of Health Care Administration.

(d) Five health care practitioners, each of whom practices in a different area of medicine, and two representatives of organizations that represent health care practitioners, all appointed by the State Surgeon General.

(3) The task force shall compile and analyze data and information on the following:

(a) The frequency and extent of the use of telehealth technology and equipment by health care practitioners and health care facilities nationally and in this state.

(b) The costs and cost savings associated with using telehealth technology and equipment.

(c) The types of telehealth services available.

(d) The extent of available health insurance coverage for telehealth services. The task force shall conduct a comparative analysis of such coverage to available coverage for in-person services. The analysis must include:

1. Covered medical or other health care services.
Section 456.51, Florida Statutes, is created to read:

2. A description of payment rates for such telehealth services and whether they are below, equal to, or above payment rates for in-person services.

3. Annual and lifetime dollar maximums on coverage for telehealth and in-person services.

4. Copayment, coinsurance, and deductible amounts; policy year, calendar year, lifetime, or other durational benefit limitations; and maximum benefits for telehealth and in-person services.

5. Any unique conditions imposed as a prerequisite to obtaining coverage for telehealth services.

(e) Barriers to implementing the use of, using, or accessing telehealth services.

(f) Consideration of opportunities for interstate cooperation in telehealth.

(4) The task force shall convene its first meeting by September 1, 2016, and shall meet as often as necessary to fulfill its responsibilities under this section. Meetings may be conducted in person, by teleconference, or by other electronic means.

(5) The task force shall submit a report by June 30, 2017, to the Governor, the President of the Senate, and the Speaker of the House of Representatives which includes its findings, conclusions, and recommendations.

(6) This section is repealed effective December 1, 2017.

Section 2. Section 456.51, Florida Statutes, is created to read:

456.51 Telehealth.—

(i) A health care practitioner, a person certified under part III of chapter 401, or a person certified under part IV of chapter 468 who is practicing within the scope of his or her license or certification may provide telehealth services. A practitioner or person who is not a physician, but who provides telehealth services within the scope of his or her license or certification, may not be considered to be practicing medicine without a license.

(2) As used in this section, the term "telehealth" means 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 or V 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. Subsection (1) of section 636.202, Florida Statutes, is amended to read:

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

(1) "Discount medical plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. The term "discount medical plan" does not include any product regulated under chapter 627, chapter 641, or part I of this chapter, or any telehealth product defined under s. 456.51, F.S.

Section 4. This act shall take effect July 1, 2016.
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
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

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

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² See s. 393.0662(1), F.S., provides eligibility for individuals with a diagnosis of Down syndrome.


⁴ Id.

⁵ Id.

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.
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.
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\(^\text{16}\) 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.\(^\text{17}\) 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.\(^\text{18}\)

**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.\(^\text{19}\) 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.\(^\text{20}\)

**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.\(^\text{21}\) 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

\(^\text{16}\) See Specific Appropriation 265 and section 41, ch. 2015-232, Laws of Florida.


\(^\text{18}\) Agency for Persons with Disabilities, *Agency Analysis of SB 7054* (on file with the Senate Committee on Children, Families, and Elder Affairs).

\(^\text{19}\) Id.


\(^\text{21}\) 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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{26}

\textbf{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{29}

\textsuperscript{22} See s. 393.11(4),(5), F.S.
\textsuperscript{23} See s. 393.11(6), F.S.
\textsuperscript{24} See s. 393.11(7), F.S.
\textsuperscript{25} See s. 393.11(11), F.S.
\textsuperscript{26} See s. 393.11(13), F.S.
\textsuperscript{27} See AdvoServ: Carlton Palms Educational Center, available at \url{http://www.advoserv.com/programs/florida-program/carlton-palms-education-center/} (last visited Feb. 4, 2016).
\textsuperscript{28} See s. 393.18, F.S.
\textsuperscript{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.\textsuperscript{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

\textsuperscript{30} See s. 393.18(4), Note (4), F.S.
Budget 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.
Appropriations Subcommittee on Health and Human Services (Sobel) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 393.063, Florida Statutes, is reordered and amended to read:

393.063 Definitions.—For the purposes of this chapter, the term:

(2). Agency “Agency” means the Agency for Persons with Disabilities.
(1) “Adult day training” means training services that take place in a nonresidential setting, separate from the home or facility in which the client resides, and are intended to support the participation of clients in daily, meaningful, and valued routines of the community. Such training may be included work-like settings that do not meet the definition of supported employment.

(3) “Algorithm” means the mathematical formula used by the agency to calculate a budget amount for clients using variables that have statistically validated relationships to clients’ needs for services provided by the home and community-based Medicaid waiver program.

(4) “Allocation methodology” means the process used to determine a client’s iBudget by summing the amount generated by the algorithm and, if applicable, any funding authorized by the agency for the client pursuant to s. 393.0662(1)(b).

(5) “Autism” means a pervasive, neurologically based developmental disability of extended duration which causes severe learning, communication, and behavior disorders with age of onset during infancy or childhood. Individuals with autism exhibit impairment in reciprocal social interaction, impairment in verbal and nonverbal communication and imaginative ability, and a markedly restricted repertoire of activities and interests.

(6) “Cerebral palsy” means a group of disabling symptoms of extended duration which results from damage to the developing brain that may occur before, during, or after birth and that results in the loss or impairment of control over voluntary muscles. For the purposes of this definition, cerebral palsy
does not include those symptoms or impairments resulting solely from a stroke.

(7) “Client” means any person determined eligible by the agency for services under this chapter.

(8) “Client advocate” means a friend or relative of the client, or of the client’s immediate family, who advocates for the best interests of the client in any proceedings under this chapter in which the client or his or her family has the right or duty to participate.

(9) “Comprehensive assessment” means the process used to determine eligibility for services under this chapter.

(10) “Comprehensive transitional education program” means the program established in s. 393.18.

(11) “Developmental disability” means a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, 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.

(12) “Developmental disabilities center” means a state-owned and state-operated facility, formerly known as a “Sunland Center,” providing for the care, habilitation, and rehabilitation of clients with developmental disabilities.

(13) “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) “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) "Down syndrome" means a disorder caused by the presence of an extra chromosome 21.

(16) "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) "Family care program" means the program established in s. 393.068.

(18) "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) "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) "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) “Habilitation” means the process by which a client is assisted in acquiring and maintaining those life skills that 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. The term includes, but is not limited to, programs of formal structured education and treatment.

(23) “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 associated with developmental disability.

(24) “Intellectual disability” means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior which manifests before the age of 18 and can reasonably be expected to continue indefinitely. For the purposes of this definition, the term:

(a) “Adaptive behavior” means the effectiveness or degree with which an individual meets the standards of personal
independence and social responsibility expected of his or her
age, cultural group, and community.

(b) “Significantly subaverage general intellectual
functioning” means performance that is two or more standard
deviations from the mean score on a standardized intelligence
test specified in the rules of the agency.

For purposes of the application of the criminal laws and
procedural rules of this state to matters relating to pretrial, trial, sentencing, and any matters relating to the imposition
and execution of the death penalty, the terms “intellectual
disability” or “intellectually disabled” are interchangeable
with and have the same meaning as the terms “mental retardation” or “retardation” and “mentally retarded” as defined in this
section before July 1, 2013.

(25) “Intermediate care facility for the
developmentally disabled” or “ICF/DD” means a residential
facility licensed and certified under part VIII of chapter 400.

(26) “Medical/dental services” means medically
necessary services that are provided or ordered for a client by
a person licensed under chapter 458, chapter 459, or chapter
466. Such services may include, but are not limited to,
prescription drugs, specialized therapies, nursing supervision,
hospitalization, dietary services, prosthetic devices, surgery,
specialized equipment and supplies, adaptive equipment, and
other services as required to prevent or alleviate a medical or
dental condition.

(27) “Personal care services” means individual
assistance with or supervision of essential activities of daily

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living for self-care, including ambulation, bathing, dressing, eating, grooming, and toileting, and other similar services that are incidental to the care furnished and essential to the health, safety, and welfare of the client if no one else is available to perform those services.

(28)(25) “Prader-Willi syndrome” means an inherited condition typified by neonatal hypotonia with failure to thrive, hyperphagia or an excessive drive to eat which leads to obesity usually at 18 to 36 months of age, mild to moderate intellectual disability, hypogonadism, short stature, mild facial dysmorphism, and a characteristic neurobehavior.

(29)(26) “Relative” means an individual who is connected by affinity or consanguinity to the client and who is 18 years of age or older.

(30)(27) “Resident” means a person who has a developmental disability and resides at a residential facility, whether or not such person is a client of the agency.

(31)(28) “Residential facility” means a facility providing room and board and personal care for persons who have developmental disabilities.

(32)(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.

(33)(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.

(34) “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.

(35) “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.

(36)(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.

(37)(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.

(38)(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.

(39)(36) “Spina bifida” means, for purposes of this chapter, a person with a medical diagnosis of spina bifida cystica or myelomeningocele.

(40)(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.

(41) “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.

(42) “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.

(43) “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.

(44) “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. Present subsections (6) and (7) of section 393.065, Florida Statutes, are redesignated as subsections (7) and (9), respectively, subsections (3) and (5) and present subsections (6) and (7) of that section are amended, 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 clients on the waiting list who are:

1. From the child welfare system with an open case in the Department of Children and Families’ statewide automated child welfare information system and who are:
   a. Transitioning out of the child welfare system at the finalization of an adoption, a reunification with a family member, 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 who need both waiver services and extended foster care services; or

2. At least 18 years old, but not yet 22 years old, and who withdrew consent pursuant to s. 39.6251(5)(c) to remain in extended foster care.

For clients who are eligible under sub-subparagraph 1.b., the agency shall provide waiver services, including residential
habilitation, and the community-based care lead agency shall 
fund room and board at the rates established in s. 409.145(4) 
and provide case management and related services as defined in 
s. 409.986(3)(e). Such clients may receive both waiver services 
and services under s. 39.6251 which may not duplicate services 
available through the Medicaid state plan.

(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 cannot 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.

Within categories 3, 4, 5, 6, and 7, the agency shall maintain a waiting list of clients placed in the order of the date that the client is determined eligible for waiver services.

(6) The agency shall allow an individual who meets the eligibility requirements pursuant to subsection (1) to receive home and community-based services in this state if the individual’s parent or legal guardian is an active duty military servicemember and if at the time of the servicemember’s transfer to this state, the individual was receiving home and community-based services in another state.

(7) The client, the client’s guardian, or the client’s family must ensure that accurate, up-to-date contact information is provided to the agency at all times. Notwithstanding s. 393.0651, the agency shall send an annual letter requesting updated information from the client, the client’s guardian, or the client’s family. The agency shall remove from the waiting list any individual who cannot be located using the contact information provided to the agency, fails to meet eligibility requirements, or becomes domiciled outside the state.

(8) Agency action that selects individuals to receive
waiver services pursuant to this section does not establish a right to a hearing or an administrative proceeding under chapter 120 for individuals remaining on the waiting list.

(9)(7) The agency and the Agency for Health Care Administration may adopt rules specifying application procedures, criteria associated with the waiting list categories, procedures for administering the waiting list, including tools for prioritizing waiver enrollment within categories, and eligibility criteria as needed to administer this section.

Section 4. Subsection (2) of section 393.066, Florida Statutes, is amended to read:

393.066 Community services and treatment.—

(2) Necessary All services needed shall be purchased, rather than provided directly by the agency, when the purchase of services such arrangement is more cost-efficient than providing them having those services provided directly. All purchased services must be approved by the agency. Persons or entities under contract with the agency to provide services shall use agency data management systems to document service provision to clients. Contracted persons and entities shall meet the minimum hardware and software technical requirements established by the agency for the use of such systems. Such persons or entities shall also meet any requirements established by the agency for training and professional development of staff providing direct services to clients.

Section 5. Section 393.0662, Florida Statutes, is amended to read:

393.0662 Individual budgets for delivery of home and
community-based services; iBudget system established.—The Legislature finds that improved financial management of the existing home and community-based Medicaid waiver program is necessary to avoid deficits that impede the provision of services to individuals who are on the waiting list for enrollment in the program. The Legislature further finds that clients and their families should have greater flexibility to choose the services that best allow them to live in their community within the limits of an established budget. Therefore, 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 which 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 algorithm.

(a) In developing each client’s iBudget, the agency shall use the 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.

(c) The agency may authorize funding approve an increase in the amount of funds allocated, as determined by the algorithm, based on 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 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 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. 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. 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. 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 budget 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 in and of itself warrant authorized funding by the agency 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 which 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 authorized funding by the agency 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 adjustments required pursuant to this paragraph and may use the services of an independent actuary in determining the amount of the portions to be reserved.

(d) (c) A client’s iBudget shall be the total of the amount determined by the algorithm and any additional funding provided pursuant to paragraph (b). A client’s annual expenditures for home and community-based services Medicaid waiver services may not exceed the limits of his or her iBudget. The total of all clients’ projected annual iBudget expenditures may not exceed the agency’s appropriation for waiver services.

(2) The Agency for Health Care Administration, in consultation with the agency, shall seek federal approval to amend current waivers, request a new waiver, and amend contracts as necessary to manage the iBudget system, to improve services for eligible and enrolled clients, and to improve the delivery of services implement the iBudget system to serve eligible, enrolled clients through the home and community-based services Medicaid waiver program and the Consumer-Directed Care Plus Program.
(3) The agency shall transition all eligible, enrolled clients to the iBudget system. The agency may gradually phase in the iBudget system.

(a) While the agency phases in the iBudget system, the agency may continue to serve eligible, enrolled clients under the four-tiered waiver system established under s. 393.065 while those clients await transitioning to the iBudget system.

(b) The agency shall design the phase-in process to ensure that a client does not experience more than one-half of any expected overall increase or decrease to his or her existing annualized cost plan during the first year that the client is provided an iBudget due solely to the transition to the iBudget system.

(3)(4) A client must use all available services authorized under the state Medicaid plan, school-based services, private insurance and other benefits, and any other resources that may be available to the client before using funds from his or her iBudget to pay for support and services.

(4)(5) The service limitations in s. 393.0661(3)(f)1., 2., and 3. do not apply to the iBudget system.

(5)(6) Rates for any or all services established under rules of the Agency for Health Care Administration shall be designated as the maximum rather than a fixed amount for individuals who receive an iBudget, except for services specifically identified in those rules that the agency determines are not appropriate for negotiation, which may include, but are not limited to, residential habilitation services.

(6)(7) The agency shall ensure that clients and caregivers
have access to training and education that inform them about the iBudget system and enhance their ability for self-direction. Such training and education must be offered in a variety of formats; and at a minimum, must address the policies and processes of the iBudget system and the roles and responsibilities of consumers, caregivers, waiver support coordinators, providers, and the agency. Information available to help the client make decisions regarding the iBudget system; and must provide examples of support and resources available in the community.

(7)(8) The agency shall collect data to evaluate the implementation and outcomes of the iBudget system.

(8)(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...
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 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 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 are 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 are necessary and, if not provided, would result in a threat of substantial harm to the person’s well-being; or
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.e. 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'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 required before a guardian ad litem is appointed pursuant to this section.

(7) HEARING.—

(d) The person who has the intellectual disability or autism must be physically present throughout the entire proceeding. If the person’s attorney believes that the person’s presence at the hearing is not in his or her best interest, the person’s presence may be waived once the court has seen the person and the hearing has commenced.

(10) COMPETENCY.—

(a) The issue of competency is separate and distinct from a determination of the appropriateness of involuntary admission to residential services due to intellectual disability or autism.

(b) The issue of the competency of a person who has an intellectual disability or autism for purposes of assigning guardianship shall be determined in a separate proceeding according to the procedures and requirements of chapter 744. The issue of the competency of a person who has an intellectual disability or autism for purposes of determining whether the person is competent to proceed in a criminal trial shall be
determined in accordance with chapter 916.

(12) APPEAL.—

(b) The filing of an appeal by the person who has an intellectual disability or autism stays admission of the person into residential care. The stay remains in effect during the pendency of all review proceedings in Florida courts until a mandate issues.

(14) REVIEW OF CONTINUED INVOLUNTARY ADMISSION TO RESIDENTIAL SERVICES.—

(a) If a person is involuntarily admitted to residential services provided by the agency, the agency shall employ or, if necessary, contract with a qualified evaluator to conduct a review annually, unless otherwise ordered, to determine the appropriateness of the person’s continued involuntary admission to residential services based on the criteria in paragraph (8)(b). The review must include an assessment of the most appropriate and least restrictive type of residential placement for the person.

(b) A placement resulting from an involuntary admission to residential services must be reviewed by the court at a hearing annually, unless a shorter review period is ordered. The agency shall provide to the court the completed reviews by the qualified evaluator. The review hearing must determine whether the person continues to meet the criteria in paragraph (8)(b) and, if so, whether the person still requires involuntary placement in a residential setting and whether the person is receiving adequate care, treatment, habilitation, and rehabilitation in the residential setting.

(c) The agency shall provide a copy of the annual review
and reasonable notice 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.

(d) As used in this subsection, the term “qualified evaluator” means a psychiatrist licensed under chapter 458 or chapter 459, or a psychologist licensed under chapter 490, who has demonstrated to the court an expertise in the diagnosis, evaluation, and treatment of persons with intellectual disabilities.

Section 8. For the purpose of incorporating the amendment made by this act to section 393.18, Florida Statutes, in a reference thereto, subsection (15) of section 393.067, Florida Statutes, is reenacted to read:

393.067 Facility licensure.—
(15) The agency is not required to contract with facilities licensed pursuant to this chapter.

Section 9. Section 26 of chapter 2015-222, Laws of Florida, is repealed.

Section 10. Section 393.18, Florida Statutes, is reenacted and amended to read:

393.18 Comprehensive transitional education program.—A comprehensive transitional education program serves individuals is a group of jointly operating centers or units, the collective purpose of which is to provide a sequential series of educational care, training, treatment, habilitation, and rehabilitation services to persons who have developmental disabilities, and who have severe or moderate maladaptive behaviors, severe maladaptive behaviors and co-occurring complex medical conditions, or a dual diagnosis of developmental
disability and mental illness. However, this section does not require such programs to provide services only to persons with developmental disabilities. All such Services provided by the program must be temporary in nature and delivered in a manner designed to achieve structured residential setting, having the primary goal of incorporating the principles of self-determination and person-centered planning to transition individuals to the most appropriate, least restrictive community living option of their choice which is not operated as a in establishing permanent residence for persons with maladaptive behaviors in facilities that are not associated with the comprehensive transitional education program. The supervisor of the clinical director of the program licensee must hold a doctorate degree with a primary focus in behavior analysis from an accredited university, be a certified behavior analyst pursuant to s. 393.17, and have at least 1 year of experience in providing behavior analysis services for individuals with developmental disabilities. The staff shall include behavior analysts and teachers, as appropriate, who must be available to provide services in each component center or unit of the program. A behavior analyst must be certified pursuant to s. 393.17.

(1) Comprehensive transitional education programs must include a minimum of two component centers or units, one of which shall be an intensive treatment and educational center or a transitional training and educational center, which provides services to persons with maladaptive behaviors in the following components sequential order:

(a) Intensive treatment and education educational center.
This component provides is a self-contained residential unit providing intensive behavioral and educational programming for individuals whose conditions persons with severe maladaptive behaviors whose behaviors preclude placement in a less restrictive environment due to the threat of danger or injury to themselves or others. Continuous-shift staff are shall be required for this component.

(b) Intensive Transitional training and education educational center.—This component provides is a residential unit for persons with moderate maladaptive behaviors providing concentrated psychological and educational programming that emphasizes a transition toward a less restrictive environment. Continuous-shift staff are shall be required for this component.

(c) Community Transition residence.—This component provides is a residential center providing educational programs and any support services, training, and care that are needed to assist persons with maladaptive behaviors to avoid regression to more restrictive environments while preparing them for more independent living. Continuous-shift staff are shall be required for this component.

(d) Alternative living center. This component is a residential unit providing an educational and family living environment for persons with maladaptive behaviors in a moderately unrestricted setting. Residential staff shall be required for this component.

(e) 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 school-aged 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 referring school district of each school-aged resident 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 centers of a the program authorized under this section may not 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 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

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 11. Subsection (2) of section 393.501, Florida
Statutes, is amended to read:

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 12. 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)
393.063(9).

Section 13. Paragraph (d) of subsection (2) of section
1002.385, Florida Statutes, is amended to read:

1002.385 Florida personal learning scholarship accounts.—
(2) DEFINITIONS.—As used in this section, the term:
(d) “Disability” means, for a 3- or 4-year-old child or for
a student in kindergarten to grade 12, autism spectrum disorder,
as defined in the Diagnostic and Statistical Manual of Mental
Disorders, Fifth Edition, published by the American Psychiatric
Association; cerebral palsy, as defined in s. 393.063(6)
393.063(4); Down syndrome, as defined in s. 393.063(15)
393.063(13); an intellectual disability, as defined in s.
393.063(24) s. 393.063(21); Prader-Willi syndrome, as defined in
s. 393.063(28) s. 393.063(25); or spina bifida, as defined in s.
393.063(39) s. 393.063(36); for a student in kindergarten, being
a high-risk child, as defined in s. 393.063(23)(a) or
393.063(20)(a); muscular dystrophy; and Williams syndrome.

Section 14. This act shall take effect 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.

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled An act relating to the Agency for Persons with Disabilities; amending s. 393.063, F.S.; redefining and defining terms; repealing s. 393.0641, F.S., relating to a program for the prevention and treatment of severe self-injurious behavior; amending s. 393.065, F.S.; providing for the assignment of priority to clients waiting for waiver services; requiring the agency to allow an individual to receive specified services if the individual’s parent or legal guardian is an active duty military servicemember, under certain circumstances; requiring the agency to send an annual letter requesting updated information to clients, their guardians, or their families;
providing that certain agency action does not establish a right to a hearing or an administrative proceeding; amending s. 393.066, F.S.; providing for the use of an agency data management system; providing requirements for persons or entities under contract with the agency; amending s. 393.0662, F.S.; revising the allocations methodology that the agency is required to use to develop each client’s iBudget; adding client needs that qualify as extraordinary needs, which may result in the approval of an increase in a client’s allocated funds; revising duties of the Agency for Health Care Administration relating to the iBudget system; creating s. 393.0679, F.S.; requiring the Agency for Persons with Disabilities to conduct a certain utilization review; requiring specified intermediate care facilities to comply with certain requests and inspections by the agency; amending s. 393.11, F.S.; providing for annual reviews for persons involuntarily committed to residential services; requiring the agency to employ or contract with a qualified evaluator; providing requirements for annual reviews; requiring a hearing to be held to consider the results of an annual review; requiring the agency to provide a copy of the review to certain persons; defining a term; reenacting s. 393.067(15), F.S., relating to contracts between the Agency for Persons with Disabilities and licensed facilities, to incorporate the amendments made to s. 393.18, F.S., in a reference thereto; repealing s. 26 of ch. 2015-222,
Laws of Florida, relating to the abrogation of the scheduled expiration of an amendment to s. 393.18, F.S., and the scheduled reversion of the text of that section; reenacting and amending s. 393.18, F.S.; revising the purposes of comprehensive transitional education programs; providing qualification requirements for the supervisor of the clinical director of a specified licensee; revising the organization and operation of components of a program; providing for the integration of educational components with the local school district; authorizing the agency to approve the admission or readmission of an individual to a program; providing for video and audio recording and monitoring of common areas and program activities and facilities; providing for licensure of such programs; amending s. 393.501, F.S.; conforming provisions to changes made by the act; amending ss. 383.141 and 1002.385, F.S.; conforming cross references; providing an effective date.
By the Committee on Children, Families, and Elder Affairs

A bill to be entitled An act relating to the Agency for Persons with Disabilities; amending s. 393.063, F.S.; revising and defining terms; repealing s. 393.0641, F.S., relating to a program for the prevention and treatment of severe self-injurious behavior; amending s. 393.065, F.S.; providing for the assignment of priority to clients waiting for waiver services; requiring an agency to allow a certain individual to receive such services if the individual’s parent or legal guardian is an active-duty military service member; requiring the agency to send an annual letter to clients and their guardians or families; providing that certain agency action does not establish a right to a hearing or an administrative proceeding; amending s. 393.066, F.S.; providing for the use of an agency data management system; providing requirements for persons or entities under contract with the agency; amending s. 393.0662, F.S.; adding client needs that qualify as extraordinary needs, which may result in the approval of an increase in a client’s allocated funds; revising duties of the Agency for Health Care Administration relating to the iBudget system; creating s. 393.0679, F.S.; requiring the Agency for Persons with Disabilities to conduct a certain utilization review; requiring certain intermediate care facilities to comply with certain requests and inspections by the agency; amending s. 393.11, F.S.; providing for annual reviews for persons involuntarily committed to residential services; requiring the agency to contract with a qualified evaluator; providing requirements for annual reviews; requiring a hearing to be held to consider the results of an annual review; requiring the agency to provide a copy of the review to certain persons; defining a term; repealing s. 26 of chapter 2015-222, Laws of Florida; abrogating the scheduled expiration of an amendment to s. 393.18, F.S., and the scheduled reversion of the text of that section; reenacting and amending s. 393.18, F.S.; revising the purposes of comprehensive transitional education programs; providing qualification requirements for the clinical director of a comprehensive transitional education program; revising the organization and operation of components of a program; providing for the integration of educational components with the local school district; authorizing the agency to approve the admission or readmission of an individual to a program; providing for video and audio recording and monitoring of common areas and program activities and facilities; providing for licensure of such programs; amending s. 393.501, F.S.; conforming provisions to changes made by the act; amending ss. 383.141 and 1002.385, F.S.; conforming cross references; providing an effective date.

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

Section 1. Section 393.063, Florida Statutes, is amended to read:

393.063 Definitions.—For the purposes of this chapter, the term:
"Agency" means the Agency for Persons with Disabilities.

"Adult day training" means training services that take place in a nonresidential setting, separate from the home or facility in which the client resides, and are intended to support the participation of clients in daily, meaningful, and valued routines of the community. Such training may be provided in work-like settings that do not meet the definition of supported employment.

"Algorithm" means the mathematical formula developed by the agency based upon statistically valid relationships between the need for services and selected health and social characteristics which is used to calculate a potential amount of financial support through the home and community-based services Medicaid waiver program.

"Allocation methodology" means the process for determining the IBudget allocation for an individual which considers:

(a) The algorithm amount applicable to an individual based on a formal assessment instrument used by the agency pursuant to s. 393.0661(1)(a); and

(b) Any needs identified by the agency during the client review process which cannot be accommodated within the funding determined by the algorithm and are provided for in s. 393.0662(1)(b).

"Autism" means a pervasive, neurologically based developmental disability of extended duration which causes severe learning, communication, and behavior disorders with age of onset during infancy or childhood. Individuals with autism exhibit impairment in reciprocal social interaction, impairment in verbal and nonverbal communication and imaginative ability, and a markedly restricted repertoire of activities and interests.

"Cerebral palsy" means a group of disabling symptoms of extended duration which results from damage to the developing brain that may occur before, during, or after birth and that results in the loss or impairment of control over voluntary muscles. For the purposes of this definition, cerebral palsy does not include those symptoms or impairments resulting solely from a stroke.

"Client" means any person determined eligible by the agency for services under this chapter.

"Client advocate" means a friend or relative of the client, or of the client’s immediate family, who advocates for the best interests of the client in any proceedings under this chapter in which the client or his or her family has the right or duty to participate.

"Comprehensive assessment" means the process used to determine eligibility for services under this chapter.

"Comprehensive transitional education program" means the program established in s. 393.18.

"Developmental disability" means a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, 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.

"Developmental disabilities center" means a state...
120 owned and state-operated facility, formerly known as a “Sunland Center,” providing for the care, habilitation, and rehabilitation of clients with developmental disabilities.

121 “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.

122 “Domicile” means the place where a client legally resides and which 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.

123 “Down syndrome” means a disorder caused by the presence of an extra chromosome 21.

124 “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.

125 “Family care program” means the program established in s. 393.068.

126 “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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CODING: Words are deletions; words are additions.
associated with developmental disability.

(24) "Initial support plan" means the first support plan that identifies the needs of the individual for supports and services prior to enrollment in the iBudget waiver.

(25) "Intellectual disability" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior which manifests before the age of 18 and can reasonably be expected to continue indefinitely. For the purposes of this definition, the term:

(a) "Adaptive behavior" means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age, cultural group, and community.

(b) "Significantly subaverage general intellectual functioning" means performance that is two or more standard deviations from the mean score on a standardized intelligence test specified in the rules of the agency.

For purposes of the application of the criminal laws and procedural rules of this state to matters relating to pretrial, trial, sentencing, and any matters relating to the imposition and execution of the death penalty, the terms "intellectual disability" or "intellectually disabled" are interchangeable with and have the same meaning as the terms "mental retardation" or "retardation" and "mentally retarded" as defined in this section before July 1, 2013.

(26) "Intermediate care facility for the developmentally disabled" or "ICF/DD" means a residential facility licensed and certified under part VIII of chapter 400.

(27) "Medical/dental services" means medically necessary services that are provided or ordered for a client by a person licensed under chapter 458, chapter 459, or chapter 466. Such services may include, but are not limited to, prescription drugs, specialized therapies, nursing supervision, hospitalization, dietary services, prosthetic devices, surgery, specialized equipment and supplies, adaptive equipment, and other services as required to prevent or alleviate a medical or dental condition.

(28) "Personal care services" means individual assistance with or supervision of essential activities of daily living for self-care, including ambulation, bathing, dressing, eating, grooming, and toileting, and other similar services that are incidental to the care furnished and essential to the health, safety, and welfare of the client if no one else is available to perform those services.

(29) "Prader-Willi syndrome" means an inherited condition typified by neonatal hypotonia with failure to thrive, hyperphagia or an excessive drive to eat which leads to obesity usually at 18 to 36 months of age, mild to moderate intellectual disability, hypogonadism, short stature, mild facial dysmorphism, and a characteristic neurobehavior.

(30) "Relative" means an individual who is connected by affinity or consanguinity to the client and who is 18 years of age or older.

(31) "Resident" means a person who has a developmental disability and resides at a residential facility, whether or not such person is a client of the agency.

(32) "Resident alien" means a person who is not a citizen.
A physical restraint is any manual method or physical

Restraint does not include physical devices, such as

A drug used as a restraint is a medication used to

Seclusion means the involuntary isolation of a

Respite service means appropriate, short-term,

Restraint means a physical device, method, or
drug used to control dangerous behavior.

(a) A physical restraint is any manual method or physical
“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.

“Spina bifida” means, for purposes of this chapter, a person with a medical diagnosis of spina bifida cystica or myelomeningocele.

“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.

“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.

“Supported living” means a category of

...
(b) Category 2, which includes: children on the waiting 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:

1. Individuals who are from the child welfare system pursuant to § 409.415(4) and provide case management and related services as defined in § 409.986(3)(e).

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 § 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 lead agency shall fund room and board at the rate established in § 409.145(4) and provide case management and related services as defined in § 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, 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.
Within categories 3, 4, 5, 6, and 7, the agency shall maintain a waiting list of clients placed in the order of the date that the client is determined eligible for waiver services.

(6) The agency shall allow an individual who meets the eligibility requirements under subsection (1) to receive home and community-based services in this state if the individual’s parent or legal guardian is an active-duty military service member and if at the time of the service member’s transfer to this state, the individual was receiving home and community-based services in another state.

(7) The client, the client’s guardian, or the client’s family must ensure that accurate, up-to-date contact information is provided to the agency at all times. Notwithstanding s. 393.0651, the agency shall send an annual letter requesting updated information from the client, the client’s guardian, or the client’s family. The agency shall remove from the waiting list any individual who cannot be located using the contact information provided to the agency, fails to meet eligibility requirements, or becomes domiciled outside the state.

(8) Agency action that selects individuals to receive waiver services pursuant to this section does not establish a right to a hearing or an administrative proceeding under chapter 120 for individuals remaining on the waiting list.

(9) The agency and the Agency for Health Care Administration may adopt rules specifying application procedures, criteria associated with the waiting list categories, procedures for administering the waiting list, including tools for prioritizing waiver enrollment within categories, and eligibility criteria as needed to administer this section.

Section 4. Subsection (2) of section 393.066, Florida Statutes, is amended to read:

(2) Necessary all services needed shall be purchased, rather than instead of provided directly by the agency, when the purchase of services such arrangement is more cost-efficient than providing them having those services provided directly. All purchased services must be approved by the agency. Persons or entities under contract with the agency to provide services shall use agency data management systems to document service provision to clients. Contracted persons and entities shall meet the minimum hardware and software technical requirements established by the agency for the use of such systems. Such persons or entities shall also meet any requirements established by the agency for training and professional development of staff providing direct services to clients.

Section 5. Section 393.0662, Florida Statutes, is amended to read:

393.0662 Individual budgets for delivery of home and community-based services; iBudget system established.—The Legislature finds that improved financial management of the existing home and community-based Medicaid waiver program is necessary to avoid deficits that impede the provision of services to individuals who are on the waiting list for enrollment in the program. The Legislature further finds that clients and their families should have greater flexibility to choose the services that best allow them to live in their community within the limits of an established budget. Therefore,
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 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
dservices 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 documented history of significant, potentially life-
threatening behaviors, such as recent attempts at suicide,
arson, nonconsensual sexual behavior, or self-injurious behavior requiring medical attention;

A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a nonlicensed person;

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

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...
adjustments required pursuant to this paragraph and may use the
services of an independent actuary in determining the amount of
the portions to be reserved.

(c) A client’s iBudget shall be the total of the amount
determined by the algorithm and any additional funding provided
pursuant to paragraph (b). A client’s annual expenditures for
home and community-based services Medicaid waiver services may
not exceed the limits of his or her iBudget. The total of all
clients’ projected annual iBudget expenditures may not exceed
the agency’s appropriation for waiver services.

(2) The Agency for Health Care Administration, in
consultation with the agency, shall seek federal approval to
amend current waivers, request a new waiver, and amend contracts
as necessary to manage the iBudget system, to improve services
for eligible and enrolled clients, and to improve the delivery
of services that implement the iBudget system to serve eligible,
enrolled clients through the home and community-based services
Medicaid waiver program and the Consumer-Directed Care Plus
Program to persons with a dual diagnosis of a developmental
disability and a mental health diagnosis.

(3) The agency shall transition all eligible, enrolled
clients to the iBudget system. The agency may gradually phase in
the iBudget system.

(a) While the agency phases in the iBudget system, the
agency may continue to serve eligible, enrolled clients under
the four-tiered waiver system established under s. 393.065 while
those clients await transitioning to the iBudget system.

(b) The agency shall design the phase-in process to ensure
that a client does not experience more than one-half of any
annualized cost plan during the first year that the client is
provided an iBudget due solely to the transition to the iBudget
system.

(3) A client must use all available services authorized
under the state Medicaid plan, school-based services, private
insurance and other benefits, and any other resources that may
be available to the client before using funds from his or her
iBudget to pay for support and services.

(4) The service limitations in s. 393.061(3)(f)1., 2., and
3. do not apply to the iBudget system.

(5) Rates for any or all services established under
rules of the Agency for Health Care Administration must shall be
designated as the maximum rather than a fixed amount for
individuals who receive an iBudget, except for services
specifically identified in those rules that the agency
determines are not appropriate for negotiation, which may
include, but are not limited to, residential habilitation
services.

(5) The agency shall ensure that clients and caregivers
have access to training and education that inform them about
the iBudget system and enhance their ability for self-direction.
Such training and education must be offered in a variety
of formats and, at a minimum, must address the policies
and processes of the iBudget system and the roles and
responsibilities of consumers, caregivers, waiver support
coordinators, providers, and the agency, and must provide
information available to help the client make decisions
regarding the iBudget system and examples of support and
Involuntary admission to residential services.—

(1) JURISDICTION.—If a person has an intellectual 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

CODING: Words underlined are additions; words underlined are deletions.
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
   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’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
(7) HEARING.—

(d) The person who has the intellectual disability or autism must be physically present throughout the entire proceeding. If the person’s attorney believes that the person’s presence at the hearing is not in his or her best interest, the person’s presence may be waived once the court has seen the person and the hearing has commenced.

(10) COMPETENCY.—

(a) The issue of competency is separate and distinct from a determination of the appropriateness of involuntary admission to residential services due to intellectual disability or autism.

(b) The issue of the competency of a person who has an intellectual disability or autism for purposes of assigning guardianship shall be determined in a separate proceeding according to the procedures and requirements of chapter 744. The issue of the competency of a person who has an intellectual disability or autism for purposes of determining whether the person is competent to proceed in a criminal trial shall be determined in accordance with chapter 916.

(12) APPEAL.—

(b) The filing of an appeal by the person who has an intellectual disability or autism stays admission of the person into residential care. The stay remains in effect during the pendency of all review proceedings in Florida courts until a mandate issues.

(14) COMMITMENT REVIEW.—

(a) For persons involuntarily admitted to residential

services by court order pursuant to this section, such involuntary admission, unless otherwise ordered by the court, must be reviewed annually. Placements resulting from an order for involuntary admission must be part of the review. The agency shall contract with a qualified evaluator to perform such reviews which must be provided to the court upon completion.

(b) Upon receipt of an annual review by the court, a hearing must be held to consider the results of the review and to determine whether the person continues to meet the criteria specified in paragraph (8)(b). If the person continues to meet the criteria, the court shall determine whether he or she still requires involuntary admission to a residential setting, whether the person is in the most appropriate and least restrictive setting, and whether the person is receiving adequate care, treatment, habilitation, and rehabilitation in the residential setting.

(c) The agency shall provide a copy of the annual review and reasonable notice 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.

(d) For purposes of this subsection, the term "qualified evaluator" means a licensed psychologist with expertise in the diagnosis, evaluation, and treatment of persons with intellectual disabilities or autism.

Section 8. Section 26 of chapter 2015-222, Laws of Florida, is repealed.

Section 9. Section 393.18, Florida Statutes, is reenacted and amended to read:

393.18 Comprehensive transitional education program.—A...
Comprehensive transitional education programs serve individuals in a group of jointly operating centers or units, the collective purpose of which is to provide a sequential series of educational care, training, treatment, habilitation, and rehabilitation services to persons who have developmental disabilities, and who have severe or moderate maladaptive behaviors, severe maladaptive behaviors and co-occurring complex medical conditions, or a dual diagnosis of developmental disability and mental illness. However, this section does not require such programs to provide services only to persons with developmental disabilities. All such Services provided by the program must be temporary in nature and delivered in a manner designed to achieve structured residential setting, having the primary goal of incorporating the principle of self-determination and person-centered planning to transition individuals to the most appropriate, least restrictive community living option of their choice which is not operated as a to establishing permanent residence for persons with maladaptive behaviors in facilities that are not associated with the comprehensive transitional education program. The clinical director of the program must hold a doctorate degree with a primary focus in behavior analysis from an accredited university, be a certified behavior analyst pursuant to s. 393.17, and have at least 1 year of experience in providing behavior analysis services for individuals with developmental disabilities. The staff must include behavior analysts and teachers, as appropriate, who must be available to provide services in each component center or unit of the program. A behavior analyst must be certified pursuant to s. 393.17.

(1) Comprehensive transitional education programs must shall include a minimum of two component centers or units, one of which shall be an intensive treatment and educational center or a transitional training and educational center, which provides services to persons with maladaptive behaviors in the following components in sequential order:

(a) Intensive treatment and education educational centers.—This component provides a self-contained residential unit providing intensive behavioral and educational programming for individuals whose conditions persons with severe maladaptive behaviors whose behaviors preclude placement in a less restrictive environment due to the threat of danger or injury to themselves or others. Continuous-shift staff are shall be required for this component.

(b) Intensive Transitional training and education educational centers.—This component provides a residential unit for persons with moderate maladaptive behaviors providing concentrated psychological and educational programming that emphasizes a transition toward a less restrictive environment. Continuous-shift staff are shall be required for this component.

(c) Community Transition residences.—This component provides a residential center providing educational programs and any support services, training, and care that are needed to assist persons with maladaptive behaviors to avoid regression to more restrictive environments while preparing them for more independent living. Continuous-shift staff may shall be required for this component.

(d) Alternative living centers.—This component is a residential unit providing an educational and family living...
Components of a comprehensive transitional education program 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.

(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 are being provided with services in any instance exceed the licensed capacity of 120 residents, and each residential unit within the component.

(8) Licensure is authorized for a comprehensive

(4) For comprehensive transitional education programs, the total number of persons in a comprehensive transitional education program incident to 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 are being provided with services in any instance exceed the licensed capacity of 120 residents, and each residential unit within the component.
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

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:

393.501 Florida personal learning scholarship accounts.—
(1) Rules.
(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).

Section 12. Paragraph (d) of subsection (2) of section
1002.385, Florida Statutes, is amended to read:
1002.385 Florida personal learning scholarship accounts.—
(2) DEFINITIONS.—As used in this section, the term:

(d) "Disability" means, for a 3- or 4-year-old child or for a student in kindergarten to grade 12, autism spectrum disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association; cerebral palsy, as defined in s. 393.063(6); Down syndrome, as defined in s. 393.063(15); an intellectual disability, as defined in s. 393.063(11); Prader-Willi syndrome, as defined in s. 393.063(29); or spina bifida, as defined in s. 393.063(41); for a student in kindergarten, being a high-risk child, as defined in s. 393.063(23)(a); muscular dystrophy; and Williams syndrome.

Section 13. This act shall take effect July 1, 2016.
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
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.
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.  

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. Applicants must also agree to cooperate with Child Support Enforcement during the application process.

<table>
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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. States can add benefits, pending federal approval. Florida has added benefits, including prescription drugs, adult dental services, and dialysis. 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

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6 Id at 10.
7 Florida Dep’t of Children and Families, Family-Related Medicaid Programs Fact Sheet, p. 3 (January 2015).
8 Id.
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.\footnote{See Section 1905 9(r) of the Social Security Act.}

**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\footnote{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.} 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.\footnote{The Agency for Health Care Administration, “Florida Statewide Medicaid Monthly Enrollment Report,” December 2015, available at \url{http://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml} (last visited Dec. 23, 2015).}

**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.\footnote{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), \url{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).}

**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.\footnote{Florida Dep’t of Elderly Affairs, \textit{Comprehensive Assessment and Review for Long-Term Care Services (CARES)}, \url{http://elderaffairs.state.fl.us/doea/cares.php} (last visited Jan. 21, 2016).} The CARES program has 18 field offices across the state which are staffed with
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 LTMC, 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 LTMC 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 DOE, 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 LTMC plans, and provide enrollment and coverage information to LTMC 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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\(^{18}\) 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](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. 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. 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.

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;

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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.

LTC 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\(^\text{25}\) 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


\(^{25}\) 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](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.

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This Senate Bill Analysis does not reflect the intent or official position of the bill’s introducer or the Florida Senate.
Appropriations Subcommittee on Health and Human Services (Bean) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 106 - 175

and insert:

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. The Department of Elderly Affairs shall request that the individual or the individual's authorized representative...
provide alternate names and their contact information.

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 screening tool that generates the priority score, and shall make publicly available on its website the specific methodology used to calculate an individual’s priority score.

   (b) Upon completion of the screening or rescreening process, the Department of Elderly Affairs shall notify the individual or the individual’s authorized representative that the individual has been placed on the wait list.

   (c) If the Department of Elderly Affairs is unable to contact the individual or the individual’s authorized representative to schedule an initial screening or rescreening, and documents the action steps to do so, it shall send a letter to the last documented address of the individual or the individual’s authorized representative. The letter must advise the individual or his or her authorized representative that he or she must contact the Department of Elderly Affairs within 30 calendar days after the date of the notice to schedule a screening or rescreening and must notify the individual that failure to complete the screening or rescreening will result in his or her termination from the screening process and the wait
list.

(d) After notification by the agency of available capacity, the CARES program shall conduct a prerelease assessment. The Department of Elderly Affairs shall release individuals from the wait list based on the priority scoring process and prerelease assessment results. Upon release, individuals who meet all eligibility criteria may enroll in the long-term care managed care program.

(e) The Department of Elderly Affairs may terminate an individual’s inclusion on the wait list if the individual:

1. Does not have a current priority score due to the individual’s action or inaction;

2. Requests to be removed from the wait list;

3. Does not keep an appointment to complete the rescreening without scheduling another appointment and has not responded to three documented attempts to contact by the Department of Elderly Affairs;

4. Receives an offer to begin the eligibility determination process for the long-term care managed care program; or

5. Begins receiving services through the long-term care managed care program.

An individual whose inclusion on the wait list is terminated must initiate a new request for placement on the wait list, and any previous priority considerations must be disregarded.

(f) Notwithstanding this subsection, the following individuals are afforded priority enrollment for home and community-based services through the long-term care managed care program and do not have to complete the screening or wait-list
process if all other long-term care managed care program eligibility requirements are met:

1. 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.

2. Nursing facility residents requesting to transition into the community who have resided in a Florida-licensed skilled nursing facility for at least 60 consecutive days.

3. Individuals referred by the department's adult protective services program as high risk and placed in an assisted living facility temporarily funded by the department.

And the title is amended as follows:

Delete line 23

and insert:

care program; authorizing the department to terminate an
By the Committee on Health Policy

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 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

CODING: Words ______ are deletions; words ______ are additions.
The Department of Elderly Affairs department shall determine that sufficient funds exist to support additional 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.

All 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 shall determine that sufficient funds exist to support additional 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
(b) Upon completion of the screening or rescreening process, the Department of Elderly Affairs shall notify the individual or the individual’s authorized representative that the individual has been placed on the wait list.

(c) If the Department of Elderly Affairs is unable to contact the individual or the individual’s authorized representative to schedule an initial screening or rescreening, it shall send a letter to the last documented address of the individual or the individual’s authorized representative. The letter must advise the individual or his or her authorized representative that he or she must contact the Department of Elderly Affairs within 3 days. Failure to contact the Department of Elderly Affairs within 3 days after the date of the notice to schedule a screening or rescreening and must notify the individual that failure to complete the screening or rescreening will result in his or her termination from the screening process and the wait list.

(d) After notification by the agency of available capacity, the CARES program shall conduct a prerelease assessment. The Department of Elderly Affairs shall release individuals from the wait list based on the priority scoring process and prerelease assessment results. Upon release, individuals who also are determined by the department to be financially eligible and by the Department of Elderly Affairs to be clinically eligible may enroll in the long-term care managed care program.

(e) The Department of Elderly Affairs shall terminate an individual’s inclusion on the wait list if the individual:

1. Does not have a current priority score due to the individual’s action or inaction;
2. Requests to be removed from the wait list;
3. Does not keep an appointment to complete the rescreening without scheduling another appointment;
4. Receives an offer to begin the eligibility determination process for the long-term care managed care program; or
5. Begins receiving services through the long-term care managed care program.

An individual whose inclusion on the wait list is terminated must initiate a new request for placement on the wait list, and any previous priority considerations must be disregarded.

(f) Notwithstanding this subsection, the following individuals are afforded priority enrollment for home and community-based services through the long-term care managed care program and do not have to complete the screening or wait-list process if all other long-term care managed care program eligibility requirements are met:

1. 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.
2. Nursing facility residents requesting to transition into the community who have resided in a Florida-licensed skilled nursing facility for at least 60 consecutive days.
3. The Department of Elderly Affairs and the agency may adopt rules to implement this subsection.
Section 3. This act shall take effect July 1, 2016.
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
10:05:59 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 Robieto, 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