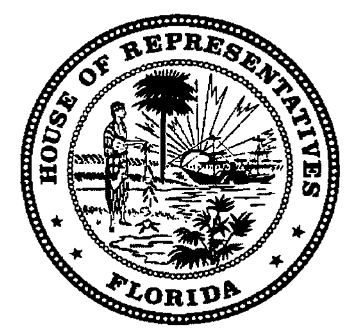
Health Care Appropriations Subcommittee

Meeting Packet

March 22, 2011
12:00 PM—3:00 PM
Webster Hall

Dean Cannon
Speaker

Matt Hudson
Chair



AGENDA
Health Care Appropriations Subcommittee
March 22, 2011
12:00 p.m. – 3:00 p.m.
Webster Hall

I. Call to Order/Roll Call

II. Opening Remarks

III. Budget Workshop—Chair's Proposal

IV. Consideration of PCB HCAS 11-01—Agency for Persons with Disabilities

V. Consideration of PCB HCAS 11-02—Biomedical Research

VI. Consideration of PCB HCAS 11-03—Correctional Medical Authority

VII. Consideration of PCB HCAS 11-04—Department of Children & Family Services

VII. Consideration of PCB HCAS 11-05—Domestic Violence

IX. Consideration of PCB HCAS 11-06—Medicaid Services

X. Closing Remarks/Adjournment

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCAS 11-01 Agency for Persons with Disabilities
SPONSOR(S): Health Care Appropriations Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee		Perritti	Pridgeon

SUMMARY ANALYSIS

The bill makes statutory changes to conform to decisions made in the House proposed General Appropriations Act (GAA) for Fiscal Year 2011-12 relating to the Agency for Persons with Disabilities. Specifically the bill:

- Amends section 393.0661, Florida Statutes, to specify certain rate reductions to the geographic differential given to providers of residential habilitation services to persons with developmental disabilities in Miami-Dade, Broward, Palm Beach, and Monroe Counties.
- Amends section 393.0661, Florida Statutes, to require the payment of a uniform reimbursement rate to all providers of companion care services.

The House proposed GAA for Fiscal Year 2011-12 reduces recurring general revenue expenditures by approximately $16.3 million as a result of revising companion care rates to a uniform rate and reducing geographic differential residential rehabilitation rates.

The bill provides an effective date of July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

The Agency for Persons with Disabilities (APD) is responsible for providing services to persons with developmental disabilities.[1] A developmental disability is defined in chapter 393, Florida Statutes, as "a disorder or syndrome that is attributable to retardation, 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."[2] Children who are at high risk of having a developmental disability and are between the ages of 3 and 5 are also eligible for services.[3]

APD contractors provide an array of services through the Home and Community Based Waiver. Home and Community-Based Services Waivers programs are the federally approved Medicaid programs authorized by Title XIX of the Social Security Act, Section 1915(c) that provide services in the home for persons who would otherwise require institutional care in a hospital, nursing facility, or intermediate care facility. As of March 2011, 30,033 individuals with developmental disability were served under the Home and Community-Based Services Waiver.

The bill will impact providers under the Home and Community Based Wavier who receive a geographic differential rate for residential habilitation services and agency providers of companion care services.

Geographic Differential Rate for Residential Habilitation Services

Residential habilitation services provide supervision and specific training activities that assist a person to acquire, maintain or improve skills related to activities of daily living. Individuals with challenging behavioral disorders may require more intense levels of residential habilitations services.

Currently, there is a geographic differential rate for residential habilitation services in Miami-Dade, Broward, and Palm Beach Counties of 7.5 percent.[4] In addition, Monroe County has a geographic differential rate of 20 percent.[5] The bill will reduce the geographic differential rate for residential habilitation services for Miami-Dade, Broward, Palm Beach and Monroe Counties to 3.5 percent.

Companion Care Services Provider Rate

Companion care services consist of nonmedical care, supervision, and goal-oriented activities provided to an adult when the caregiver is unavailable.

The current rate for companion care services for agency providers is higher than the rate for independent providers that do not have employees. The bill provides that APD must pay a uniform reimbursement rate to all providers of companion care services that will be set by the agency. Agency provider rates would be adjusted to be more uniform with independent provider rates. To offset the reduction agency providers may reduce services in the following areas: behavior analysis, companion, dietician services, in home support, private duty nursing, residential habilitation, residential nursing, and respite, skilled nursing, specialized mental health, supported employment, and supported living. The bill authorizes APD to seek federal approval to amend current waivers in order to comply with this provision.

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[1] s. 20.197, F.S.
[2] s. 393.063(9), F.S.
[3] "High-risk child" is defined in s. 393.063(19), F.S.
[4] s. 393.0661(4), F.S.
[5] s. 393.0661(f), F.S.

B. SECTION DIRECTORY:

Section 1. Amends s. 393.0661, F.S., related to Geographic Rates and Companion Services Rates.

Section 2. Amends s. 393.0661, F.S., provides the bill is effective July 1, 2011.

Section 3. Provides the bill is effective July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The following issues are included in the House proposed GAA for FY 2011-12:

	FY 2011-12
Agency for Persons with Disabilities	
Geographic Differential Rate for Residential Habilitation Services	
General Revenue	(1,287,000)
Operations and Maintenance Trust Fund	(1,634,017)
	(2,921,017)
Companion Care Services Provider Rate	
General Revenue	(14,978,830)
Operations and Maintenance Trust Fund	(19,017,606)
	(33,996,436)
NET REDUCTION	(36,917,453)

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The geographic differential rate for providers of residential habilitations services in Miami-Dade, Broward and Palm Beach Counties will be reduced from 7.5 percent to 3.5 percent. The geographic differential rate for providers of residential habilitations services in Monroe County will be reduced from 20.0 percent to 3.5 percent.

Companion care services rates will be adjusted to be more uniform between agency providers and individual providers. Current service rates for agency providers are higher than service rates for independent providers.

D. FISCAL COMMENTS:

The proposed change to the Companion Care Service Provider Rate will have an annualized savings of $11,332,137 with $4,992,939 in state general revenue savings in Fiscal Year 2012-13.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   None.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The agency has sufficient rulemaking authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the Agency for Persons with Disabilities; amending s. 393.0661, F.S.; reducing the geographic differentials for residential habilitation services in certain counties; specifying that the agency shall pay a uniform reimbursement rate to all providers of companion care services and authorizing the agency to seek federal approval to amend current waivers to comply with that requirement; providing an effective date.

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

Section 1. Subsections (4) and (5) of section 393.0661, Florida Statutes, are amended, present subsection (8) is renumbered as subsection (9), and a new subsection (8) is added to that section, to read:

393.0661 Home and community-based services delivery system; comprehensive redesign.—The Legislature finds that the home and community-based services delivery system for persons with developmental disabilities and the availability of appropriated funds are two of the critical elements in making services available. Therefore, it is the intent of the Legislature that the Agency for Persons with Disabilities shall develop and implement a comprehensive redesign of the system.

(4) The geographic differential for Miami-Dade, Broward, and Palm Beach Counties for residential habilitation services shall be 3.5 ~~7.5~~ percent.

(5) The geographic differential for Monroe County for

29 residential habilitation services shall be 3.5 ~~20~~ percent.

30 (8) Beginning July 1, 2011, the agency shall pay a uniform
31 reimbursement rate to all providers of companion care services.
32 The rate shall be set by the agency. The agency is authorized to
33 seek federal approval to amend current waivers in order to
34 comply with this subsection.

35 Section 2. This act shall take effect July 1, 2011.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCAS 11-02 Biomedical Research
SPONSOR(S): Health Care Appropriations Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee		Clark	Pridgeon

SUMMARY ANALYSIS

The bill makes statutory changes to conform to the funding decisions included in the House proposed General Appropriations Act (GAA) for Fiscal Year 2011-2012.

The bill repeals provisions of statute related to the funding of the biomedical research programs for the James and Esther King Biomedical Research Program, the William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program, and the H. Lee Moffitt Cancer Center and Research Institute from the state cigarette surcharge revenues collected pursuant to s. 210.011, Florida Statutes. This statute imposes a surcharge of $1 per pack of cigarettes and is deposited into the Health Care Trust Fund.

During Fiscal Year 2010-11, these programs were appropriated $50 million from the state cigarette surcharge revenues.

The bill provides an effective date of July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Cigarette Surcharge

The "Protecting Florida's Health Act" was passed during the 2009 legislative session. This bill levied a surcharge on the sale, receipt, purchase, possession, consumption, handling, distribution, and use of cigarettes in Florida.[1] The surcharge imposed on a standard 20-cigarette pack is $1; and a proportionate surcharge is imposed on other sizes and quantities of cigarettes. The revenue produced from the cigarette surcharge is required to be deposited into the Health Care Trust Fund within the Agency for Health Care Administration.

Biomedical Research

In Fiscal Year 2009-10, s. 215.5602(12), F.S., was created and required 5 percent of the cigarette surcharge revenue to be deposited into the Health Care Trust Fund and reserved for research of tobacco-related or cancer-related illnesses; however the sum of revenue reserved was not to exceed $50 million. Approximately 2.5 percent, not to exceed $25 million, of the revenue deposited into the Health Care Trust Fund was required to be transferred to the Biomedical Research Trust Fund within the Department of Health for the James and Esther King Biomedical Research Program.

In Fiscal Year 2010-11, s. 215.5602(12), F.S., was amended to require $50 million from the cigarette surcharge revenue deposited into the Health Care Trust Fund be transferred to the Biomedical Research Trust Fund within the Department of Health for the James and Esther King Biomedical Research Program, the William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program, and the H. Lee Moffitt Cancer Center and Research Institute.

James and Esther King Biomedical Research Program

According to s. 215.5602, F.S., the purpose of the James and Esther King Biomedical Research program is to provide an annual and perpetual source of funding in order to support research initiatives that address the health care problems of Floridians in the areas of tobacco-related cancer, cardiovascular disease, stroke, and pulmonary disease. The goals of the program are to:

- Improve the health of Floridians by researching better prevention, diagnoses, treatments, and cures for tobacco-related diseases;
- Expand the foundation of biomedical knowledge related to the prevention, diagnosis, treatment, and cure of related to tobacco use;
- Improve the quality of the state's academic health centers by bringing the advances of biomedical research into the training of physicians and other health care providers;
- Increase the state's per capita funding for research by undertaking new initiatives in public health and biomedical research that will attract additional funding from outside the state; and
- Stimulate economic activity in the state in areas related to biomedical research.[2]

During Fiscal Year 2010-11, the program received $20 million from the state cigarette surcharge plus $2.2 million of interest earnings from the Lawton Chiles Endowment Fund, established with monies received from Florida's legal settlement with the tobacco industry in 1998. The Program is managed by the Florida Department of Health and an eleven-member Biomedical Research Advisory Council.[3]

[1] s. 210.011(1), F.S

[2] s. 215.5602(1), F.S.

[3] s. 215.5602(3), F.S.

The William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program

According to s. 381.922, F.S., the purpose of the Bankhead-Coley program is to advance progress towards cures for cancer through grants awarded through a peer-reviewed, competitive process. The goals of the program are to:

- Expand the cancer research capacity in Florida;
- Increase participation in cancer clinical trials networks; and
- Reduce the impact of cancer on disparate groups.

During Fiscal Year 2010-11, the program received $20 million from the state cigarette surcharge. The Program is managed by the Florida Department of Health and the eleven-member Biomedical Research Advisory Council.

H. Lee Moffitt Cancer Center and Research Institute

According to s. 1004.43, F.S., the H. Lee Moffitt Cancer Center and Research Institute is a statewide resource for basic and clinical research and multidisciplinary approaches to patient care. During Fiscal Year 2010-11, the program received $10 million from the state cigarette surcharge. Current law establishes the Moffitt Center at the University of South Florida.[4] A not-for-profit corporation governs the Moffitt Center in accordance with an agreement with the State Board of Education. A board of directors manages the not-for-profit corporation, and a chief executive officer administers the Moffitt Center.

Currently, s. 215.5602, F.S. provides that beginning in the 2010-2011 fiscal year and thereafter, $50 million from the revenue deposited into the Health Care Trust Fund must be reserved for research of tobacco related or cancer related illnesses. Of the revenue deposited into the Health Care Trust Fund, $50 million must be transferred to the Biomedical Research Trust Fund within the Department of Health. This section of statute provides that subject to annual appropriations in the general appropriations act, $20 million will be appropriated to the James and Esther King Biomedical Research Program, $20 million will be appropriated to the Bankhead-Coley Program and $10 million shall be appropriated to the H. Lee Moffitt Cancer Center and Research Institute.

This PCB repeals portions of statute which requires the transfer of $50 million to the Biomedical Research Trust Fund from the state cigarette surcharge for research of tobacco related or cancer related illnesses. The bill also repeals provisions in statute establishing the funding for the James and Esther King Biomedical Research Program, the William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program, and the H. Lee Moffitt Cancer Center and Research Institute from proceeds from the state cigarette surcharge.

B. SECTION DIRECTORY:

Section 1. Amends s. 215.5602, F.S., relating to James and Esther King Biomedical Research Program.

Section 2. Amends s. 381.922, F.S., relating to William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program.

Section 3. Provides effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

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[4] s. 1004.43, F.S.

1. Revenues:

Revenues from the state cigarette surcharge will still be received; however, they will not be redirected to fund biomedical research programs. The funds will be used as state match for the state's Medicaid program.

2. Expenditures:

Repeal of the funding provisions in statute will result in no state cigarette surcharge funds being appropriated to the James and Esther King Biomedical Research Program, the William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program, or the H. Lee Moffitt Cancer Center and Research Center.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal government.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to biomedical research; amending s.
3 215.5602, F.S.; deleting provisions that specify amounts
4 of revenue to be appropriated to the James and Esther King
5 Biomedical Research Program, the William G. "Bill"
6 Bankhead, Jr., and David Coley Cancer Research Program,
7 and the H. Lee Moffitt Cancer Center and Research
8 Institute; amending s. 381.922, F.S.; conforming a
9 reference; providing an effective date.
10
11 Be It Enacted by the Legislature of the State of Florida:
12
13 Section 1. Subsection (12) of section 215.5602, Florida
14 Statutes, is amended to read:
15 215.5602 James and Esther King Biomedical Research
16 Program.—
17 (12) From funds appropriated to accomplish the goals of
18 this section, up to $250,000 shall be available for the
19 operating costs of the Florida Center for Universal Research to
20 Eradicate Disease. ~~Beginning in the 2010-2011 fiscal year and~~
21 ~~thereafter, $50 million from the revenue deposited into the~~
22 ~~Health Care Trust Fund pursuant to ss. 210.011(9) and 210.276(7)~~
23 ~~shall be reserved for research of tobacco-related or cancer-~~
24 ~~related illnesses. Of the revenue deposited in the Health Care~~
25 ~~Trust Fund pursuant to this section, $50 million shall be~~
26 ~~transferred to the Biomedical Research Trust Fund within the~~
27 ~~Department of Health. Subject to annual appropriations in the~~
28 ~~General Appropriations Act, $20 million shall be appropriated to~~

29 ~~the James and Esther King Biomedical Research Program, $20~~
30 ~~million shall be appropriated to the William G. "Bill" Bankhead,~~
31 ~~Jr., and David Coley Cancer Research Program created under s.~~
32 ~~381.922, and $10 million shall be appropriated to the H. Lee~~
33 ~~Moffitt Cancer Center and Research Institute established under~~
34 ~~s. 1004.43.~~
35 Section 2. Subsection (5) of section 381.922, Florida
36 Statutes, is amended to read:
37 381.922 William G. "Bill" Bankhead, Jr., and David Coley
38 Cancer Research Program.—
39 (5) ~~The William G. "Bill" Bankhead, Jr., and David Coley~~
40 ~~Cancer Research Program is funded pursuant to s. 215.5602(12).~~
41 Funds appropriated for the William G. "Bill" Bankhead, Jr., and
42 David Coley Cancer Research Program shall be distributed
43 pursuant to this section to provide grants to researchers
44 seeking cures for cancer and cancer-related illnesses, with
45 emphasis given to the goals enumerated in this section. From the
46 total funds appropriated, an amount of up to 10 percent may be
47 used for administrative expenses. From funds appropriated to
48 accomplish the goals of this section, up to $250,000 shall be
49 available for the operating costs of the Florida Center for
50 Universal Research to Eradicate Disease.
51 Section 3. This act shall take effect July 1, 2011.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCAS 11-03 Correctional Medical Authority
SPONSOR(S): Health Care Appropriations Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee		Clark	Pridgeon

SUMMARY ANALYSIS

The bill makes statutory changes to conform to the funding decisions included in the House proposed General Appropriations Act (GAA) for Fiscal Year 2011-2012.

Specifically, the bill repeals sections of statute creating and establishing the duties of the Correctional Medical Authority which monitors the quality of the physical and mental health care services provided to inmates in Florida's correctional institutions.

The House proposed GAA for FY 2011-2012 reduces recurring general revenue expenditures by $717,680 and 6.0 FTE as a result of eliminating the Correctional Medical Authority.

The bill provides an effective date of July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

The Correctional Medical Authority (CMA) was created in 1986.[1] The CMA is housed within the Department of Health (DOH) for administrative purposes but is not subject to the control or supervision of DOH or the Department of Corrections.[2]

The governing board of the authority is composed of nine persons appointed by the Governor subject to confirmation by the Senate. Members of the CMA are not compensated for performance of their duties but are paid expenses incurred while engaged in the performance of such duties pursuant to s. 112.061, F.S.[3]

According to section 945.603, F.S.:

> The purpose of the authority is to assist in the delivery of health care services for inmates in the Department of Corrections by advising the Secretary of Corrections on the professional conduct of primary, convalescent, dental, and mental health care and the management of costs consistent with quality care, by advising the Governor and the Legislature on the status of the Department of Corrections' health care delivery system, and by assuring that adequate standards of physical and mental health care for inmates are maintained at all Department of Corrections institutions.

Pursuant to this section, the CMA is authorized to:

1. Review and advise the Secretary of Corrections on cost containment measures the Department of Corrections could implement.
2. Review and make recommendations regarding health care for the delivery of health care services including, but not limited to, acute hospital-based services and facilities, primary and tertiary care services, ancillary and clinical services, dental services, mental health services, intake and screening services, medical transportation services, and the use of nurse practitioner and physician assistant personnel to act as physician extenders as these relate to inmates in the Department of Corrections.
3. Develop and recommend to the Governor and the Legislature an annual budget for all or part of the operation of the State of Florida prison health care system.
4. Review and advise the Secretary of Corrections on contracts between the Department of Corrections and third parties for quality management programs.
5. Review and advise the Secretary of Corrections on minimum standards needed to ensure that an adequate physical and mental health care delivery system is maintained by the Department of Corrections.
6. Review and advise the Secretary of Corrections on the sufficiency, adequacy, and effectiveness of the Department of Corrections' Office of Health Services' quality management program.
7. Review and advise the Secretary of Corrections on the projected medical needs of the inmate population and the types of programs and resources required to meet such needs.
8. Review and advise the Secretary of Corrections on the adequacy of preservice, inservice, and continuing medical education programs for all health care personnel and, if necessary, recommend changes to such programs within the Department of Corrections.
9. Identify and recommend to the Secretary of Corrections the professional incentives required to attract and retain qualified professional health care staff within the prison health care system.
10. Coordinate the development of prospective payment arrangements as described in s. 408.50 when appropriate for the acquisition of inmate health care services.

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[1] Ch. 86-183, L.O.F.
[2] s. 945.602, F.S.
[3] Id.

11. Review the Department of Corrections' health services plan and advise the Secretary of Corrections on its implementation.
12. Sue and be sued in its own name and plead and be impleaded.
13. Make and execute agreements of lease, contracts, deeds, mortgages, notes, and other instruments necessary or convenient in the exercise of its powers and functions under this act.
14. Employ or contract with health care providers, medical personnel, management consultants, consulting engineers, architects, surveyors, attorneys, accountants, financial experts, and such other employees, entities, or agents as may be necessary in its judgment to carry out the mandates of the Correctional Medical Authority and fix their compensation.
15. Recommend to the Legislature such performance and financial audits of the Office of Health Services in the Department of Corrections as the authority considers advisable.

Section 945.6031, F.S. requires the CMA to submit reports to the Governor and Legislature on the status of DOC's health care delivery system.[4] This section also requires CMA to conduct surveys of the physical and mental health care system at each correctional institution and report the survey findings for each institution to the Secretary of Corrections. A process by which DOC must respond to such surveys is set forth in this section.

Sections 945.6035 and 945.6036, F.S.; sets forth a process to resolve any disputes which arise between the authority and the department regarding the physical and mental health care of inmates.

The PCB repeals sections of statute which establish and set forth the duties of the Correctional Medical Authority. The PCB also removes references to the CMA from various sections of statute.

B. SECTION DIRECTORY:

Section 1. Amends s. 381.90, F.S. relating to Health Information Systems Council; legislative intent; creation; appointment; duties.

Section 2. Amends s. 766.101, F.S. relating to medical review committee.

Section 3. Amends s. 944.8041, F.S. relating to elderly offenders; annual review.

Section 4. Amends s. 945.35, F.S. relating to requirement for education on human immunodeficiency virus, acquired immune deficiency syndrome, and other communicable diseases.

Section 5. Repeals s. 945.601, F.S. relating to Correctional Medical Authority.

Section 6. Repeals s. 945.602, F.S. relating to State of Florida Correctional Medical Authority; creation; members.

Section 7. Repeals s. 945.603, F.S. relating to powers and duties of authority.

Section 8. Repeals s. 945.6031, F.S. relating to required reports and surveys.

Section 9. Repeals s. 945.6032, F.S. relating to quality management program requirements.

Section 10. Amends s. 945.6034, F.S relating to minimum health care standards

Section 11. Repeals s. 945.6035, F.S. relating to dispute resolution.

Section 12. Repeals s. 945.6036, F.S. relating to enforcement.

Section 13. Amends s. 951.27, F.S. relating to blood tests of inmates.

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[4] http://www.doh.state.fl.us/cma/reports/index.html

Section 14. Provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Repeal of the Correctional Medical Authority will result in a reduction of 6.0 FTE and a General Revenue savings of $717,680.

6.0 FTE with Salary Rate of *$376,338*	
Salaries/Benefits	$493,580
Expenses	$168,775
OPS	$52,145
OCO	$168
Contracted Services	$1,491
Transfer DMS/HR Svs	$1,521
TOTAL	**$717,680**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

   None.

D. FISCAL COMMENTS:

   None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appeal to affect county or municipal government.

2. Other:

   Costello litigation: In 1972, a complaint was filed in the U.S. District Court of the Middle District of Florida, by inmates named Michael Costello and Roberto Celestineo. This is commonly referred to

as the Costello v. Wainwright case. The suit alleged violations of the Eighth and Fourteenth Amendments due to inadequate physical and mental health care by what was then the Division of Corrections within the Department of Health and Human Services. As a result of the case, the federal court oversaw the delivery of inmate health care in the Florida correctional system from 1972 to 1993.

In March 1993, Judge Susan Black signed an order closing the Costello lawsuit and relinquishing oversight of Florida's prison health care system. As part of the order, the judge stated the following:

> Federal supervision of state functions is a difficult feature of federalism. The federal courts have struggled for years to disentangle themselves from state functions without jeopardizing resolution of the basic constitutional issues achieved by the litigation. The CMA is an innovative solution to the recurring problem of institutionalizing the changes effected by prison litigation, thereby permitting termination of federal involvement. The CMA provides independent, objective verification of the Department's activities and actions.
>
> Florida's creation of an independent state entity to address potential problems in the delivery of physical and mental health care, as well as in overcrowding, made it possible two years ago for this Court to relinquish the prison monitoring and oversight function it had performed for the last twenty years. See Order Relinquishing Physical Health Care Survey and Monitoring Responsibilities to the Florida Correctional Medical Authority, entered on December 11, 1990. Furthermore, the CMA's statutory responsibility to report to the Governor, the Cabinet, and the Florida Legislature gives it a moral and legal authority which, as long as it is appropriately funded and staffed, should make future involvement of the federal courts unnecessary in the Florida correctional system.
>
> It is exemplary that a major state such as Florida, with its significant prison population, would take such a creative step. Without innovations such as the CMA, there is little hope for satisfactory withdrawal of federal supervision.
>
> *Celestineo v. Singletary* 147 F.R.D. 258, 263 (M.D.Fla.,1993)

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to the Correctional Medical Authority;
3 repealing ss. 945.601, 945.602, 945.603, 945.6031,
4 945.6032, 945.6035, and 945.6036, F.S., relating to the
5 Correctional Medical Authority definitions, creation,
6 powers, reports and surveys, quality management, dispute
7 resolution, and enforcement, respectively; amending ss.
8 381.90, 766.101, 944.8041, 945.35, 945.6034, and 951.27,
9 F.S.; conforming provisions to changes made by the act;
10 providing an effective date.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. Sections 945.601, 945.602, 945.603, 945.6031,
15 945.6032, 945.6035, and 945.6036, Florida Statutes, are
16 repealed.
17 Section 2. Subsection (3) of section 381.90, Florida
18 Statutes, is amended to read:
19 381.90 Health Information Systems Council; legislative
20 intent; creation, appointment, duties.—
21 (3) The council shall be composed of the following members
22 or their senior executive-level designees:
23 (a) The State Surgeon General;
24 (b) The Executive Director of the Department of Veterans'
25 Affairs;
26 (c) The Secretary of Children and Family Services;
27 (d) The Secretary of Health Care Administration;
28 (e) The Secretary of Corrections;

29 (f) The Attorney General;
30 ~~(g) The Executive Director of the Correctional Medical~~
31 ~~Authority;~~
32 (g) ~~(h)~~ Two members representing county health departments,
33 one from a small county and one from a large county, appointed
34 by the Governor;
35 (h) ~~(i)~~ A representative from the Florida Association of
36 Counties;
37 (i) ~~(j)~~ The Chief Financial Officer;
38 (j) ~~(k)~~ A representative from the Florida Healthy Kids
39 Corporation;
40 (k) ~~(l)~~ A representative from a school of public health
41 chosen by the Commissioner of Education;
42 (l) ~~(m)~~ The Commissioner of Education;
43 (m) ~~(n)~~ The Secretary of Elderly Affairs; and
44 (n) ~~(o)~~ The Secretary of Juvenile Justice.
45
46 Representatives of the Federal Government may serve without
47 voting rights.
48 Section 3. Paragraph (a) of subsection (1) of section
49 766.101, Florida Statutes, is amended to read:
50 766.101 Medical review committee, immunity from
51 liability.—
52 (1) As used in this section:
53 (a) The term "medical review committee" or "committee"
54 means:
55 1.a. A committee of a hospital or ambulatory surgical
56 center licensed under chapter 395 or a health maintenance

57 organization certificated under part I of chapter 641;~~,~~
58 b. A committee of a physician-hospital organization, a
59 provider-sponsored organization, or an integrated delivery
60 system;~~,~~
61 c. A committee of a state or local professional society of
62 health care providers;~~,~~
63 d. A committee of a medical staff of a licensed hospital
64 or nursing home, provided the medical staff operates pursuant to
65 written bylaws that have been approved by the governing board of
66 the hospital or nursing home;~~,~~
67 e. A committee of the Department of Corrections ~~or the~~
68 ~~Correctional Medical Authority as created under s. 945.602,~~ or
69 employees, agents, or consultants of ~~either~~ the department; ~~or~~
70 ~~the authority or both,~~
71 f. A committee of a professional service corporation
72 formed under chapter 621 or a corporation organized under
73 chapter 607 or chapter 617, which is formed and operated for the
74 practice of medicine as defined in s. 458.305(3), and which has
75 at least 25 health care providers who routinely provide health
76 care services directly to patients;~~,~~
77 g. A committee of the Department of Children and Family
78 Services which includes employees, agents, or consultants to the
79 department as deemed necessary to provide peer review,
80 utilization review, and mortality review of treatment services
81 provided pursuant to chapters 394, 397, and 916;~~,~~
82 h. A committee of a mental health treatment facility
83 licensed under chapter 394 or a community mental health center
84 as defined in s. 394.907, provided the quality assurance program

85 operates pursuant to the guidelines which have been approved by
86 the governing board of the agency;~~,~~
87 i. A committee of a substance abuse treatment and
88 education prevention program licensed under chapter 397 provided
89 the quality assurance program operates pursuant to the
90 guidelines which have been approved by the governing board of
91 the agency;~~,~~
92 j. A peer review or utilization review committee organized
93 under chapter 440;~~,~~
94 k. A committee of the Department of Health, a county
95 health department, healthy start coalition, or certified rural
96 health network, when reviewing quality of care, or employees of
97 these entities when reviewing mortality records;~~,~~ or
98 l. A continuous quality improvement committee of a
99 pharmacy licensed pursuant to chapter 465,
100
101 which committee is formed to evaluate and improve the quality of
102 health care rendered by providers of health service, to
103 determine that health services rendered were professionally
104 indicated or were performed in compliance with the applicable
105 standard of care, or that the cost of health care rendered was
106 considered reasonable by the providers of professional health
107 services in the area; or
108 2. A committee of an insurer, self-insurer, or joint
109 underwriting association of medical malpractice insurance, or
110 other persons conducting review under s. 766.106.
111 Section 4. Section 944.8041, Florida Statutes, is amended
112 to read:

113 944.8041 Elderly offenders; annual review.—For the purpose
114 of providing information to the Legislature on elderly offenders
115 within the correctional system, the department ~~and the~~
116 ~~Correctional Medical Authority~~ shall ~~each~~ submit annually a
117 report on the status and treatment of elderly offenders in the
118 state-administered and private state correctional systems and
119 the department's geriatric facilities and dorms. ~~In order to~~
120 ~~adequately prepare the reports, the department and the~~
121 ~~Department of Management Services shall grant access to the~~
122 ~~Correctional Medical Authority that includes access to the~~
123 ~~facilities, offenders, and any information the agencies require~~
124 ~~to complete their reports.~~ The <u>report</u> ~~review~~ shall ~~also~~ include
125 an examination of promising geriatric policies, practices, and
126 programs currently implemented in other correctional systems
127 within the United States. The <u>report</u> ~~reports~~, with specific
128 findings and recommendations for implementation, shall be
129 submitted to the President of the Senate and the Speaker of the
130 House of Representatives on or before December 31 of each year.
131 Section 5. Subsections (3) and (9) of section 945.35,
132 Florida Statutes, are amended to read:
133 945.35 Requirement for education on human immunodeficiency
134 virus, acquired immune deficiency syndrome, and other
135 communicable diseases.—
136 (3) When there is evidence that an inmate, while in the
137 custody of the department, has engaged in behavior which places
138 the inmate at a high risk of transmitting or contracting a human
139 immunodeficiency disorder or other communicable disease, the
140 department may begin a testing program which is consistent with

141 guidelines of the Centers for Disease Control and Prevention ~~and~~
142 ~~recommendations of the Correctional Medical Authority~~. For
143 purposes of this subsection, "high-risk behavior" includes:
144 (a) Sexual contact with any person.
145 (b) An altercation involving exposure to body fluids.
146 (c) The use of intravenous drugs.
147 (d) Tattooing.
148 (e) Any other activity medically known to transmit the
149 virus.
150 (9) The department shall establish policies consistent
151 with guidelines of the Centers for Disease Control and
152 Prevention ~~and recommendations of the Correctional Medical~~
153 ~~Authority~~ on the housing, physical contact, dining, recreation,
154 and exercise hours or locations for inmates with
155 immunodeficiency disorders as are medically indicated and
156 consistent with the proper operation of its facilities.
157 Section 6. Subsections (2) and (3) of section 945.6034,
158 Florida Statutes, are amended to read:
159 945.6034 Minimum health care standards.—
160 ~~(2) The department shall submit all health care standards~~
161 ~~to the authority for review prior to adoption. The authority~~
162 ~~shall review all department health care standards to determine~~
163 ~~whether they conform to the standard of care generally accepted~~
164 ~~in the professional health community at large.~~
165 (2) ~~(3)~~ The department shall comply with all adopted
166 department health care standards. Failure of the department to
167 comply with the standards ~~may result in a dispute resolution~~
168 ~~proceeding brought by the authority pursuant to s. 945.6035, but~~

169 shall not create a cause of action for any third parties,
170 including inmates or former inmates.
171 Section 7. Subsection (1) of section 951.27, Florida
172 Statutes, is amended to read:
173 951.27 Blood tests of inmates.—
174 (1) Each county and each municipal detention facility
175 shall have a written procedure developed, in consultation with
176 the facility medical provider, establishing conditions under
177 which an inmate will be tested for infectious disease, including
178 human immunodeficiency virus pursuant to s. 775.0877, which
179 procedure is consistent with guidelines of the Centers for
180 Disease Control and Prevention ~~and recommendations of the~~
181 ~~Correctional Medical Authority~~. It is not unlawful for the
182 person receiving the test results to divulge the test results to
183 the sheriff or chief correctional officer.
184 Section 8. This act shall take effect July 1, 2011.

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V

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCAS 11-04 Department of Children & Family Services
SPONSOR(S): Health Care Appropriations Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee		Perritti	Pridgeon

SUMMARY ANALYSIS

The bill creates or amends several statutes to conform to decisions made in the House proposed General Appropriations Act (GAA) for Fiscal Year 2011-12

- The bill amends Section 409.1451, Florida Statutes, changing the maximum age of eligibility from 23 to 21 for independent living transition services and for the road-to-independence award for former foster children. Independent living transition services and the road-to-independence award provide services and a monthly stipend to assist former foster children in obtaining training and education. The House proposed GAA for Fiscal Year 2011-12 reduces $8.1 million from General Revenue funds by changing the maximum age of eligibility from 23 to 21 for independent living services.

- The bill creates Section 415.1114, Florida Statutes, allowing the Department of Children and Family Services to transfer responsibilities for adult protective investigations to the sheriff of a county. In order to implement such a transfer, the department of Children and Family Services and the appropriate Sheriff's Office will enter into a contract for the provision of these services. The House proposed General Appropriations Act (GAA) for Fiscal Year 2011-12 proposes transferring adult protective investigations in Citrus County to the Citrus County Sheriff's Office. This will result in the reduction of 3.00 positions and the transfer of $187,243 in funding to the Citrus County Sheriff's Office through a contract to provide adult protective investigations.

The effective date of the bill is July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Independent Living

The Independent Living Program provides services to youth in foster care and young adults who were formerly in foster care. The program is designed to assist youth in obtaining life skills and education necessary to become self-sufficient, live independently and maintain employment.

In Fiscal Year 2010-11, the Legislature appropriated $29.9 million to the Independent Living Program within the Department of Children and Family Services. This includes $8.5 million in federal funds from the Chafee Foster Care Independence Program and Education and Training Voucher funds, and $21.4 million in state general revenue funds.

The largest component of Florida's Independent Living Program is the Road-to- Independence stipend, which provides money to assist young adults ages 18 to 23 who are in high school, seeking a GED, or pursuing a postsecondary education. Section 409.1451, Florida Statutes provides that the amount of each young adult's Road-to-Independence stipend must be based on their living and educational needs, but shall not exceed the amount earned by working 40 hours a week at a job paying the federal minimum wage. In Fiscal Year 2009-10, the maximum Road-to-Independence stipend was $1,256 per month, or $15,072 per year.

In addition to the Road-to- Independence stipend, former foster children receive case management services, life skills training, aftercare support and transitional services.

The federal government provides funding and requirements for independent living programs through the Chafee Act. The Chafee Act requires that states serve young adults from age 16 until they reach their 21st birthday and provides flexibility to continue providing Education and Training Vouchers until their 23rd birthday. Florida is one of five states that provide independent living services to you ages 13 or younger.[1] In Fiscal Year 2009-10 the department served 1,100 young adults age 21 and older.

The bill changes the maximum age of eligibility for Independent Living Transition Services from 23 to 21. The House proposed GAA for Fiscal Year 2011-12 reduces $8.1 million from general revenue by changing the maximum age of eligibility from 23 to 21.

Adult Protective Investigations

The Adult Protective Services Program within the Department of Children and Family Services is charged with protecting vulnerable adults from being harmed (Chapter 415, Florida .Statutes.). These adults may experience abuse, neglect, or exploitation by second parties or may fail to take care of themselves adequately. The Florida Abuse Hotline screens allegations of child and adult abuse/neglect to determine whether the information meets the criteria of an abuse report. If the criteria are met, a protective investigation is initiated to confirm whether or not there is evidence that abuse, neglect, or exploitation occurred; whether there is an immediate or long-term risk to the victim; and whether the victim needs additional services to safeguard his or her well-being.

The bill provides for the transfer of adult protection services from the Department to County Sheriffs if agreed to by the sheriff. This language is similar to provisions in s. 39.3065, F.S. which authorize the department to transfer child protective services to a sheriff's office. To implement the transfer, the Department of Children and Family Services and the appropriate Sheriff's Office will enter into a contract for the provision of these services. The House proposed General Appropriations Act (GAA) for

[1] "Comparisons to Other States and Funding Options for the Independent Living Program" Research Memorandum, February 2, 2011, Office of Program Policy Analysis and Government Accountability.

Fiscal Year 2011-12 proposes transferring adult protective investigations in Citrus County to the Citrus County Sheriff's Office. This will result in the reduction of 3.00 positions and the transfer of $187,243 in funding to the Citrus County Sheriff's Office through contract with the department to provide adult protective investigations.

B. SECTION DIRECTORY:

Section 1. Amends s. 409.1451, F.S., related to independent living services.

Section 2. Creates s. 415.1114, F.S., related to adult protection investigations.

Section 3. Provides the bill is effective July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

		FY 2011-12
Department of Children and Families		
Independent Living Program		
General Revenue		(8,214,576)
	Total	**(8,214,576)**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   County Sheriffs who assume adult protective investigation services will receive funding through a contract with the Department of Children and Families.

2. Expenditures:

   County Sheriffs who assume adult protective investigation services from the department will expend contracted funds as necessary to provide these services.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill authorizes but does not require sheriffs to assume responsibilities relating to adult protective investigations. A participating sheriff's office will receive state funding for the provision of these services upon entering into a contract with the Department of Children and Family Services.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The Department of Children and Families has sufficient rule-making authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to the Department of Children and Family
3 Services; amending s. 409.1451, F.S.; revising the age up
4 to which young adults are eligible for independent living
5 services; creating s. 415.1114, F.S.; transferring the
6 responsibility for adult protective investigations from
7 the Department of Children and Family Services to county
8 sheriffs' offices under certain circumstances; providing
9 contract requirements for implementation of the transfer
10 of responsibilities; providing conditions for funding and
11 performance evaluation; providing an effective date.
12
13 Be It Enacted by the Legislature of the State of Florida:
14
15 Section 1. Paragraph (b) of subsection (2) and subsection
16 (5) of section 409.1451, Florida Statutes, are amended to read:
17 409.1451 Independent living transition services.—
18 (2) ELIGIBILITY.—
19 (b) The department shall serve young adults who have
20 reached 18 years of age but are not yet 21 ~~23~~ years of age and
21 who were in foster care when they turned 18 years of age or,
22 after reaching 16 years of age, were adopted from foster care or
23 placed with a court-approved dependency guardian and have spent
24 a minimum of 6 months in foster care within the 12 months
25 immediately preceding such placement or adoption, by providing
26 services pursuant to subsection (5). Young adults to be served
27 must meet the eligibility requirements set forth for specific
28 services in this section.

29 (5) SERVICES FOR YOUNG ADULTS FORMERLY IN FOSTER CARE.—
30 Based on the availability of funds, the department shall provide
31 or arrange for the following services to young adults formerly
32 in foster care who meet the prescribed conditions and are
33 determined eligible by the department. The department, or a
34 community-based care lead agency when the agency is under
35 contract with the department to provide the services described
36 under this subsection, shall develop a plan to implement those
37 services. A plan shall be developed for each community-based
38 care service area in the state. Each plan that is developed by a
39 community-based care lead agency shall be submitted to the
40 department. Each plan shall include the number of young adults
41 to be served each month of the fiscal year and specify the
42 number of young adults who will reach 18 years of age who will
43 be eligible for the plan and the number of young adults who will
44 reach <u>21</u> ~~23~~ years of age and will be ineligible for the plan or
45 who are otherwise ineligible during each month of the fiscal
46 year; staffing requirements and all related costs to administer
47 the services and program; expenditures to or on behalf of the
48 eligible recipients; costs of services provided to young adults
49 through an approved plan for housing, transportation, and
50 employment; reconciliation of these expenses and any additional
51 related costs with the funds allocated for these services; and
52 an explanation of and a plan to resolve any shortages or
53 surpluses in order to end the fiscal year with a balanced
54 budget. The categories of services available to assist a young
55 adult formerly in foster care to achieve independence are:
56 (a) Aftercare support services.—

57 1. Aftercare support services are available to assist
58 young adults who were formerly in foster care in their efforts
59 to continue to develop the skills and abilities necessary for
60 independent living. The aftercare support services available
61 include, but are not limited to, the following:
62 a. Mentoring and tutoring.
63 b. Mental health services and substance abuse counseling.
64 c. Life skills classes, including credit management and
65 preventive health activities.
66 d. Parenting classes.
67 e. Job and career skills training.
68 f. Counselor consultations.
69 g. Temporary financial assistance.
70 h. Financial literacy skills training.
71
72 The specific services to be provided under this subparagraph
73 shall be determined by an aftercare services assessment and may
74 be provided by the department or through referrals in the
75 community.
76 2. Temporary assistance provided to prevent homelessness
77 shall be provided as expeditiously as possible and within the
78 limitations defined by the department.
79 3. A young adult who has reached 18 years of age but is
80 not yet <u>21</u> ~~23~~ years of age who leaves foster care at 18 years of
81 age but who requests services prior to reaching <u>21</u> ~~23~~ years of
82 age is eligible for such services.
83 (b) Road-to-Independence Program.—
84 1. The Road-to-Independence Program is intended to help

85 eligible students who are former foster children in this state
86 to receive the educational and vocational training needed to
87 achieve independence. The amount of the award shall be based on
88 the living and educational needs of the young adult and may be
89 up to, but may not exceed, the amount of earnings that the
90 student would have been eligible to earn working a 40-hour-a-
91 week federal minimum wage job.
92 2. A young adult who has earned a standard high school
93 diploma or its equivalent as described in s. 1003.43 or s.
94 1003.435, has earned a special diploma or special certificate of
95 completion as described in s. 1003.438, or has reached 18 years
96 of age but is not yet 21 years of age is eligible for the
97 initial award~~,~~ and ~~a young adult under 23 years of age is~~
98 ~~eligible~~ for renewal awards, if he or she:
99 a. Was a dependent child, under chapter 39, and was living
100 in licensed foster care or in subsidized independent living at
101 the time of his or her 18th birthday or is currently living in
102 licensed foster care or subsidized independent living, or, after
103 reaching the age of 16, was adopted from foster care or placed
104 with a court-approved dependency guardian and has spent a
105 minimum of 6 months in foster care immediately preceding such
106 placement or adoption;
107 b. Spent at least 6 months living in foster care before
108 reaching his or her 18th birthday;
109 c. Is a resident of this state as defined in s. 1009.40;
110 and
111 d. Meets one of the following qualifications:
112 (I) Has earned a standard high school diploma or its

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113 equivalent as described in s. 1003.43 or s. 1003.435, or has
114 earned a special diploma or special certificate of completion as
115 described in s. 1003.438, and has been admitted for full-time
116 enrollment in an eligible postsecondary education institution as
117 defined in s. 1009.533;
118 (II) Is enrolled full time in an accredited high school;
119 or
120 (III) Is enrolled full time in an accredited adult
121 education program designed to provide the student with a high
122 school diploma or its equivalent.
123 3. A young adult applying for the Road-to-Independence
124 Program must apply for any other grants and scholarships for
125 which he or she may qualify. The department shall assist the
126 young adult in the application process and may use the federal
127 financial aid grant process to determine the funding needs of
128 the young adult.
129 4. An award shall be available to a young adult who is
130 considered a full-time student or its equivalent by the
131 educational institution in which he or she is enrolled, unless
132 that young adult has a recognized disability preventing full-
133 time attendance. The amount of the award, whether it is being
134 used by a young adult working toward completion of a high school
135 diploma or its equivalent or working toward completion of a
136 postsecondary education program, shall be determined based on an
137 assessment of the funding needs of the young adult. This
138 assessment must consider the young adult's living and
139 educational costs and other grants, scholarships, waivers,
140 earnings, and other income to be received by the young adult. An

141 award shall be available only to the extent that other grants
142 and scholarships are not sufficient to meet the living and
143 educational needs of the young adult, but an award may not be
144 less than $25 in order to maintain Medicaid eligibility for the
145 young adult as provided in s. 409.903.
146 5. The amount of the award may be disregarded for purposes
147 of determining the eligibility for, or the amount of, any other
148 federal or federally supported assistance.
149 6.a. The department must advertise the criteria,
150 application procedures, and availability of the program to:
151 (I) Children and young adults in, leaving, or formerly in
152 foster care.
153 (II) Case managers.
154 (III) Guidance and family services counselors.
155 (IV) Principals or other relevant school administrators.
156 (V) Guardians ad litem.
157 (VI) Foster parents.
158 b. The department shall issue awards from the program for
159 each young adult who meets all the requirements of the program
160 to the extent funding is available.
161 c. An award shall be issued at the time the eligible
162 student reaches 18 years of age.
163 d. A young adult who is eligible for the Road-to-
164 Independence Program, transitional support services, or
165 aftercare services and who so desires shall be allowed to reside
166 with the licensed foster family or group care provider with whom
167 he or she was residing at the time of attaining his or her 18th
168 birthday or to reside in another licensed foster home or with a

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169 group care provider arranged by the department.
170 e. If the award recipient transfers from one eligible
171 institution to another and continues to meet eligibility
172 requirements, the award must be transferred with the recipient.
173 f. Funds awarded to any eligible young adult under this
174 program are in addition to any other services or funds provided
175 to the young adult by the department through transitional
176 support services or aftercare services.
177 g. The department shall provide information concerning
178 young adults receiving funding through the Road-to-Independence
179 Program to the Department of Education for inclusion in the
180 student financial assistance database, as provided in s.
181 1009.94.
182 h. Funds are intended to help eligible young adults who
183 are former foster children in this state to receive the
184 educational and vocational training needed to become independent
185 and self-supporting. The funds shall be terminated when the
186 young adult has attained one of four postsecondary goals under
187 subsection (3) or reaches 21 ~~23~~ years of age, whichever occurs
188 earlier. In order to initiate postsecondary education, to allow
189 for a change in career goal, or to obtain additional skills in
190 the same educational or vocational area, a young adult may earn
191 no more than two diplomas, certificates, or credentials. A young
192 adult attaining an associate of arts or associate of science
193 degree shall be permitted to work toward completion of a
194 bachelor of arts or a bachelor of science degree or an
195 equivalent undergraduate degree. Road-to-Independence Program
196 funds may not be used for education or training after a young

197 adult has attained a bachelor of arts or a bachelor of science
198 degree or an equivalent undergraduate degree.
199 i. The department shall evaluate and renew each award
200 annually during the 90-day period before the young adult's
201 birthday. In order to be eligible for a renewal award for the
202 subsequent year, the young adult must:
203 (I) Complete the number of hours, or the equivalent
204 considered full time by the educational institution, unless that
205 young adult has a recognized disability preventing full-time
206 attendance, in the last academic year in which the young adult
207 earned an award, except for a young adult who meets the
208 requirements of s. 1009.41.
209 (II) Maintain appropriate progress as required by the
210 educational institution, except that, if the young adult's
211 progress is insufficient to renew the award at any time during
212 the eligibility period, the young adult may restore eligibility
213 by improving his or her progress to the required level.
214 j. Funds may be terminated during the interim between an
215 award and the evaluation for a renewal award if the department
216 determines that the award recipient is no longer enrolled in an
217 educational institution as defined in sub-subparagraph 2.d., or
218 is no longer a state resident. The department shall notify a
219 recipient who is terminated and inform the recipient of his or
220 her right to appeal.
221 k. An award recipient who does not qualify for a renewal
222 award or who chooses not to renew the award may subsequently
223 apply for reinstatement. An application for reinstatement must
224 be made before the young adult reaches 21 ~~23~~ years of age, and a

225 student may not apply for reinstatement more than once. In order
226 to be eligible for reinstatement, the young adult must meet the
227 eligibility criteria and the criteria for award renewal for the
228 program.
229 (c) Transitional support services.—
230 1. In addition to any services provided through aftercare
231 support or the Road-to-Independence Program, a young adult
232 formerly in foster care may receive other appropriate short-term
233 funding and services, which may include financial, housing,
234 counseling, employment, education, mental health, disability,
235 and other services, if the young adult demonstrates that the
236 services are critical to the young adult's own efforts to
237 achieve self-sufficiency and to develop a personal support
238 system. The department or community-based care provider shall
239 work with the young adult in developing a joint transition plan
240 that is consistent with a needs assessment identifying the
241 specific need for transitional services to support the young
242 adult's own efforts. The young adult must have specific tasks to
243 complete or maintain included in the plan and be accountable for
244 the completion of or making progress towards the completion of
245 these tasks. If the young adult and the department or community-
246 based care provider cannot come to agreement regarding any part
247 of the plan, the young adult may access a grievance process to
248 its full extent in an effort to resolve the disagreement.
249 2. A young adult formerly in foster care is eligible to
250 apply for transitional support services if he or she has reached
251 18 years of age but is not yet 21 ~~23~~ years of age, was a
252 dependent child pursuant to chapter 39, was living in licensed

253 foster care or in subsidized independent living at the time of
254 his or her 18th birthday, and had spent at least 6 months living
255 in foster care before that date.
256 3. If at any time the services are no longer critical to
257 the young adult's own efforts to achieve self-sufficiency and to
258 develop a personal support system, they shall be terminated.
259 (d) Payment of aftercare, Road-to-Independence Program, or
260 transitional support funds.—
261 1. Payment of aftercare, Road-to-Independence Program, or
262 transitional support funds shall be made directly to the
263 recipient unless the recipient requests in writing to the
264 community-based care lead agency, or the department, that the
265 payments or a portion of the payments be made directly on the
266 recipient's behalf in order to secure services such as housing,
267 counseling, education, or employment training as part of the
268 young adult's own efforts to achieve self-sufficiency.
269 2. After the completion of aftercare support services that
270 satisfy the requirements of sub-subparagraph (a)1.h., payment of
271 awards under the Road-to-Independence Program shall be made by
272 direct deposit to the recipient, unless the recipient requests
273 in writing to the community-based care lead agency or the
274 department that:
275 a. The payments be made directly to the recipient by check
276 or warrant;
277 b. The payments or a portion of the payments be made
278 directly on the recipient's behalf to institutions the recipient
279 is attending to maintain eligibility under this section; or
280 c. The payments be made on a two-party check to a business

281 or landlord for a legitimate expense, whether reimbursed or not.
282 A legitimate expense for the purposes of this sub-subparagraph
283 shall include automobile repair or maintenance expenses;
284 educational, job, or training expenses; and costs incurred,
285 except legal costs, fines, or penalties, when applying for or
286 executing a rental agreement for the purposes of securing a home
287 or residence.
288 3. The community-based care lead agency may purchase
289 housing, transportation, or employment services to ensure the
290 availability and affordability of specific transitional services
291 thereby allowing an eligible young adult to utilize these
292 services in lieu of receiving a direct payment. Prior to
293 purchasing such services, the community-based care lead agency
294 must have a plan approved by the department describing the
295 services to be purchased, the rationale for purchasing the
296 services, and a specific range of expenses for each service that
297 is less than the cost of purchasing the service by an individual
298 young adult. The plan must include a description of the
299 transition of a young adult using these services into
300 independence and a timeframe for achievement of independence. An
301 eligible young adult who prefers a direct payment shall receive
302 such payment. The plan must be reviewed annually and evaluated
303 for cost-efficiency and for effectiveness in assisting young
304 adults in achieving independence, preventing homelessness among
305 young adults, and enabling young adults to earn a livable wage
306 in a permanent employment situation.
307 4. The young adult who resides with a foster family may
308 not be included as a child in calculating any licensing

309 restriction on the number of children in the foster home.
310 (e) Appeals process.—
311 1. The Department of Children and Family Services shall
312 adopt by rule a procedure by which a young adult may appeal an
313 eligibility determination or the department's failure to provide
314 aftercare, Road-to-Independence Program, or transitional support
315 services, or the termination of such services, if such funds are
316 available.
317 2. The procedure developed by the department must be
318 readily available to young adults, must provide timely
319 decisions, and must provide for an appeal to the Secretary of
320 Children and Family Services. The decision of the secretary
321 constitutes final agency action and is reviewable by the court
322 as provided in s. 120.68.
323 Section 2. Section 415.1114, Florida Statutes, is created
324 to read:
325 415.1114 Adult protective investigations; procedures;
326 funding.—
327 (1) The department may transfer all responsibility for
328 adult protective investigations to the sheriff of a county in
329 which the abuse, neglect, or exploitation of a vulnerable adult
330 in need of services is alleged to have occurred. Each sheriff is
331 responsible for the provision of adult protective investigations
332 in his or her county. An individual who provides these services
333 must complete the training required of protective investigators
334 employed by the department.
335 (2) In order to implement the transfer of responsibilities
336 for adult protective investigations, the department and a

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337 sheriff's office shall enter into a contract for the provision
338 of these services. Funding for the services shall be
339 appropriated to the department and the department shall transfer
340 to the respective sheriff's office funding for the investigative
341 responsibilities assumed by the sheriffs, including any federal
342 funds for which a provider is eligible and agrees to receive and
343 that portion of general revenue funds currently designated to
344 provide those services, including, but not limited to, funding
345 for all investigative positions, training, associated equipment
346 and furnishings, and other fixed capital items. The contract
347 must specify whether the department will continue to perform any
348 adult protective investigations during the initial year and
349 specify if services are to be performed by employees of the
350 department or by persons appointed by the sheriff.
351 (3) A sheriff's office that is providing adult protective
352 investigations shall operate in accordance with the performance
353 standards and outcome measures established by the Legislature
354 for protective investigations conducted by the department.
355 (4) Funds for adult protective investigations must be
356 identified in the annual appropriation made to the department,
357 which shall award grants for the full amount identified in the
358 General Appropriations Act to the respective sheriffs' offices.
359 Notwithstanding the provisions of ss. 216.181(16)(b) and
360 216.351, the department may advance payments to a sheriff's
361 office for adult protective investigations. Funds for adult
362 protective investigations may not be integrated into the regular
363 budget of the sheriff's office. Budgetary data and other data
364 relating to the performance of adult protective investigations

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365 must be maintained separately from all other records of the
366 sheriff's office and reported to the department as specified in
367 the grant agreement.
368 (5) The program performance evaluation shall be based on
369 criteria mutually agreed upon by the respective sheriffs'
370 offices and the department. The program performance evaluation
371 shall be conducted by the adult protective services program in
372 collaboration with the respective sheriff's office.
373 Section 3. This act shall take effect July 1, 2011.

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HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCAS 11-05 Domestic Violence
SPONSOR(S): Health Care Appropriations Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee		Perritti	Pridgeon

SUMMARY ANALYSIS

The bill makes statutory changes to conform to decisions made in the House proposed General Appropriations Act (GAA) for Fiscal Year 2011-12.

The bill amends the duties and functions of the Department of Children and Families relating to the domestic violence program as follows:

- The bill limits the Department's role in certification of domestic violence shelters to initial certification, suspension and revocation. Ongoing certification of domestic violence shelters will be performed by the Florida Coalition Against Domestic Violence (FCADV).
- The Department will partner with the FCADA to coordinate and administer the statewide activities related to the prevention of domestic violence.
- The bill eliminates certification of batterers' intervention programs as well as the authority to collect fees by the Department associated with the certification program.

The House proposed GAA for Fiscal Year 2010-11 reduces recurring general revenue expenditures by $372,054 and $762,276 in recurring trust funds and 11.0 FTE as a result of limiting the Department of Children and Families role to the domestic violence program and eliminating the Department's authority to certify batterer's intervention programs. The House proposed GAA for Fiscal Year 2010-11 also provides for a transfer of $307,331 in recurring general revenue and $644,520 in recurring trust funds to the FCADV for the certification program.

The bill repeals the Department's authority to assess and collect fees for the certification of batterers' intervention programs. This is estimated to have a negative fiscal impact to the Domestic Violence Trust Fund of $117,738, however this loss is offset since the Department will no longer be required to certify the batterers' intervention programs and positions associated with this function are eliminated.

The bill provides an effective date of July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Domestic Violence Program

Background:

The Department of Children and Families (department) is currently responsible for the statewide Domestic Violence Program, which provides supervision, direction, coordination, and administration of activities related to domestic violence prevention and intervention services.[1]

Domestic Violence centers are community-based agencies that provide services to the victims of domestic violence. Minimum services include temporary emergency shelter; information and referrals; safety planning, counseling and case management; a 24-hour emergency hotline; educational services for community awareness; assessment and appropriate referral of resident children; and training for law enforcement and other professionals.[2]

The 1978 Florida Legislature enacted the certification of domestic violence centers.[3] The department is responsible for monitoring certification on an annual basis to ensure that the certified centers continue to remain in compliance with the standards for certification.[4] In order for a domestic violence center to receive funding, it must be certified.[5]

The Florida Coalition Against Domestic Violence serves as the professional association for the state's 42 certified domestic violence centers and is the primary representative of battered women and their children in the public policy arena. Funding sources for the coalition have included the federal Family Violence Prevention Services Act, the federal Violence Against Women Act, membership fees, private donations, and funds from the state. The Coalition administers state and federal funding earmarked to the 42 domestic violence centers in the state. Effective January 1, 2004, the Coalition became responsible for approving or rejecting applications for funding and contracting with certified centers. In order to receive state funds, a center must obtain certification by the State of Florida; however, the issuance of certification does not obligate the coalition to provide state funding. The Coalition monitors the centers fiscally and programmatically under their new authority to administer funds. This review process also includes compliance with rule and law.

Effect of bill:

The bill maintains the department's operation of the domestic violence program, but requires the department to partner with the Florida Coalition Against Domestic Violence to perform specific duties currently performed by the department. Pursuant to the bill, the department retains the responsibility of establishing certification standards for centers; however, ongoing certification activities would be performed by the Coalition. The department retains the authority to deny, suspend or revoke certification of a center. The bill provides that certification will be renewed annually by the department upon a favorable monitoring report by the Coalition.

The bill retains the authorization for the department to enter and inspect the premises of domestic violence centers applying for an initial certification after July 1, 2011. The bill removes the authority of the department to enter and inspect existing certified domestic violence centers and gives this authority to the Coalition.

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[1] s. 39.903(3), F.S.
[2] s. 39.905, F.S.
[3] Ch. 78-281, L.O.F.
[4] s. 39.903(1)(d), F.S.
[5] s. 39.905(6)(a), F.S.

The department will be required to contract with the Coalition to implement, administer and evaluate all services provided by the certified domestic violence centers and will have the ability to approve or reject funding and to determine compliance with certification minimum standards. Further, the Coalition will be required to report to the Legislature information that is currently reported by the department regarding the status and number of domestic violence cases.

The bill requires information relating to domestic violence advocates who are employed or who volunteer at a domestic violence center and may claim a privilege to refuse to disclose confidential communications to be reported to the Coalition rather than the department. The bill also requires a new center applying for certification in an area where a center already exists to demonstrate the unmet need by the existing center and describe efforts to reduce duplication of services.

The bill codifies that the department will serve as the lead agency application of relevant federal grants and coordinator of the State Violence Against Women STOP Implementation Plan that promotes domestic violence awareness, increases services to victims and strengthens perpetrator accountability. The bill requires the department to contract with the Coalition for the administration of contracts and grants associated with federal grants as directed by the department.

Batterer Intervention Program

Background:

Section 741.32, F.S. provides for certification of batterers' intervention programs by the department. According to that section of statute, the "purpose of certification of programs is to uniformly and systematically standardize programs to hold those who perpetrate acts of domestic violence responsible for those acts and to ensure safety for victims of domestic violence."

Section 741.325, F.S. requires the department to promulgate rules setting forth certain requirements of the programs. Several sections of statute authorize or require judges to order an offender to participate in a batterers' intervention program. For example, section 948.038, F.S. provides that as a condition of probation, community control, or any other court-ordered community supervision, a judge must, with certain exceptions, order a person convicted of an offense of domestic violence to attend and successfully complete a batterers' intervention program. This section requires that the batterers' intervention program must be a program certified under s. 741.32, and the offender must pay the cost of attending the program.

Section 741.327, F.S. authorizes the department to assess and collect fees for the certification of batterers' intervention programs as follows:

- An annual certification fee not to exceed $300 for the certification and monitoring of batterers' intervention programs.
- An annual certification fee not to exceed $200 for the certification and monitoring of assessment personnel providing direct services to persons who:
    - Are ordered by the court to participate in a domestic violence prevention program;
    - Are adjudged to have committed an act of domestic violence as defined in s. 741.28;
    - Have an injunction entered for protection against domestic violence; or
    - Agree to attend a program as part of a diversion or pretrial intervention agreement by the offender with the state attorney.

Further, this section requires all persons required by the court to attend domestic violence programs certified by the department to pay an additional $30 fee for each program to the department. The fees assessed and collected under this section are deposited in the Executive Office of the Governor's Domestic Violence Trust Fund established in s. 741.01 and directed to the Department of Children and Family Services to fund the cost of certifying and monitoring batterers' intervention programs. The Department has indicated that the current fee collections do not support the cost associated with the certifying and monitoring batterers' intervention programs.

Effect of bill:

The bill eliminates the department's certification role in the Batterer's Intervention program. The bill amends s. 741.325, F.S. to require that batterers' intervention programs meet the requirements currently in law but removes the authority for the department to promulgate rules to establish these requirements. The bill retains references to batterers' intervention programs elsewhere in statute but eliminates references to the programs being certified by the department.

The bill provides an effective date of July 1, 2011.

B. SECTION DIRECTORY:

Section 1. Amends s. 39.303, F.S., relating to duties and functions of the Department of Children and Family Services with respect to domestic violence, specifically regarding certification of newly established domestic violence centers.

Section 2. Amends 39.904, F.S., relating to reports to the Legislature on the status of domestic violence cases. Requiring FCADV to report to the Legislature and changing the changing the information required in the report.

Section 3. Amends 39.905, F.S., relating to requirements for certification as a domestic violence center. Requires the center to file with the FCADV

Section 4. Amends 381.006(18), F.S., relating to environmental health to conform to the new duties delegated to FCADV.

Section 5. Amends s. 381.0072, F.S., relating to food service protection to conform to the new duties delegate to FCADV to monitor domestic violence centers.

Section 6. Amends s. 741.281, F.S., relating to court ordered batter's intervention programs. Removes the requirement that it must be a certified program.

Section 7. Amends s. 741.2902, F.S., relating to the legislative intent with respect to judiciary's role in domestic violence.

Section 8. Amends s. 741.316, F.S., to assign the domestic violence fatality review teams to the FCADV and remove from the department.

Section 9. Amends s. 741.32, F.S., relating to batterers' intervention programs. Removes the requirement that the program be certified by the department.

Section 10. Amends s. 41.325, F.S., relating to requirements for batterers' intervention programs, to remove the department's responsibility to create guidelines and conforming to removal of certification.

Section 11. Repeals s. 741.327, F.S.

Section 12. Amends s. 948.038, F.S. relating to batterers' intervention programs, conforming to removal of certification.

Section 13. Provides the bill is effective July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The Domestic Violence Trust Fund revenues will be reduced by approximately $117,738 in fees associated with cost of certifying and monitoring batterers' intervention programs however this loss is offset since the Department will no longer be required to certify the batterers' intervention programs.

2. Expenditures:

	FTE	FY 2011-12
Domestic Violence Program		
Positions	(9.00)	
General Revenue		(307,331)
Trust Funds		(644,520)
Total	**(9.00)**	**(951,851)**
Batterer's Intervention Program		
Positions	(2.00)	
General Revenue		(64,741)
Trust Funds		(117,738)
Total	**(2.00)**	**(182,479)**
Total	**(11.00)**	**(1,134,330)**
Transfer to FCADV		
Positions		
General Revenue		307,331
Trust Funds		644,520
Total		**951,851**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   None.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to domestic violence; amending s. 39.903,
3 F.S.; revising provisions relating to certification of
4 domestic violence centers; providing specified additional
5 duties for and authority of the Florida Coalition Against
6 Domestic Violence; revising the duties of the Department
7 of Children and Family Services; requiring the department
8 to contract with the Florida Coalition Against Domestic
9 Violence for specified purposes; amending s. 39.904, F.S.;
10 requiring the Florida Coalition Against Domestic Violence
11 rather than the department to make a specified annual
12 report; revising the contents of the report; amending s.
13 39.905, F.S.; requiring the Florida Coalition Against
14 Domestic Violence rather than the department to perform
15 certain duties relating to certification of domestic
16 violence centers; revising provisions relating to
17 certification of domestic violence centers; requiring a
18 demonstration of need for certification of a new domestic
19 violence center; revising provisions relating to
20 expiration of a center's annual certificate; amending ss.
21 381.006, 381.0072, 741.281, 741.2902, 741.30, and 741.316,
22 F.S.; conforming provisions to changes made by the act;
23 amending s. 741.32, F.S.; deleting provisions relating to
24 certification of batterers' intervention programs by the
25 Department of Children and Family Services; amending s.
26 741.325, F.S.; revising the requirements for batters'
27 intervention programs; repealing s. 741.327, F.S.,
28 relating to certification and monitoring of batterers'

29 intervention programs; amending ss. 948.038 and 938.01,
30 F.S.; conforming provisions to changes made by the act;
31 providing an effective date.
32
33 Be It Enacted by the Legislature of the State of Florida:
34
35 Section 1. Section 39.903, Florida Statutes, is amended to
36 read:
37 39.903 Duties and functions of the department with respect
38 to domestic violence.—
39 (1) The department shall:
40 (a) Develop by rule criteria for the approval or rejection
41 of domestic violence centers applying for initial certification
42 after July 1, 2011 ~~certification or funding of domestic violence~~
43 ~~centers~~.
44 (b) Develop by rule minimum standards for domestic
45 violence centers to ensure the health and safety of the clients
46 in the centers.
47 (c) Receive and approve or reject applications for initial
48 certification of domestic violence centers. Such certification
49 shall be renewed annually thereafter by the department upon a
50 favorable monitoring report by the Florida Coalition Against
51 Domestic Violence. If any of the required services are exempted
52 from certification by the department under s. 39.905(1)(c), the
53 center may ~~shall~~ not receive funding from the Florida Coalition
54 Against Domestic Violence for those services.
55 (d) Have ~~Evaluate each certified domestic violence center~~
56 ~~annually to ensure compliance with the minimum standards. The~~

57 ~~department has~~ the right to enter and inspect the premises of
58 domestic violence centers applying for an initial certification
59 after July 1, 2011, ~~certified domestic violence centers at any~~
60 ~~reasonable hour in order~~ to effectively evaluate the state of
61 compliance with minimum standards ~~of these centers with this~~
62 ~~part and rules relating to this part~~. The Florida Coalition
63 Against Domestic Violence has the right to enter and inspect the
64 premises of certified domestic violence centers for monitoring
65 purposes.
66 (e) Adopt rules to implement this part.
67 (f) Promote the involvement of certified domestic violence
68 centers in the coordination, development, and planning of
69 domestic violence programming in the circuits ~~districts and the~~
70 ~~state~~.
71 ~~(2) The department shall serve as a clearinghouse for~~
72 ~~information relating to domestic violence.~~
73 (2)~~(3)~~ The department shall operate the domestic violence
74 program and partner with the Florida Coalition Against Domestic
75 Violence in~~, which provides supervision, direction,~~
76 coordination~~,~~ and administration of statewide activities related
77 to the prevention of domestic violence.
78 (3)~~(4)~~ The department shall coordinate with state agencies
79 having health, education, or criminal justice responsibilities
80 to raise awareness of domestic violence and promote consistent
81 policy implementation ~~enlist the assistance of public and~~
82 ~~voluntary health, education, welfare, and rehabilitation~~
83 ~~agencies in a concerted effort to prevent domestic violence and~~
84 ~~to treat persons engaged in or subject to domestic violence.~~

85 ~~With the assistance of these agencies, the department, within~~
86 ~~existing resources, shall formulate and conduct a research and~~
87 ~~evaluation program on domestic violence. Efforts on the part of~~
88 ~~these agencies to obtain relevant grants to fund this research~~
89 ~~and evaluation program must be supported by the department~~.
90 (4) The department shall serve as the lead agency for
91 application of relevant federal grants and the coordinator of
92 the state's STOP Implementation Plan pursuant to the federal
93 Violence Against Women Act which promotes domestic violence
94 awareness, increases services to victims, and strengthens
95 perpetrator accountability.
96 ~~(5) The department shall develop and provide educational~~
97 ~~programs on domestic violence for the benefit of the general~~
98 ~~public, persons engaged in or subject to domestic violence,~~
99 ~~professional persons, or others who care for or may be engaged~~
100 ~~in the care and treatment of persons engaged in or subject to~~
101 ~~domestic violence.~~
102 (5) ~~(6)~~ The department shall cooperate with, assist in, and
103 participate in~~,~~ programs of other properly qualified state
104 agencies, federal agencies, private organizations ~~including any~~
105 ~~agency of the Federal Government~~, schools of medicine,
106 hospitals, and clinics, in planning and conducting research on
107 the prevention of domestic violence and provision of services to
108 clients~~, care, treatment, and rehabilitation of persons engaged~~
109 ~~in or subject to domestic violence~~.
110 (6) ~~(7)~~ The department shall contract with the Florida
111 Coalition Against Domestic Violence, the ~~a~~ statewide association
112 whose primary purpose is to represent and provide technical

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113 assistance to certified domestic violence centers, for the
114 delivery and management of the delivery of services for the
115 state's domestic violence program. Services under this contract
116 shall include, but are not limited to, administration of
117 contracts and grants associated with the implementation of the
118 state's STOP Implementation Plan pursuant to the federal
119 Violence Against Women Act and the implementation of other
120 federal grants as directed by the department. As part of its
121 management of the delivery of services for the state's domestic
122 violence program, the coalition ~~This association~~ shall
123 implement, administer, and evaluate all services provided by the
124 certified domestic violence centers, ~~. The association shall~~
125 receive and approve or reject applications for funding of
126 certified domestic violence centers, and evaluate certified
127 domestic violence centers to determine compliance with
128 certification minimum standards. When approving funding for a
129 newly certified domestic violence center, the association shall
130 make every effort to minimize any adverse economic impact on
131 existing certified domestic violence centers or services
132 provided within the same service area. In order to minimize
133 duplication of services, the association shall make every effort
134 to encourage subcontracting relationships with existing
135 certified domestic violence centers within the same service
136 area. In distributing funds allocated by the Legislature for
137 certified domestic violence centers, the association shall use a
138 formula approved by the department as specified in s.
139 39.905(7)(a).

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140 (7) The department shall consider and award applications
141 from certified domestic violence centers for capital improvement
142 grants pursuant to s. 39.9055.
143 Section 2. Section 39.904, Florida Statutes, is amended to
144 read:
145 39.904 Report to the Legislature on the status of domestic
146 violence cases.—On or before January 1 of each year, the Florida
147 Coalition Against Domestic Violence ~~department~~ shall furnish to
148 the President of the Senate and the Speaker of the House of
149 Representatives a report on the status of domestic violence in
150 this state, which ~~report~~ shall include, but is not limited to,
151 the following:
152 (1) The incidence of domestic violence in this state.
153 (2) An identification of the areas of the state where
154 domestic violence is of significant proportions, indicating the
155 number of cases of domestic violence officially reported, as
156 well as an assessment of the degree of unreported cases of
157 domestic violence.
158 (3) An identification and description of the types of
159 programs in the state that assist victims of domestic violence
160 or persons who commit domestic violence, including information
161 on funding for the programs.
162 (4) The number of persons who receive services from ~~are~~
163 ~~treated by or assisted by~~ local certified domestic violence
164 programs that receive funding through the Florida Coalition
165 Against Domestic Violence ~~department~~.
166 (5) The incidence of domestic violence homicides in the
167 state, including information and data collected from state and

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168 local domestic violence fatality review teams.
169 ~~(5) A statement on the effectiveness of such programs in~~
170 ~~preventing future domestic violence.~~
171 ~~(6) An inventory and evaluation of existing prevention~~
172 ~~programs.~~
173 ~~(7) A listing of potential prevention efforts identified~~
174 ~~by the department; the estimated annual cost of providing such~~
175 ~~prevention services, both for a single client and for the~~
176 ~~anticipated target population as a whole; an identification of~~
177 ~~potential sources of funding; and the projected benefits of~~
178 ~~providing such services.~~
179 Section 3. Paragraphs (c), (g), and (i) of subsection (1),
180 subsections (2), (3), and (5), paragraph (a) of subsection (6),
181 and paragraph (b) of subsection (7) of section 39.905, Florida
182 Statutes, are amended to read:
183 39.905 Domestic violence centers.—
184 (1) Domestic violence centers certified under this part
185 must:
186 (c) Provide minimum services that ~~which~~ include, but are
187 not limited to, information and referral services, counseling
188 and case management services, temporary emergency shelter for
189 more than 24 hours, a 24-hour hotline, training for law
190 enforcement personnel, assessment and appropriate referral of
191 resident children, and educational services for community
192 awareness relative to the incidence of domestic violence, the
193 prevention of such violence, and the services available ~~care,~~
194 ~~treatment, and rehabilitation~~ for persons engaged in or subject
195 to domestic violence. If a 24-hour hotline, professional

196 training, or community education is already provided by a
197 certified domestic violence center within its designated service
198 area ~~a district~~, the department may exempt such certification
199 requirements for a new center serving the same service area
200 ~~district~~ in order to avoid duplication of services.
201 (g) File with the Florida Coalition Against Domestic
202 Violence ~~department~~ a list of the names of the domestic violence
203 advocates who are employed or who volunteer at the domestic
204 violence center who may claim a privilege under s. 90.5036 to
205 refuse to disclose a confidential communication between a victim
206 of domestic violence and the advocate regarding the domestic
207 violence inflicted upon the victim. The list must include the
208 title of the position held by the advocate whose name is listed
209 and a description of the duties of that position. A domestic
210 violence center must file amendments to this list as necessary.
211 (i) If its center is a new center applying for
212 certification, demonstrate that the services provided address a
213 need identified in the most current statewide needs assessment
214 approved by the department. If the center applying for initial
215 certification proposes providing services in an area where a
216 certified domestic violence center exists, it must demonstrate
217 the unmet need by the existing center and describe any efforts
218 to reduce duplication of services.
219 (2) If the department finds that there is failure by a
220 center to comply with the requirements established under this
221 part or with the rules adopted pursuant thereto, the department
222 may deny, suspend, or revoke the certification of the center.
223 The grant, denial, suspension, or revocation of certification

224 does not constitute agency action under chapter 120.
225 (3) The annual certificate ~~shall~~ automatically expires
226 ~~expire~~ on December 31 unless the certification is temporarily
227 extended to allow the center to implement corrective action
228 plans ~~the termination date shown on the certificate~~.
229 (5) Domestic violence centers may be established
230 throughout the state when private, local, state, or federal
231 funds are available and a need is demonstrated.
232 (6) In order to receive state funds, a center must:
233 (a) Obtain certification pursuant to this part. However,
234 the issuance of a certificate does ~~will~~ not obligate the Florida
235 Coalition Against Domestic Violence ~~department~~ to provide
236 funding.
237 (7)
238 (b) A contract between the Florida Coalition Against
239 Domestic Violence ~~statewide association~~ and a certified domestic
240 violence center shall contain provisions ensuring ~~assuring~~ the
241 availability and geographic accessibility of services throughout
242 the service area ~~district~~. For this purpose, a center may
243 distribute funds through subcontracts or to center satellites,
244 if ~~provided~~ such arrangements and any subcontracts are approved
245 by the Florida Coalition Against Domestic Violence ~~statewide~~
246 ~~association~~.
247 Section 4. Subsection (18) of section 381.006, Florida
248 Statutes, is amended to read:
249 381.006 Environmental health.—The department shall conduct
250 an environmental health program as part of fulfilling the
251 state's public health mission. The purpose of this program is to

252 detect and prevent disease caused by natural and manmade factors
253 in the environment. The environmental health program shall
254 include, but not be limited to:
255 (18) A food service inspection function for domestic
256 violence centers that are certified and monitored by the Florida
257 Coalition Against Domestic Violence ~~Department of Children and~~
258 ~~Family Services~~ under part XIII of chapter 39 and group care
259 homes as described in subsection (16), which shall be conducted
260 annually and be limited to the requirements in department rule
261 applicable to community-based residential facilities with five
262 or fewer residents.
263
264 The department may adopt rules to carry out the provisions of
265 this section.
266 Section 5. Paragraph (b) of subsection (1) of section
267 381.0072, Florida Statutes, is amended to read:
268 381.0072 Food service protection.—It shall be the duty of
269 the Department of Health to adopt and enforce sanitation rules
270 consistent with law to ensure the protection of the public from
271 food-borne illness. These rules shall provide the standards and
272 requirements for the storage, preparation, serving, or display
273 of food in food service establishments as defined in this
274 section and which are not permitted or licensed under chapter
275 500 or chapter 509.
276 (1) DEFINITIONS.—As used in this section, the term:
277 (b) "Food service establishment" means detention
278 facilities, public or private schools, migrant labor camps,
279 assisted living facilities, adult family-care homes, adult day

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280 care centers, short-term residential treatment centers,
281 residential treatment facilities, homes for special services,
282 transitional living facilities, crisis stabilization units,
283 hospices, prescribed pediatric extended care centers,
284 intermediate care facilities for persons with developmental
285 disabilities, boarding schools, civic or fraternal
286 organizations, bars and lounges, vending machines that dispense
287 potentially hazardous foods at facilities expressly named in
288 this paragraph, and facilities used as temporary food events or
289 mobile food units at any facility expressly named in this
290 paragraph, where food is prepared and intended for individual
291 portion service, including the site at which individual portions
292 are provided, regardless of whether consumption is on or off the
293 premises and regardless of whether there is a charge for the
294 food. The term does not include any entity not expressly named
295 in this paragraph; nor does the term include a domestic violence
296 center certified and monitored by the Florida Coalition Against
297 Domestic Violence ~~Department of Children and Family Services~~
298 under part XIII of chapter 39 if the center does not prepare and
299 serve food to its residents and does not advertise food or drink
300 for public consumption.
301 Section 6. Section 741.281, Florida Statutes, is amended
302 to read:
303 741.281 Court to order batterers' intervention program
304 attendance.—If a person is found guilty of, has ~~had~~ adjudication
305 withheld on, or pleads ~~has pled~~ nolo contendere to a crime of
306 domestic violence, as defined in s. 741.28, that person shall be
307 ordered by the court to a minimum term of 1 year's probation and

308 the court shall order that the defendant attend a batterers'
309 intervention program as a condition of probation. The court must
310 impose the condition of the batterers' intervention program for
311 a defendant under this section, but the court, in its
312 discretion, may determine not to impose the condition if it
313 states on the record why a batterers' intervention program might
314 be inappropriate. The court must impose the condition of the
315 batterers' intervention program for a defendant placed on
316 probation unless the court determines that the person does not
317 qualify for the batterers' intervention program pursuant to s.
318 741.325. ~~Effective July 1, 2002, the batterers' intervention~~
319 ~~program must be a certified program under s. 741.32.~~ The
320 imposition of probation under this section does ~~shall~~ not
321 preclude the court from imposing any sentence of imprisonment
322 authorized by s. 775.082.
323 Section 7. Paragraph (g) of subsection (2) of section
324 741.2902, Florida Statutes, is amended to read:
325 741.2902 Domestic violence; legislative intent with
326 respect to judiciary's role.—
327 (2) It is the intent of the Legislature, with respect to
328 injunctions for protection against domestic violence, issued
329 pursuant to s. 741.30, that the court shall:
330 (g) Consider requiring the perpetrator to complete a
331 batterers' intervention program. It is preferred that such
332 program include requirements as stated in s. 741.325 ~~be~~
333 ~~certified under s. 741.32~~.
334 Section 8. Paragraphs (a) and (e) of subsection (6) of
335 section 741.30, Florida Statutes, are amended to read:

336 741.30 Domestic violence; injunction; powers and duties of
337 court and clerk; petition; notice and hearing; temporary
338 injunction; issuance of injunction; statewide verification
339 system; enforcement.—
340 (6)(a) Upon notice and hearing, when it appears to the
341 court that the petitioner is either the victim of domestic
342 violence as defined by s. 741.28 or has reasonable cause to
343 believe he or she is in imminent danger of becoming a victim of
344 domestic violence, the court may grant such relief as the court
345 deems proper, including an injunction:
346 1. Restraining the respondent from committing any acts of
347 domestic violence.
348 2. Awarding to the petitioner the exclusive use and
349 possession of the dwelling that the parties share or excluding
350 the respondent from the residence of the petitioner.
351 3. On the same basis as provided in chapter 61, providing
352 the petitioner with 100 percent of the time-sharing in a
353 temporary parenting plan that shall remain in effect until the
354 order expires or an order is entered by a court of competent
355 jurisdiction in a pending or subsequent civil action or
356 proceeding affecting the placement of, access to, parental time
357 with, adoption of, or parental rights and responsibilities for
358 the minor child.
359 4. On the same basis as provided in chapter 61,
360 establishing temporary support for a minor child or children or
361 the petitioner. An order of temporary support remains in effect
362 until the order expires or an order is entered by a court of
363 competent jurisdiction in a pending or subsequent civil action

364 or proceeding affecting child support.
365 5. Ordering the respondent to participate in treatment,
366 intervention, or counseling services to be paid for by the
367 respondent. When the court orders the respondent to participate
368 in a batterers' intervention program, the court, or any entity
369 designated by the court, must provide the respondent with a list
370 of all certified batterers' intervention programs and all
371 programs that ~~which~~ have submitted an application ~~to the~~
372 ~~Department of Children and Family Services~~ to become certified
373 ~~under s. 741.32,~~ from which the respondent must choose a program
374 in which to participate. If there are no certified batterers'
375 intervention programs in the circuit, the court shall provide a
376 list of acceptable programs from which the respondent must
377 choose a program in which to participate.
378 6. Referring a petitioner to a certified domestic violence
379 center. The court must provide the petitioner with a list of
380 certified domestic violence centers in the circuit which the
381 petitioner may contact.
382 7. Ordering such other relief as the court deems necessary
383 for the protection of a victim of domestic violence, including
384 injunctions or directives to law enforcement agencies, as
385 provided in this section.
386 (e) An injunction for protection against domestic violence
387 entered pursuant to this section, on its face, may order that
388 the respondent attend a batterers' intervention program as a
389 condition of the injunction. Unless the court makes written
390 factual findings in its judgment or order which are based on
391 substantial evidence, stating why batterers' intervention

392 programs would be inappropriate, the court shall order the
393 respondent to attend a batterers' intervention program if:
394 1. It finds that the respondent willfully violated the ex
395 parte injunction;
396 2. The respondent, in this state or any other state, has
397 been convicted of, had adjudication withheld on, or pled nolo
398 contendere to a crime involving violence or a threat of
399 violence; or
400 3. The respondent, in this state or any other state, has
401 had at any time a prior injunction for protection entered
402 against the respondent after a hearing with notice.
403
404 It is mandatory that such programs be certified under <u>this part</u>
405 ~~s. 741.32~~.
406 Section 9. Subsection (5) of section 741.316, Florida
407 Statutes, is amended to read:
408 741.316 Domestic violence fatality review teams;
409 definition; membership; duties.—
410 (5) The domestic violence fatality review teams are
411 assigned to the <u>Florida Coalition Against Domestic Violence</u>
412 ~~Department of Children and Family Services~~ for administrative
413 purposes.
414 Section 10. Section 741.32, Florida Statutes, is amended
415 to read:
416 741.32 ~~Certification of~~ Batterers' intervention programs.—
417 ~~(1)~~ The Legislature finds that the incidence of domestic
418 violence in <u>this state</u> ~~Florida~~ is disturbingly high~~,~~ and <u>that,</u>
419 despite <u>the</u> efforts of many to curb this violence, ~~that~~ one

420 person dies at the hands of a spouse, ex-spouse, or cohabitant
421 approximately every 3 days. Further, a child who witnesses the
422 perpetration of this violence becomes a victim as he or she
423 hears or sees it occurring. This child is at high risk of also
424 being the victim of physical abuse by the parent who is
425 perpetrating the violence and, to a lesser extent, by the parent
426 who is the victim. These children are also at a high risk of
427 perpetrating violent crimes as juveniles and, later, becoming
428 perpetrators of the same violence that they witnessed as
429 children. The Legislature finds that there should be
430 standardized programming available to the justice system to
431 protect victims and their children and to hold the perpetrators
432 of domestic violence accountable for their acts. Finally, the
433 Legislature recognizes that in order for batterers' intervention
434 programs to be successful in protecting victims and their
435 children, all participants in the justice system as well as
436 social service agencies and local and state governments must
437 coordinate their efforts at the community level.
438 ~~(2) There is hereby established in the Department of~~
439 ~~Children and Family Services an Office for Certification and~~
440 ~~Monitoring of Batterers' Intervention Programs. The department~~
441 ~~may certify and monitor both programs and personnel providing~~
442 ~~direct services to those persons who are adjudged to have~~
443 ~~committed an act of domestic violence as defined in s. 741.28,~~
444 ~~those against whom an injunction for protection against domestic~~
445 ~~violence is entered, those referred by the department, and those~~
446 ~~who volunteer to attend such programs. The purpose of~~
447 ~~certification of programs is to uniformly and systematically~~

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448 ~~standardize programs to hold those who perpetrate acts of~~
449 ~~domestic violence responsible for those acts and to ensure~~
450 ~~safety for victims of domestic violence. The certification and~~
451 ~~monitoring shall be funded by user fees as provided in s.~~
452 ~~741.327.~~
453 Section 11. Section 741.325, Florida Statutes, is amended
454 to read:
455 741.325 Requirements for batterers' intervention programs
456 ~~Guideline authority~~.—
457 (1) A batterers' intervention program shall meet the
458 following requirements ~~The Department of Children and Family~~
459 ~~Services shall promulgate guidelines to govern purpose,~~
460 ~~policies, standards of care, appropriate intervention~~
461 ~~approaches, inappropriate intervention approaches during the~~
462 ~~batterers' program intervention phase (to include couples~~
463 ~~counseling and mediation), conflicts of interest, assessment,~~
464 ~~program content and specifics, qualifications of providers, and~~
465 ~~credentials for facilitators, supervisors, and trainees. The~~
466 ~~department shall, in addition, establish specific procedures~~
467 ~~governing all aspects of program operation, including~~
468 ~~administration, personnel, fiscal matters, victim and batterer~~
469 ~~records, education, evaluation, referral to treatment and other~~
470 ~~matters as needed. In addition, the rules shall establish~~:
471 (a) ~~(1)~~ ~~That~~ The primary purpose of the program ~~programs~~
472 shall be victim safety and the safety of the children, if
473 present.
474 (b) ~~(2)~~ ~~That~~ The batterer shall be held accountable for
475 acts of domestic violence.

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476 (c)~~(3)~~ ~~That~~ The program ~~programs~~ shall be at least 29
477 weeks in length and shall include 24 weekly sessions, plus
478 appropriate intake, assessment, and orientation programming.
479 (d)~~(4)~~ ~~That~~ The program shall be a psychoeducational model
480 that employs a program content based on tactics of power and
481 control by one person over another.
482 ~~(5) That the programs and those who are facilitators,~~
483 ~~supervisors, and trainees be certified to provide these programs~~
484 ~~through initial certification and that the programs and~~
485 ~~personnel be annually monitored to ensure that they are meeting~~
486 ~~specified standards.~~
487 (e)~~(6)~~ ~~The intent that~~ The program shall ~~programs~~ be user-
488 fee funded with fees from the batterers who attend the program
489 as payment, which ~~for programs~~ is important to the batterer
490 taking responsibility for the act of violence~~, and from those~~
491 ~~seeking certification~~. Exception shall be made for those local,
492 state, or federal programs that fund batterers' intervention
493 programs in whole or in part.
494 ~~(7) Standards for rejection and suspension for failure to~~
495 ~~meet certification standards.~~
496 (2)~~(8)~~ The requirements of this section ~~That these~~
497 ~~standards shall~~ apply only to programs that address the
498 perpetration of violence between intimate partners, spouses, ex-
499 spouses, or those who share a child in common or who are
500 cohabitants in intimate relationships for the purpose of
501 exercising power and control by one over the other. It will
502 endanger victims if courts and other referral agencies refer
503 family and household members who are not perpetrators of the

504 type of domestic violence encompassed by these requirements
505 ~~standards~~. Accordingly, the court and others who make referrals
506 should refer perpetrators only to programming that appropriately
507 addresses the violence committed.
508 Section 12. Section 741.327, Florida Statutes, is
509 repealed.
510 Section 13. Section 948.038, Florida Statutes, is amended
511 to read:
512 948.038 Batterers' intervention program as a condition of
513 probation, community control, or other court-ordered community
514 supervision.—As a condition of probation, community control, or
515 any other court-ordered community supervision, the court shall
516 order a person convicted of an offense of domestic violence, as
517 defined in s. 741.28, to attend and successfully complete a
518 batterers' intervention program unless the court determines that
519 the person does not qualify for the batterers' intervention
520 program pursuant to s. 741.325. ~~The batterers' intervention~~
521 ~~program must be a program certified under s. 741.32, and~~ The
522 offender must pay the cost of attending the program.
523 Section 14. Paragraph (a) of subsection (1) of section
524 938.01, Florida Statutes, is amended to read:
525 938.01 Additional Court Cost Clearing Trust Fund.—
526 (1) All courts created by Art. V of the State Constitution
527 shall, in addition to any fine or other penalty, require every
528 person convicted for violation of a state penal or criminal
529 statute or convicted for violation of a municipal or county
530 ordinance to pay $3 as a court cost. Any person whose
531 adjudication is withheld pursuant to the provisions of s.

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532 318.14(9) or (10) shall also be liable for payment of such cost.
533 In addition, $3 from every bond estreature or forfeited bail
534 bond related to such penal statutes or penal ordinances shall be
535 remitted to the Department of Revenue as described in this
536 subsection. However, no such assessment may be made against any
537 person convicted for violation of any state statute, municipal
538 ordinance, or county ordinance relating to the parking of
539 vehicles.
540 (a) All costs collected by the courts pursuant to this
541 subsection shall be remitted to the Department of Revenue in
542 accordance with administrative rules adopted by the executive
543 director of the Department of Revenue for deposit in the
544 Additional Court Cost Clearing Trust Fund. These funds and the
545 funds deposited in the Additional Court Cost Clearing Trust Fund
546 pursuant to s. 318.21(2)(c) shall be distributed as follows:
547 1. Ninety-two percent to the Department of Law Enforcement
548 Criminal Justice Standards and Training Trust Fund.
549 2. Six and three-tenths percent to the Department of Law
550 Enforcement Operating Trust Fund for the Criminal Justice Grant
551 Program.
552 3. One and seven-tenths percent to the Department of
553 Children and Family Services Domestic Violence Trust Fund for
554 the domestic violence program pursuant to s. 39.903(2)~~(3)~~.
555 Section 15. This act shall take effect July 1, 2011.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCAS 11-06 Medicaid Services
SPONSOR(S): Health Care Appropriations Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee		Hicks	Pridgeon

SUMMARY ANALYSIS

This bill conforms statutes to the funding decisions included in the proposed General Appropriations Act (GAA) for Fiscal Year 2011-2012. The bill:

- Repeals the sunset of the Medically Needy for adults and the Medicaid Aged and Disabled (MEDS-AD) waiver, which will sunset June 30, 2011.
- Eliminates optional Medicaid coverage of chiropractic and hearing services for adult recipients.
- Modifies the formula used for calculating reimbursements to providers of prescribed drugs.
- Repeals the sunset date for the freeze on Medicaid institutional unit cost; and deletes obsolete workgroups and reporting requirements.
- Provides for the allowed aggregated amount of assessments for all nursing home facilities to increase to conform to federal regulations.
- Revises the years of audited data used in determining Medicaid and charity care days for hospitals in the Disproportionate Share Hospital (DSH) Program; and changes the distribution criteria for Medicaid DSH payments to implement funding decisions for the DSH program.
- Eliminates the requirement to implement a wireless handheld clinical pharmacology drug information database for practitioners; and allowing electronic access to certain pharmacology drug information.
- Authorizes the implementation of a home delivery of pharmacy products program; establishes the requirements for the procurement and the program; and eliminates the requirement for the expansion of the mail-order-pharmacy diabetes-supply program.
- Eliminates certain specific components of the prescription drug management system program.
- Authorizes an additional Program of All-inclusive Care for the Elderly (PACE) site in Palm Beach County and approves up to 150 initial enrollees, subject to a specific appropriation.

The House Proposed GAA appropriates:

- $1,161.95 million to restore the Medically Needy program with recurring funds;
- $889.3 million to restore the MEDS-AD waiver program with recurring funds; and
- $246.6 million to implement the changes in DSH program funding.

The House Proposed GAA includes the following reductions:

- $393.9 million due to the continuation of the institutional providers unit cost freeze;
- $6.7 million due to an adjustment in the reimbursement formula for prescribed drugs;
- $3.7 million for the elimination of chiropractic and hearing coverage for adults; and
- $3.4 million due to elimination of certain contractual arrangements.

This bill has an effective date of July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Optional Medicaid Eligibility and Coverage

Current law allows Medicaid reimbursement for medical assistance and related services for beneficiaries deemed eligible subject to income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible beneficiaries is subject to the availability of moneys and any limitations established by the GAA or chapter 216, F.S.

- **The Medicaid Aged and Disabled Program (MEDS-AD)** eligibility category is an optional Medicaid eligibility group. The program provides Medicaid coverage to individuals who are age 65 or older or totally and permanently disabled, have incomes less than 88 percent of the federal poverty level, not eligible for Medicare and meet asset limits. The 2005 Legislature through chapter 2005-60, L.O.F, directed the Agency for Health Care Administration (AHCA) to seek federal waiver authority to revise Medicaid eligibility coverage for the Medicaid MEDS-AD eligibility group beginning January 1, 2006. The AHCA received approval of the 1115 Research and Demonstration Waiver on November 22, 2005. The waiver was subsequently renewed on January 1, 2011. In accordance with the approved waiver, the revised program covers:

    - Individuals without Medicare residing in the community or receiving Medicaid-covered institutional care services, hospice services, or home and community based services (HCBS), and
    - Individuals eligible for Medicare and also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community based waiver services.

  Medicaid is required to provide Medicare "buy-in" coverage for aged and disabled individuals who are Medicare beneficiaries. Therefore, if Medicaid coverage is eliminated for persons eligible under the criteria for the MEDS-AD program, those who are eligible for Medicare will continue to have Medicaid coverage for Medicare premiums, deductibles, and coinsurance. This program is expected to have an average monthly enrollment of approximately 42,115 individuals in Fiscal Year 2011-12.

- **The Medically Needy** eligibility category is an optional Medicaid eligibility group. Title XIX of the Social Security Act specifies categories of individuals that the federal government gives state Medicaid programs the option of covering through their state plan. The Medically Needy program covers persons who have experienced a catastrophic illness and either have no health insurance, or have exhausted their benefits. On a month by month basis, the individual's medical expenses are subtracted from his or her income. If the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid for the full or partial month depending on the date the medical expenses were incurred. The amount of expenses that must be deducted from the individual's income to make him or her eligible for Medicaid is called "share of cost." A person eligible for the Medically Needy Program is eligible for all Medicaid services with the exception of skilled nursing facility, state mental hospital, intermediate care facility for the developmentally disabled, assistive care services, community-based waiver services, or the payment of Medicare premiums by Medicaid. This program is expected to serve an average monthly enrollment of approximately 46,096 individuals in Fiscal Year 2011-12.

Current law allows Medicaid reimbursement to providers for at least 27 optional services, including chiropractic and hearing services.

- **Chiropractic Services** – Medicaid reimburses chiropractic services rendered by a licensed, Medicaid participating chiropractic physician. Chiropractic services include manual manipulation of the spine, initial services and screening, and x-rays provided by a licensed chiropractic physician. For Fiscal Year 2011-2012, it is estimated that approximately 8,242 adult beneficiaries would be eligible for this Medicaid coverage.

- **Hearing Services** – Medicaid reimburses for hearing services rendered by licensed, Medicaid participating otolaryngologists, otologists, audiologists, and hearing aid specialists. Reimbursable hearing services include cochlear implant services, diagnostic audiological testing, hearing aids, hearing evaluations to determine hearing aid candidacy, hearing aid fitting and dispensing, hearing aid repairs and accessories, and mandatory newborn hearing screening. For Fiscal Year 2011-2012, it is estimated that approximately 880,184 adult beneficiaries would be eligible for this Medicaid coverage.

The bill repeals the June 30, 2011 sunset date for the MEDS-AD and Medically Needy programs, restoring Medicaid coverage to eligible individuals with recurring funds. The bill also eliminates Medicaid reimbursement for optional Medicaid chiropractic and hearing services for adult recipients effective September 30, 2011.

<u>Reimbursement Rates for Medicaid Providers</u>

Currently, Medicaid reimburses Medicaid providers in one of the following ways:

Capitated Rate Setting - Capitated reimbursement is provided for in ss. 409.9124, and 409.91211. F.S, and is a methodology used for managed care providers.

- Fee-For-Service Method -
  Capitated rates are set annually based upon two years of fee-for-service claims and financial data for all recipients eligible for enrollment in a health maintenance organization (HMO) plan, and must be actuarially sound for comparable recipients. Thus, current rates are based upon data from State Fiscal Years 2007-2008 and 2008-2009, and are based upon 25 different service categories, such as hospital inpatient, laboratory, x-ray, etc. Actuarially sound rates are established for recipient categories, such as TANF, SSI without Medicare, SSI with Medicare Parts A and B, and SSI with Medicare Part B only; in all 11 AHCA areas for age/gender bands (birth to 2 months; 3-11 months, 1-5 years, 6-13 years, 14-20 years female; 14-20 years male; 21-54 years female; 21-54 years male; and 55+). Age and gender bands are only utilized in non-reform rate setting. Reform has composite rates.

- Financial/Encounter Data Method -
  In addition to the Fee-for-Service data, plan financial data for Calendar Years 2008 and 2009 for non-pharmacy services was used. The non-pharmacy encounter data was used as a source for validation of the plan specific financial reporting. The Financial Data Method receives 24 percent weight for Non-Reform rates and 50 percent for Reform rates for non-pharmacy services in rate calculation for the TANF and SSI without Medicare categories for Fiscal Year 2010-2011.

- Pharmacy Encounter Data Method –
  Pharmacy encounter data was used from State Fiscal Year 2008-2009. The pharmacy encounter data was submitted by the HMOs to develop the pharmacy component of the capitation rates. The Pharmacy Encounter Data Method received 100% weight for pharmacy services in the rate calculation for the TANF and SSI without Medicare categories.

- Risk Adjustment –
  The Reform Area final rates are risk adjusted for age, gender, medical conditions and diagnosis.

Fee-For-Service - Fee-for-service reimbursement is accomplished through the assignment of an established fee for each service provided by specific Medicaid provider types, which is established by Medicaid based upon funding provided in the GAA. The types of services typically reimbursed through a fee for service payment are physician, nursing care, dental services, pharmaceuticals, laboratory services, durable medical equipment and supplies, home health agency services, dialysis center services, and emergency transportation services. Reimbursement rates for physicians are set for periodic adjustment pursuant to federal directive, which is based upon updates to the Resource Based Relative Value Scale that requires budget neutrality as part of adjustments.

Cost-based Reimbursement - Cost-based reimbursement is accomplished through periodically establishing fees for each provider type based upon the provider type's historic cost of providing services, which, for institutional providers, is generally indexed to pre-determined health care inflation indices (price level increases). AHCA collects the cost data from individual providers to use in calculating and setting cost-based reimbursement rates. Nursing homes, hospitals, intermediate care facilities for the developmentally disabled, rural health clinics, county health departments, hospices, and federally qualified health centers are the types of providers that are reimbursed using cost-based methodologies, and provider types may be subject to specified reimbursement ceilings and targets.

Section 5, chapter 2008-143, L.O.F., directed AHCA to establish provider rates for hospitals, nursing homes, community intermediate care facilities for the developmentally disabled and county health departments in a manner that would result in the elimination of automatic cost-based rate increases for a period of two fiscal years. The unit cost rate freeze is set to expire July 1, 2011.

The bill repeals the sunset date for unit cost rate freeze on Medicaid provider rates for hospitals, nursing homes, community intermediate care facilities for the developmentally disabled and county health departments. The bill also repeals an obsolete provision to establish workgroups to evaluate alternate reimbursement and payment methods for hospitals, nursing facilities, and managed care plans and the reporting requirement on its evaluation.

Medicaid Reimbursement for Prescribed Drugs Services

Reimbursement for prescribed drug claims is made in accordance with the provisions of 42 CFR 447.512-516; and ss. 409.906(20), 409.908, 409.912(39) (a), F.S. The current reimbursement for covered drugs dispensed by a licensed pharmacy, approved as a Medicaid provider, or an enrolled dispensing physician filling his own prescriptions, is the lesser of:

- Average Wholesale Price (AWP) minus 16.4%, plus a dispensing fee of $3.73 or
- Wholesaler Acquisition Cost (WAC) plus 4.75%, plus a dispensing fee of $3.73 or
- The Federal Upper Limit (FUL) established by the CMS, plus a dispensing fee of $3.73 or
- The State Maximum Allowable Cost (SMAC), plus a dispensing fee of $3.73 or
- The provider's Usual and Customary (UAC) charge, inclusive of dispensing fee.

AWP and WAC are published by First Data Bank (FDB) as reference prices for pharmaceuticals. AWP is a "list price" and is higher than the cost wholesalers actually pay. WAC is slightly more representative of costs actually paid by wholesalers, and is more accurate with respect to branded pharmaceuticals than generics. Third party payors and State Medicaid Programs use these published prices (AWP and WAC) in their retail pharmacy reimbursement calculations.

On March 30, 2009, the U.S. District Court for the District of Massachusetts entered a Final Order and Judgment approving a class action settlement that involved two major publishers of drug pricing information, FDB and Medi-Span. The Plaintiffs in this case alleged that FDB's and Medi-Span's policies and practices caused them to pay inflated prices for certain pharmaceutical products.

The settlement requires FDB and Medi-Span to reduce the AWP mark-up factor to a standard ceiling of 120 percent of WAC on all National Drug Codes (NDCs). This change took effect on September 26, 2009, and will affect all prescriptions where the reimbursement calculation was based on AWP. With

respect to Florida Medicaid, 25.39 percent of prescriptions are reimbursed based on AWP. These are primarily branded pharmaceuticals still under patent. Both FDB and Medi-Span have independently announced plans to discontinue publishing AWP by September, 2011.

This bill modifies the reimbursement formula for prescribed drugs by adjusting the WAC-based formula to WAC plus 3.75 percent. Upon the loss of the AWP-based formula, WAC plus 3.75 percent will be the reimbursement rate used to reimburse Medicaid pharmacy providers.

Disproportionate Share Program (DSH)

Each year the Low-Income Pool Council (formerly Disproportionate Share Council) makes recommendations to the Legislature on the Medicaid Disproportionate Share Hospital Program funding distributions to hospitals that provide a disproportionate share of the Medicaid or charity care services to uninsured individuals. However, the legislature delineates how the funds will be distributed to each eligible facility.

The bill amends several provisions of chapter 409, F.S., to update for the most recent years of audited data used to implement the changes in DSH program funding for Fiscal Year 2011-2012. The bill:

- Revises the method for calculating disproportionate share payments to hospitals for Fiscal Year 2011-2012 by changing the years of averaged audited data from 2003, 2004, and 2005 to 2004, 2005, and 2006;
- Revises the time period from Fiscal Year 2010-2011 to 2011-2012 during which the AHCA is prohibited from distributing funds under the Disproportionate Share Program for regional perinatal intensive care centers;
- Requires that funds for statutorily defined teaching hospitals in Fiscal Year 2011-2012 be distributed in the same proportion as funds were distributed under the Disproportionate Share Program for teaching hospitals in Fiscal Year 2003-2004, or as otherwise provided in the GAA; and
- Revises the time period from Fiscal Year 2010-2011 to Fiscal Year 2011-2012 during which the AHCA is prohibited from distributing funds under the primary care disproportionate share program.

Program of All-Inclusive Care for the Elderly (PACE)

PACE is a capitated benefit model authorized by the federal Balanced Budget Act of 1997 that features a comprehensive service delivery system and integrated federal Medicare and state Medicaid financing. The model was tested through CMS demonstration projects that began in the mid-1980s.[1] The PACE model was developed to address the needs of long-term care clients, providers, and payors.

For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than receiving services in other more costly long term care settings. Capitated financing allows providers to deliver all the services that participants need rather than being limited to those services reimbursable under the Medicare and Medicaid fee-for-service systems. [2]

The Balanced Budget Act of 1997 established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide the PACE services to Medicaid beneficiaries as a state option without a Medicaid waiver. The state plan must include PACE as an optional Medicaid benefit before the State and the Secretary of the Department of Health and Human Services can enter into program agreements with PACE providers.[3]

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[1] Centers for Medicare and Medicaid Services website: http://www.cms.hhs.gov/PACE/ (last visited on March 17, 2011).

[2] *Id.*

[3] *Id.*

A PACE organization is a not-for-profit private or public entity that is primarily engaged in providing the PACE services and must:[4]

- Have a governing board that includes community representation;
- Be able to provide the complete service package regardless of frequency or duration of services;
- Have a physical site to provide adult day services;
- Have a defined service area;
- Have safeguards against conflicts of interest;
- Have demonstrated fiscal soundness; and
- Have a formal participant bill of rights.

The PACE project is a unique federal/state partnership. The federal government establishes the PACE organization requirements and application process. The state Medicaid agency or other state agency is responsible for oversight of the entire application process, which includes reviewing the initial application and providing an on-sight readiness review before a PACE organization can be authorized to serve patients. An approved PACE organization must sign a contract with the CMS and the state Medicaid agency.[5]

Florida PACE Project

The Florida PACE project is one project among many that provide alternative, long-term care options for elders who qualify for Medicare and the state Medicaid program. The PACE project was initially authorized in chapter 98-327, Laws of Florida, and is codified in s. 430.707(2), F.S. The PACE model targets individuals who would otherwise qualify for Medicaid nursing home placement and provides them with a comprehensive array of home and community based services at a cost less than the cost of nursing home care. The PACE project is administered by DOEA in consultation with AHCA.

Section 3, chapter 2006-25, L.O.F., included proviso language in the 2006-2007 GAA to authorize 150 additional clients for the existing PACE project in Miami-Dade County and funding for the development of PACE projects to serve 200 clients in Martin and St. Lucie counties, and 200 clients in Lee County.

Section 3, chapter 2008-152, L.O.F., included proviso language in the 2008-09 GAA to reallocate 150 unused PACE slots to Miami-Dade, Lee and Pinellas Counties. Each site received 50 slots.

Section 20, chapter 2009-55, L.O.F., directed the AHCA, upon federal approval of an application to be a site for PACE, to contract with one private, not-for-profit hospice organization located in Hillsborough County, which provides comprehensive services, including hospice care for frail and elderly persons. This section also authorized the AHCA, in consultation with DOEA and subject to an appropriation, to approve up to 100 slots for the program.

Section 14, chapter 2010-156, L.O.F., directed the AHCA to contract with a private health care organization to provide comprehensive services to frail and elderly persons residing in Polk, Highlands, Hardee, and Hillsborough Counties. This section also authorized 150 initial slots for the program.

Section 15, chapter 2010-156, L.O.F., directed AHCA to contract for a new PACE site in Southwest Miami-Dade County and approved 50 initial slots for the program.

In addition to receiving the necessary legislative authority, the development of a new PACE organization or the expansion of an existing program is a lengthy process that includes: identifying a service area, acquiring and renovating a PACE facility and processing the PACE application through the state and the federal review system.

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[4] PACE Fact Sheet, available at http://www.cms.hhs.gov/PACE/Downloads/PACEFactSheet.pdf.

[5] *Id.*

The bill authorizes, subject to an appropriation, up to 150 initial enrollee slots for a new PACE project in Palm Beach County.

Modifications in Contractual Arrangements

- **Wireless Handheld Devices** – Pursuant to s. 409.912 (16)(b), F.S., the AHCA was directed to contract with an entity in the state to implement a wireless handheld clinical pharmacology drug information database for practitioners. The device was envisioned to provide continuous updates of clinical pharmacology information, reference to the Medicaid Preferred Drug List (PDL), specific patient medication history, and ongoing education and support. Initially, the vendor provided a pilot group of 1,000 high volume practitioners with the wireless handheld device. The objective with this pilot group was to prevent duplicate prescribing and improve clinical outcomes. The device gave the practitioners a specific patient drug profile and access to clinical drug information at the point of care. The 2004 Legislature expanded the program to 3,000 devices. In 2005, e-prescribing capability was added giving practitioners access to continuous updates of clinical pharmacology information, reference to the Medicaid PDL and specific patient medication history at the point of care. Prescriptions could also be submitted electronically to the patient's pharmacy of choice. However, utilization remained at less than capacity. In 2009, the number of handheld devices was reduced to 1,000 due to low utilization by practitioners. Currently, the vendor provides 555 handheld devices to high volume practitioners to support e-prescribing.

  The bill removes the requirement for the AHCA to implement a wireless handheld program and grants the AHCA authority to provide electronic access to pharmacology drug information to Medicaid providers to ensure adequate access to e-prescribing in the most cost effective manner.

- **Therapy Management Contract (Prescribed Drugs)** - The 2005 Legislature directed the AHCA to implement a prescription drug management system with various components to reduce costs, waste, and fraud, while improving recipient safety. The drug management system implemented must rely on cooperation between physician and pharmacist to determine appropriate practice patterns and clinical guidelines to improve prescribing, dispensing, and medication usage for recipients in the Medicaid program. The AHCA entered into a contractual arrangement to reduce clinical risk, lower prescribed drug costs and the rate of inappropriate spending for certain Medicaid prescription drugs.

  There are over 4,000 pharmacy providers in Florida. There are 841 pharmacies enrolled in the program and 200 of those pharmacies are actively participating in the program.

  This bill eliminates specific components of the prescription drug management system, but continues general authority that allows the AHCA to implement a drug management system.

- **Home Delivery of Pharmacy Products** - During Special Session 2001C Session, the Legislature expanded the home delivery of pharmacy products. The AHCA was directed to expand the current mail-order-pharmacy diabetes supply program to include all generic and brand name drugs used by Medicaid patients with diabetes. The program was established as voluntary participation for Medicaid recipients with diabetes. Pharmacies were prohibited from charging higher reimbursement rate for this expansion in service. The initiative was limited to the geographic area covered by the current contract.

  In 2010, the Legislature directed the AHCA, through specific proviso language, to issue an invitation to negotiate with a pharmacy or pharmacies to provide mail order delivery services at no cost to the patients who elect to receive their drugs by mail order delivery services for patients with chronic disease states. Participation was limited to 20,000 patients statewide.

  This bill grants statutory authority to the AHCA to implement a mail order home delivery pharmacy program with a focus on serving recipients with chronic diseases. The bill also eliminates the requirement to expand the current mail-order-pharmacy diabetes-supply program.

Nursing Home Facility Providers Quality Assessment Program

Section 409.9082, F.S., establishes a quality assessment program for nursing home facility providers. The program had an effective date of April 1, 2009. Current federal regulations provide that assessment revenues cannot exceed 5.5 percent of the total aggregate net patient service revenue of the assessed facilities. The AHCA was authorized to calculate the assessment annually on a per-resident-day basis, exclusive of those days funded by the Medicare program. Certain nursing home facilities are exempt from the imposition of the quality assessment. The purpose of the nursing home quality assessment is to ensure continued quality of care and that the collected assessments are used to obtain federal financial participation through the Medicaid program in order to make Medicaid payments for nursing home facility services up to the amount of nursing home facility Medicaid rates as calculated in accordance with the approved state Medicaid plan in effect on December 31, 2007.

Effective October 1, 2011, federal regulations will allow the total aggregate amount of assessment for all nursing home facilities to increase to 6.0 percent. This bill modifies statutory authority to conform to federal regulations.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.904, F.S., repealing the sunset of provisions authorizing the Medically Aged and Disabled waiver and Medically Needy programs; and eliminating the limit to services placed on the Medically Needy program.

Section 2: Amends s. 409.906, F.S., eliminating adult Medicaid coverage for chiropractic and hearing services.

Section 3: Amends s. 409.908, F.S., updating the formula used for calculating reimbursements to providers for prescribed drugs; continuing the institutional providers reimbursement rate freeze; deleting an obsolete requirement; and eliminating the repeal date of the institutional providers reimbursement rate freeze.

Section 4: Amends s. 409.9082, F.S., revising the allowed aggregated amount of assessment for all nursing home facilities to conform to federal law.

Section 5: Amends s. 409.911, F.S., updating the share data used to calculate disproportionate share payments to hospitals.

Section 6: Amends s. 409.9112, F.S., prohibiting the distribution of disproportionate share payments to regional perinatal intensive care centers for Fiscal Year 2010-2011.

Section 7: Amends s. 409.9113, F.S., requiring the AHCA to distribute moneys provided in the GAA to statutorily defined teaching hospitals and family practice teaching hospitals under the teaching hospitals disproportionate share program for Fiscal Year 2010-2011.

Section 8: Amends s. 409.9117, F.S., prohibiting the distribution of moneys under the primary care disproportionate share program for Fiscal Year 2010-2011.

Section 9: Amends s. 409.912, F.S., allowing for the continuation of electronic access to certain pharmacology drug information; eliminating the requirement to implement a wireless handheld clinical pharmacology drug information database; updating the formula used for calculating reimbursements to providers of prescribed drugs; authorizing the implementation of a pharmacy products home delivery program; eliminating the requirement for the expansion of the mail order pharmacy diabetes supply program; and eliminating certain provisions of the Medicaid prescription drug management program.

Section 10: Amends s. 430.707, F.S., providing for an additional PACE site.

Section 11: Provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   $138,178,151 million in federal Medicaid funds will be generated through the implementation of the DSH programs.

2. Expenditures:

	FY 2011-12
OPTIONAL MEDICAID ELIGIBILITY AND COVERAGE	
MEDS-AD Program	
General Revenue	$ 199,733,536
Grants and Donations Trust Fund	$ 40,548,529
Public Medical Assistance Trust Fund	$ 182,000,000
Medical Care Trust Fund	$ 467,043,395
Total	**$ 889,325,460**
Medically Needy Program	
General Revenue	$ 487,238,897
Grants and Donations Trust Fund	$ 80,315,819
Medical Care Trust Fund	$ 594,402,255
Total	**$1,161,956,971**
Chiropractic Services	
General Revenue	($ 438,965)
Medical Care Trust Fund	($ 557,097)
Refugee Assistance Trust Fund	($ 3,392)
Total	**($ 999,454)**
Hearing Services	
General Revenue	($ 1,187,273)
Medical Care Trust Fund	($ 1,507,400)
Total	**($ 2,694,673)**
INSTITUTIONAL PROVIDERS UNIT COST FREEZE	
General Revenue	($ 137,016,867)
Grants and Donations Trust Fund	($ 35,718,646)
Medical Care Trust Fund	($ 219,925,441)
Refugee Assistance Trust Fund	($ 1,226,741)
Total	**($ 393,887,695)**
PHARMACY PROGRAM REDUCTION	
General Revenue	($ 2,961,900)
Medical Care Trust Fund	($ 3,760,524)
Refugee Assistance Trust Fund	($ 14,823)
Total	**($ 6,737,247)**

DISPROPORTIONATE SHARE PROGRAM	
General Revenue	$ 750,000
Grants and Donations Trust Fund	$ 107,642,426
Medical Care Trust Fund	$ 138,178,151
Total	**$ 246,570,577**

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY	
General Revenue	$ 325,191
Operations & Maintenance Trust Fund	$ 412,872
Total	**$ 738,063**

MODIFICATIONS IN CONTRACTUAL SERVICES

Wireless Handheld Devices	
General Revenue	($ 610,672)
Grants and Donations Trust Fund	($ 551,530)
Medical Care Trust Fund	($ 1,162,206)
Total	**($ 2,324,408)**

Therapy Management (Prescribed Drugs)	
General Revenue	($ 520,000)
Medical Care Trust Fund	($ 520,000)
Total	**($ 1,040,000)**

BUDGETARY INCREASES	
General Revenue	**$ 687,722,433**
Grants and Donations Trust Fund	**$ 228,506,774**
Public Medical Assistance Trust Fund	**$ 182,000,000**
Medical Care Trust Fund	**$1,199,623,801**
Grand Total – Increases	**$2,297,853,008**

BUDGETARY DECREASES	
General Revenue	**($ 142,735,677)**
Grants and Donations Trust Fund	**($ 36,270,176)**
Medical Care Trust Fund	**($ 227,432,668)**
Refugee Assistance Trust Fund	**($ 1,244,956)**
Grand Total – Decreases	**($ 407,683,477)**

TOTAL BUDGETARY IMPACT	
General Revenue	**$ 544,986,756**
Grants and Donations Trust Fund	**$ 192,236,598**
Public Medical Assistance Trust Fund	**$ 182,000,000**
Medical Care Trust Fund	**$ 972,191,133**
Refugee Assistance Trust Fund	**($ 1,244,956)**
Grand Total – All	**$ 1,890,169,531**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

Local governments and other local political subdivisions may provide $107,642,426 million in contributions for the DSH programs.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals providing a disproportionate share of Medicaid or charity care services will receive additional reimbursements towards the cost of providing care to uninsured individuals.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This legislation does not appear to require counties or municipalities to take an action requiring the expenditure of funds; reduce the authority that municipalities or counties have to raise revenue in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The AHCA has sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to Medicaid services; amending s. 409.904,
3 F.S.; repealing the sunset of provisions authorizing the
4 federal waiver for certain persons age 65 and older or who
5 have a disability; repealing the sunset of provisions
6 authorizing a specified medically needy program;
7 eliminating the limit to services placed on the medically
8 needy program for pregnant women and children younger than
9 age 21; amending s. 409.906, F.S.; eliminating adult
10 Medicaid optional coverage for chiropractic services;
11 eliminating adult Medicaid optional coverage for hearing
12 services; amending s. 409.908, F.S.; updating the formula
13 used for calculating reimbursements to Medicaid providers
14 for prescribed drugs; continuing the requirement that the
15 Agency for Health Care Administration set certain
16 institutional provider reimbursement rates in a manner
17 that results in no automatic cost-based statewide
18 expenditure increase; deleting an obsolete requirement to
19 establish workgroups to evaluate alternate reimbursement
20 and payment methods; eliminating the repeal date of the
21 suspension of the use of cost data to set certain
22 institutional provider reimbursement rates; amending s.
23 409.9082, F.S.; revising the allowed aggregated amount of
24 assessments for all nursing home facilities to conform
25 with federal law; amending s. 409.911, F.S.; updating the
26 audited data specified for use in calculating
27 disproportionate share; amending s. 409.9112, F.S.;
28 continuing the prohibition against distributing moneys

29 under the perinatal intensive care centers
30 disproportionate share program; amending s. 409.9113,
31 F.S.; continuing authorization for the distribution of
32 moneys to certain teaching hospitals under the
33 disproportionate share program; amending s. 409.9117,
34 F.S.; continuing the prohibition against distributing
35 moneys under the primary care disproportionate share
36 program; amending s. 409.912, F.S.; allowing the agency to
37 continue to contract for electronic access to certain
38 pharmacology drug information; eliminating the requirement
39 to implement a wireless handheld clinical pharmacology
40 drug information database for practitioners; updating the
41 formula used for calculating reimbursement to Medicaid
42 providers for prescribed drugs; authorizing the agency to
43 seek federal approval and to issue a procurement in order
44 to implement a home delivery of pharmacy products program;
45 establishing the provisions for the procurement and the
46 program; eliminating the requirement for the expansion of
47 the mail-order-pharmacy diabetes-supply program;
48 eliminating certain provisions of the Medicaid
49 prescription drug management program; authorizing the
50 agency to contract with an organization to provide certain
51 benefits under a federal program in Palm Beach County;
52 providing an exemption from ch. 641, F.S., for the
53 organization; authorizing, subject to appropriation,
54 enrollment slots for the Program of All-inclusive Care for
55 the Elderly in Palm Beach County; providing an effective
56 date.

57
58 Be It Enacted by the Legislature of the State of Florida:
59
60 Section 1. Subsections (1) and (2) of section 409.904,
61 Florida Statutes, are amended to read:
62 409.904 Optional payments for eligible persons.—The agency
63 may make payments for medical assistance and related services on
64 behalf of the following persons who are determined to be
65 eligible subject to the income, assets, and categorical
66 eligibility tests set forth in federal and state law. Payment on
67 behalf of these Medicaid eligible persons is subject to the
68 availability of moneys and any limitations established by the
69 General Appropriations Act or chapter 216.
70 (1) Effective January 1, 2006, and subject to federal
71 waiver approval, a person who is age 65 or older or is
72 determined to be disabled, whose income is at or below 88
73 percent of the federal poverty level, whose assets do not exceed
74 established limitations, and who is not eligible for Medicare
75 or, if eligible for Medicare, is also eligible for and receiving
76 Medicaid-covered institutional care services, hospice services,
77 or home and community-based services. The agency shall seek
78 federal authorization through a waiver to provide this coverage.
79 ~~This subsection expires June 30, 2011.~~
80 (2)~~(a)~~ A family, a pregnant woman, a child under age 21, a
81 person age 65 or over, or a blind or disabled person, who would
82 be eligible under any group listed in s. 409.903(1), (2), or
83 (3), except that the income or assets of such family or person
84 exceed established limitations. For a family or person in one of

85 these coverage groups, medical expenses are deductible from
86 income in accordance with federal requirements in order to make
87 a determination of eligibility. A family or person eligible
88 under the coverage known as the "medically needy," is eligible
89 to receive the same services as other Medicaid recipients, with
90 the exception of services in skilled nursing facilities and
91 intermediate care facilities for the developmentally disabled.
92 ~~This paragraph expires June 30, 2011.~~
93 ~~(b) Effective July 1, 2011, a pregnant woman or a child~~
94 ~~younger than 21 years of age who would be eligible under any~~
95 ~~group listed in s. 409.903, except that the income or assets of~~
96 ~~such group exceed established limitations. For a person in one~~
97 ~~of these coverage groups, medical expenses are deductible from~~
98 ~~income in accordance with federal requirements in order to make~~
99 ~~a determination of eligibility. A person eligible under the~~
100 ~~coverage known as the "medically needy" is eligible to receive~~
101 ~~the same services as other Medicaid recipients, with the~~
102 ~~exception of services in skilled nursing facilities and~~
103 ~~intermediate care facilities for the developmentally disabled.~~
104 Section 2. Subsections (7) and (12) of section 409.906,
105 Florida Statutes, are amended to read:
106 409.906 Optional Medicaid services.—Subject to specific
107 appropriations, the agency may make payments for services which
108 are optional to the state under Title XIX of the Social Security
109 Act and are furnished by Medicaid providers to recipients who
110 are determined to be eligible on the dates on which the services
111 were provided. Any optional service that is provided shall be
112 provided only when medically necessary and in accordance with

113 state and federal law. Optional services rendered by providers
114 in mobile units to Medicaid recipients may be restricted or
115 prohibited by the agency. Nothing in this section shall be
116 construed to prevent or limit the agency from adjusting fees,
117 reimbursement rates, lengths of stay, number of visits, or
118 number of services, or making any other adjustments necessary to
119 comply with the availability of moneys and any limitations or
120 directions provided for in the General Appropriations Act or
121 chapter 216. If necessary to safeguard the state's systems of
122 providing services to elderly and disabled persons and subject
123 to the notice and review provisions of s. 216.177, the Governor
124 may direct the Agency for Health Care Administration to amend
125 the Medicaid state plan to delete the optional Medicaid service
126 known as "Intermediate Care Facilities for the Developmentally
127 Disabled." Optional services may include:
128 (7) CHIROPRACTIC SERVICES.—Effective October 1, 2011, the
129 agency may pay for manual manipulation of the spine and initial
130 services, screening, and X rays provided to a recipient under
131 the age of 21 by a licensed chiropractic physician.
132 (12) HEARING SERVICES.—Effective October 1, 2011, the
133 agency may pay for hearing and related services, including
134 hearing evaluations, hearing aid devices, dispensing of the
135 hearing aid, and related repairs, if provided to a recipient
136 under the age of 21 by a licensed hearing aid specialist,
137 otolaryngologist, otologist, audiologist, or physician.
138 Section 3. Subsections (14) and (23) of section 409.908,
139 Florida Statutes, are amended to read:
140 409.908 Reimbursement of Medicaid providers.—Subject to

141 specific appropriations, the agency shall reimburse Medicaid
142 providers, in accordance with state and federal law, according
143 to methodologies set forth in the rules of the agency and in
144 policy manuals and handbooks incorporated by reference therein.
145 These methodologies may include fee schedules, reimbursement
146 methods based on cost reporting, negotiated fees, competitive
147 bidding pursuant to s. 287.057, and other mechanisms the agency
148 considers efficient and effective for purchasing services or
149 goods on behalf of recipients. If a provider is reimbursed based
150 on cost reporting and submits a cost report late and that cost
151 report would have been used to set a lower reimbursement rate
152 for a rate semester, then the provider's rate for that semester
153 shall be retroactively calculated using the new cost report, and
154 full payment at the recalculated rate shall be effected
155 retroactively. Medicare-granted extensions for filing cost
156 reports, if applicable, shall also apply to Medicaid cost
157 reports. Payment for Medicaid compensable services made on
158 behalf of Medicaid eligible persons is subject to the
159 availability of moneys and any limitations or directions
160 provided for in the General Appropriations Act or chapter 216.
161 Further, nothing in this section shall be construed to prevent
162 or limit the agency from adjusting fees, reimbursement rates,
163 lengths of stay, number of visits, or number of services, or
164 making any other adjustments necessary to comply with the
165 availability of moneys and any limitations or directions
166 provided for in the General Appropriations Act, provided the
167 adjustment is consistent with legislative intent.
168 (14) A provider of prescribed drugs shall be reimbursed

169 the least of the amount billed by the provider, the provider's
170 usual and customary charge, or the Medicaid maximum allowable
171 fee established by the agency, plus a dispensing fee. The
172 Medicaid maximum allowable fee for ingredient cost shall ~~will~~ be
173 based on the lowest ~~lower~~ of: the average wholesale price (AWP)
174 minus 16.4 percent, the wholesaler acquisition cost (WAC) plus
175 3.75 ~~4.75~~ percent, the federal upper limit (FUL), the state
176 maximum allowable cost (SMAC), or the usual and customary (UAC)
177 charge billed by the provider. Medicaid providers are required
178 to dispense generic drugs if available at lower cost and the
179 agency has not determined that the branded product is more cost-
180 effective, unless the prescriber has requested and received
181 approval to require the branded product. The agency is directed
182 to implement a variable dispensing fee for payments for
183 prescribed medicines while ensuring continued access for
184 Medicaid recipients. The variable dispensing fee may be based
185 upon, but not limited to, either or both the volume of
186 prescriptions dispensed by a specific pharmacy provider, the
187 volume of prescriptions dispensed to an individual recipient,
188 and dispensing of preferred-drug-list products. The agency may
189 increase the pharmacy dispensing fee authorized by statute and
190 in the annual General Appropriations Act by $0.50 for the
191 dispensing of a Medicaid preferred-drug-list product and reduce
192 the pharmacy dispensing fee by $0.50 for the dispensing of a
193 Medicaid product that is not included on the preferred drug
194 list. The agency may establish a supplemental pharmaceutical
195 dispensing fee to be paid to providers returning unused unit-
196 dose packaged medications to stock and crediting the Medicaid

197 program for the ingredient cost of those medications if the
198 ingredient costs to be credited exceed the value of the
199 supplemental dispensing fee. The agency is authorized to limit
200 reimbursement for prescribed medicine in order to comply with
201 any limitations or directions provided for in the General
202 Appropriations Act, which may include implementing a prospective
203 or concurrent utilization review program.
204 (23)(a) The agency shall establish rates at a level that
205 ensures no increase in statewide expenditures resulting from a
206 change in unit costs ~~for 2 fiscal years~~ effective July 1, 2011
207 ~~2009~~. Reimbursement rates ~~for the 2 fiscal years~~ shall be as
208 provided in the General Appropriations Act.
209 (b) This subsection applies to the following provider
210 types:
211 1. Inpatient hospitals.
212 2. Outpatient hospitals.
213 3. Nursing homes.
214 4. County health departments.
215 5. Community intermediate care facilities for the
216 developmentally disabled.
217 6. Prepaid health plans.
218
219 The agency shall apply the effect of this subsection to the
220 reimbursement rates for nursing home diversion programs.
221 ~~(c) The agency shall create a workgroup on hospital~~
222 ~~reimbursement, a workgroup on nursing facility reimbursement,~~
223 ~~and a workgroup on managed care plan payment. The workgroups~~
224 ~~shall evaluate alternative reimbursement and payment~~

225 ~~methodologies for hospitals, nursing facilities, and managed~~
226 ~~care plans, including prospective payment methodologies for~~
227 ~~hospitals and nursing facilities. The nursing facility workgroup~~
228 ~~shall also consider price-based methodologies for indirect care~~
229 ~~and acuity adjustments for direct care. The agency shall submit~~
230 ~~a report on the evaluated alternative reimbursement~~
231 ~~methodologies to the relevant committees of the Senate and the~~
232 ~~House of Representatives by November 1, 2009.~~
233 ~~(d) This subsection expires June 30, 2011.~~
234 Section 4. Subsection (2) of section 409.9082, Florida
235 Statutes, is amended to read:
236 409.9082 Quality assessment on nursing home facility
237 providers; exemptions; purpose; federal approval required;
238 remedies.—
239 (2) Effective April 1, 2009, there is imposed upon each
240 nursing home facility a quality assessment. The aggregated
241 amount of assessments for all nursing home facilities in a given
242 year shall be an amount not exceeding the maximum percentage
243 allowed under federal law ~~5.5 percent~~ of the total aggregate net
244 patient service revenue of assessed facilities. The agency shall
245 calculate the quality assessment rate annually on a per-
246 resident-day basis, exclusive of those resident days funded by
247 the Medicare program, as reported by the facilities. The per-
248 resident-day assessment rate shall be uniform except as
249 prescribed in subsection (3). Each facility shall report monthly
250 to the agency its total number of resident days, exclusive of
251 Medicare Part A resident days, and shall remit an amount equal
252 to the assessment rate times the reported number of days. The

253 agency shall collect, and each facility shall pay, the quality
254 assessment each month. The agency shall collect the assessment
255 from nursing home facility providers by no later than the 15th
256 of the next succeeding calendar month. The agency shall notify
257 providers of the quality assessment and provide a standardized
258 form to complete and submit with payments. The collection of the
259 nursing home facility quality assessment shall commence no
260 sooner than 5 days after the agency's initial payment of the
261 Medicaid rates containing the elements prescribed in subsection
262 (4). Nursing home facilities may not create a separate line-item
263 charge for the purpose of passing through the assessment to
264 residents.
265 Section 5. Paragraph (a) of subsection (2) of section
266 409.911, Florida Statutes, is amended to read:
267 409.911 Disproportionate share program.—Subject to
268 specific allocations established within the General
269 Appropriations Act and any limitations established pursuant to
270 chapter 216, the agency shall distribute, pursuant to this
271 section, moneys to hospitals providing a disproportionate share
272 of Medicaid or charity care services by making quarterly
273 Medicaid payments as required. Notwithstanding the provisions of
274 s. 409.915, counties are exempt from contributing toward the
275 cost of this special reimbursement for hospitals serving a
276 disproportionate share of low-income patients.
277 (2) The Agency for Health Care Administration shall use
278 the following actual audited data to determine the Medicaid days
279 and charity care to be used in calculating the disproportionate
280 share payment:

281 (a) The average of the 2004, 2005, and 2006 ~~2003, 2004,~~
282 ~~and 2005~~ audited disproportionate share data to determine each
283 hospital's Medicaid days and charity care for the 2011-2012
284 ~~2010-2011~~ state fiscal year.
285 Section 6. Section 409.9112, Florida Statutes, is amended
286 to read:
287 409.9112 Disproportionate share program for regional
288 perinatal intensive care centers.—In addition to the payments
289 made under s. 409.911, the agency shall design and implement a
290 system for making disproportionate share payments to those
291 hospitals that participate in the regional perinatal intensive
292 care center program established pursuant to chapter 383. The
293 system of payments must conform to federal requirements and
294 distribute funds in each fiscal year for which an appropriation
295 is made by making quarterly Medicaid payments. Notwithstanding
296 s. 409.915, counties are exempt from contributing toward the
297 cost of this special reimbursement for hospitals serving a
298 disproportionate share of low-income patients. For the 2011-2012
299 ~~2010-2011~~ state fiscal year, the agency may not distribute
300 moneys under the regional perinatal intensive care centers
301 disproportionate share program.
302 (1) The following formula shall be used by the agency to
303 calculate the total amount earned for hospitals that participate
304 in the regional perinatal intensive care center program:
305
306 TAE = HDSP/THDSP
307 Where:
308 TAE = total amount earned by a regional perinatal intensive

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

V

309 care center.
310 HDSP = the prior state fiscal year regional perinatal
311 intensive care center disproportionate share payment to the
312 individual hospital.
313 THDSP = the prior state fiscal year total regional
314 perinatal intensive care center disproportionate share payments
315 to all hospitals.
316
317 (2) The total additional payment for hospitals that
318 participate in the regional perinatal intensive care center
319 program shall be calculated by the agency as follows:
320
321 TAP = TAE x TA
322 Where:
323 TAP = total additional payment for a regional perinatal
324 intensive care center.
325 TAE = total amount earned by a regional perinatal intensive
326 care center.
327 TA = total appropriation for the regional perinatal
328 intensive care center disproportionate share program.
329
330 (3) In order to receive payments under this section, a
331 hospital must be participating in the regional perinatal
332 intensive care center program pursuant to chapter 383 and must
333 meet the following additional requirements:
334 (a) Agree to conform to all departmental and agency
335 requirements to ensure high quality in the provision of
336 services, including criteria adopted by departmental and agency

337 rule concerning staffing ratios, medical records, standards of
338 care, equipment, space, and such other standards and criteria as
339 the department and agency deem appropriate as specified by rule.
340 (b) Agree to provide information to the department and
341 agency, in a form and manner to be prescribed by rule of the
342 department and agency, concerning the care provided to all
343 patients in neonatal intensive care centers and high-risk
344 maternity care.
345 (c) Agree to accept all patients for neonatal intensive
346 care and high-risk maternity care, regardless of ability to pay,
347 on a functional space-available basis.
348 (d) Agree to develop arrangements with other maternity and
349 neonatal care providers in the hospital's region for the
350 appropriate receipt and transfer of patients in need of
351 specialized maternity and neonatal intensive care services.
352 (e) Agree to establish and provide a developmental
353 evaluation and services program for certain high-risk neonates,
354 as prescribed and defined by rule of the department.
355 (f) Agree to sponsor a program of continuing education in
356 perinatal care for health care professionals within the region
357 of the hospital, as specified by rule.
358 (g) Agree to provide backup and referral services to the
359 county health departments and other low-income perinatal
360 providers within the hospital's region, including the
361 development of written agreements between these organizations
362 and the hospital.
363 (h) Agree to arrange for transportation for high-risk
364 obstetrical patients and neonates in need of transfer from the

365 community to the hospital or from the hospital to another more
366 appropriate facility.
367 (4) Hospitals which fail to comply with any of the
368 conditions in subsection (3) or the applicable rules of the
369 department and agency may not receive any payments under this
370 section until full compliance is achieved. A hospital which is
371 not in compliance in two or more consecutive quarters may not
372 receive its share of the funds. Any forfeited funds shall be
373 distributed by the remaining participating regional perinatal
374 intensive care center program hospitals.
375 Section 7. Section 409.9113, Florida Statutes, is amended
376 to read:
377 409.9113 Disproportionate share program for teaching
378 hospitals.—In addition to the payments made under ss. 409.911
379 and 409.9112, the agency shall make disproportionate share
380 payments to statutorily defined teaching hospitals for their
381 increased costs associated with medical education programs and
382 for tertiary health care services provided to the indigent. This
383 system of payments must conform to federal requirements and
384 distribute funds in each fiscal year for which an appropriation
385 is made by making quarterly Medicaid payments. Notwithstanding
386 s. 409.915, counties are exempt from contributing toward the
387 cost of this special reimbursement for hospitals serving a
388 disproportionate share of low-income patients. For the 2011-2012
389 ~~2010-2011~~ state fiscal year, the agency shall distribute the
390 moneys provided in the General Appropriations Act to statutorily
391 defined teaching hospitals and family practice teaching
392 hospitals under the teaching hospital disproportionate share

393 program. The funds provided for statutorily defined teaching
394 hospitals shall be distributed in the same proportion as the
395 state fiscal year 2003-2004 teaching hospital disproportionate
396 share funds were distributed or as otherwise provided in the
397 General Appropriations Act. The funds provided for family
398 practice teaching hospitals shall be distributed equally among
399 family practice teaching hospitals.
400 (1) On or before September 15 of each year, the agency
401 shall calculate an allocation fraction to be used for
402 distributing funds to state statutory teaching hospitals.
403 Subsequent to the end of each quarter of the state fiscal year,
404 the agency shall distribute to each statutory teaching hospital,
405 as defined in s. 408.07, an amount determined by multiplying
406 one-fourth of the funds appropriated for this purpose by the
407 Legislature times such hospital's allocation fraction. The
408 allocation fraction for each such hospital shall be determined
409 by the sum of the following three primary factors, divided by
410 three:
411 (a) The number of nationally accredited graduate medical
412 education programs offered by the hospital, including programs
413 accredited by the Accreditation Council for Graduate Medical
414 Education and the combined Internal Medicine and Pediatrics
415 programs acceptable to both the American Board of Internal
416 Medicine and the American Board of Pediatrics at the beginning
417 of the state fiscal year preceding the date on which the
418 allocation fraction is calculated. The numerical value of this
419 factor is the fraction that the hospital represents of the total
420 number of programs, where the total is computed for all state

421 statutory teaching hospitals.
422 (b) The number of full-time equivalent trainees in the
423 hospital, which comprises two components:
424 1. The number of trainees enrolled in nationally
425 accredited graduate medical education programs, as defined in
426 paragraph (a). Full-time equivalents are computed using the
427 fraction of the year during which each trainee is primarily
428 assigned to the given institution, over the state fiscal year
429 preceding the date on which the allocation fraction is
430 calculated. The numerical value of this factor is the fraction
431 that the hospital represents of the total number of full-time
432 equivalent trainees enrolled in accredited graduate programs,
433 where the total is computed for all state statutory teaching
434 hospitals.
435 2. The number of medical students enrolled in accredited
436 colleges of medicine and engaged in clinical activities,
437 including required clinical clerkships and clinical electives.
438 Full-time equivalents are computed using the fraction of the
439 year during which each trainee is primarily assigned to the
440 given institution, over the course of the state fiscal year
441 preceding the date on which the allocation fraction is
442 calculated. The numerical value of this factor is the fraction
443 that the given hospital represents of the total number of full-
444 time equivalent students enrolled in accredited colleges of
445 medicine, where the total is computed for all state statutory
446 teaching hospitals.
447
448 The primary factor for full-time equivalent trainees is computed

449 as the sum of these two components, divided by two.
450 (c) A service index that comprises three components:
451 1. The Agency for Health Care Administration Service
452 Index, computed by applying the standard Service Inventory
453 Scores established by the agency to services offered by the
454 given hospital, as reported on Worksheet A-2 for the last fiscal
455 year reported to the agency before the date on which the
456 allocation fraction is calculated. The numerical value of this
457 factor is the fraction that the given hospital represents of the
458 total Agency for Health Care Administration Service Index
459 values, where the total is computed for all state statutory
460 teaching hospitals.
461 2. A volume-weighted service index, computed by applying
462 the standard Service Inventory Scores established by the Agency
463 for Health Care Administration to the volume of each service,
464 expressed in terms of the standard units of measure reported on
465 Worksheet A-2 for the last fiscal year reported to the agency
466 before the date on which the allocation factor is calculated.
467 The numerical value of this factor is the fraction that the
468 given hospital represents of the total volume-weighted service
469 index values, where the total is computed for all state
470 statutory teaching hospitals.
471 3. Total Medicaid payments to each hospital for direct
472 inpatient and outpatient services during the fiscal year
473 preceding the date on which the allocation factor is calculated.
474 This includes payments made to each hospital for such services
475 by Medicaid prepaid health plans, whether the plan was
476 administered by the hospital or not. The numerical value of this

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477 factor is the fraction that each hospital represents of the
478 total of such Medicaid payments, where the total is computed for
479 all state statutory teaching hospitals.
480
481 The primary factor for the service index is computed as the sum
482 of these three components, divided by three.
483 (2) By October 1 of each year, the agency shall use the
484 following formula to calculate the maximum additional
485 disproportionate share payment for statutorily defined teaching
486 hospitals:
487 TAP = THAF x A
488 Where:
489 TAP = total additional payment.
490 THAF = teaching hospital allocation factor.
491 A = amount appropriated for a teaching hospital
492 disproportionate share program.
493 Section 8. Section 409.9117, Florida Statutes, is amended
494 to read:
495 409.9117 Primary care disproportionate share program.—For
496 the 2011-2012 ~~2010-2011~~ state fiscal year, the agency shall not
497 distribute moneys under the primary care disproportionate share
498 program.
499 (1) If federal funds are available for disproportionate
500 share programs in addition to those otherwise provided by law,
501 there shall be created a primary care disproportionate share
502 program.
503 (2) The following formula shall be used by the agency to
504 calculate the total amount earned for hospitals that participate

505 in the primary care disproportionate share program:

506

507 TAE = HDSP/THDSP

508 Where:

509 TAE = total amount earned by a hospital participating in

510 the primary care disproportionate share program.

511 HDSP = the prior state fiscal year primary care

512 disproportionate share payment to the individual hospital.

513 THDSP = the prior state fiscal year total primary care

514 disproportionate share payments to all hospitals.

515

516 (3) The total additional payment for hospitals that

517 participate in the primary care disproportionate share program

518 shall be calculated by the agency as follows:

519

520 TAP = TAE x TA

521

522 Where:

523 TAP = total additional payment for a primary care hospital.

524 TAE = total amount earned by a primary care hospital.

525 TA = total appropriation for the primary care

526 disproportionate share program.

527

528 (4) In the establishment and funding of this program, the

529 agency shall use the following criteria in addition to those

530 specified in s. 409.911, and payments may not be made to a

531 hospital unless the hospital agrees to:

532 (a) Cooperate with a Medicaid prepaid health plan, if one

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533 exists in the community.
534 (b) Ensure the availability of primary and specialty care
535 physicians to Medicaid recipients who are not enrolled in a
536 prepaid capitated arrangement and who are in need of access to
537 such physicians.
538 (c) Coordinate and provide primary care services free of
539 charge, except copayments, to all persons with incomes up to 100
540 percent of the federal poverty level who are not otherwise
541 covered by Medicaid or another program administered by a
542 governmental entity, and to provide such services based on a
543 sliding fee scale to all persons with incomes up to 200 percent
544 of the federal poverty level who are not otherwise covered by
545 Medicaid or another program administered by a governmental
546 entity, except that eligibility may be limited to persons who
547 reside within a more limited area, as agreed to by the agency
548 and the hospital.
549 (d) Contract with any federally qualified health center,
550 if one exists within the agreed geopolitical boundaries,
551 concerning the provision of primary care services, in order to
552 guarantee delivery of services in a nonduplicative fashion, and
553 to provide for referral arrangements, privileges, and
554 admissions, as appropriate. The hospital shall agree to provide
555 at an onsite or offsite facility primary care services within 24
556 hours to which all Medicaid recipients and persons eligible
557 under this paragraph who do not require emergency room services
558 are referred during normal daylight hours.
559 (e) Cooperate with the agency, the county, and other
560 entities to ensure the provision of certain public health

561 services, case management, referral and acceptance of patients,
562 and sharing of epidemiological data, as the agency and the
563 hospital find mutually necessary and desirable to promote and
564 protect the public health within the agreed geopolitical
565 boundaries.
566 (f) In cooperation with the county in which the hospital
567 resides, develop a low-cost, outpatient, prepaid health care
568 program to persons who are not eligible for the Medicaid
569 program, and who reside within the area.
570 (g) Provide inpatient services to residents within the
571 area who are not eligible for Medicaid or Medicare, and who do
572 not have private health insurance, regardless of ability to pay,
573 on the basis of available space, except that hospitals may not
574 be prevented from establishing bill collection programs based on
575 ability to pay.
576 (h) Work with the Florida Healthy Kids Corporation, the
577 Florida Health Care Purchasing Cooperative, and business health
578 coalitions, as appropriate, to develop a feasibility study and
579 plan to provide a low-cost comprehensive health insurance plan
580 to persons who reside within the area and who do not have access
581 to such a plan.
582 (i) Work with public health officials and other experts to
583 provide community health education and prevention activities
584 designed to promote healthy lifestyles and appropriate use of
585 health services.
586 (j) Work with the local health council to develop a plan
587 for promoting access to affordable health care services for all
588 persons who reside within the area, including, but not limited

589 to, public health services, primary care services, inpatient
590 services, and affordable health insurance generally.
591
592 Any hospital that fails to comply with any of the provisions of
593 this subsection, or any other contractual condition, may not
594 receive payments under this section until full compliance is
595 achieved.
596 Section 9. Paragraph (b) of subsection (16) and paragraph
597 (a) of subsection (39) of section 409.912, Florida Statutes, are
598 amended to read:
599 409.912 Cost-effective purchasing of health care.—The
600 agency shall purchase goods and services for Medicaid recipients
601 in the most cost-effective manner consistent with the delivery
602 of quality medical care. To ensure that medical services are
603 effectively utilized, the agency may, in any case, require a
604 confirmation or second physician's opinion of the correct
605 diagnosis for purposes of authorizing future services under the
606 Medicaid program. This section does not restrict access to
607 emergency services or poststabilization care services as defined
608 in 42 C.F.R. part 438.114. Such confirmation or second opinion
609 shall be rendered in a manner approved by the agency. The agency
610 shall maximize the use of prepaid per capita and prepaid
611 aggregate fixed-sum basis services when appropriate and other
612 alternative service delivery and reimbursement methodologies,
613 including competitive bidding pursuant to s. 287.057, designed
614 to facilitate the cost-effective purchase of a case-managed
615 continuum of care. The agency shall also require providers to
616 minimize the exposure of recipients to the need for acute

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617 inpatient, custodial, and other institutional care and the
618 inappropriate or unnecessary use of high-cost services. The
619 agency shall contract with a vendor to monitor and evaluate the
620 clinical practice patterns of providers in order to identify
621 trends that are outside the normal practice patterns of a
622 provider's professional peers or the national guidelines of a
623 provider's professional association. The vendor must be able to
624 provide information and counseling to a provider whose practice
625 patterns are outside the norms, in consultation with the agency,
626 to improve patient care and reduce inappropriate utilization.
627 The agency may mandate prior authorization, drug therapy
628 management, or disease management participation for certain
629 populations of Medicaid beneficiaries, certain drug classes, or
630 particular drugs to prevent fraud, abuse, overuse, and possible
631 dangerous drug interactions. The Pharmaceutical and Therapeutics
632 Committee shall make recommendations to the agency on drugs for
633 which prior authorization is required. The agency shall inform
634 the Pharmaceutical and Therapeutics Committee of its decisions
635 regarding drugs subject to prior authorization. The agency is
636 authorized to limit the entities it contracts with or enrolls as
637 Medicaid providers by developing a provider network through
638 provider credentialing. The agency may competitively bid single-
639 source-provider contracts if procurement of goods or services
640 results in demonstrated cost savings to the state without
641 limiting access to care. The agency may limit its network based
642 on the assessment of beneficiary access to care, provider
643 availability, provider quality standards, time and distance
644 standards for access to care, the cultural competence of the

645 provider network, demographic characteristics of Medicaid
646 beneficiaries, practice and provider-to-beneficiary standards,
647 appointment wait times, beneficiary use of services, provider
648 turnover, provider profiling, provider licensure history,
649 previous program integrity investigations and findings, peer
650 review, provider Medicaid policy and billing compliance records,
651 clinical and medical record audits, and other factors. Providers
652 shall not be entitled to enrollment in the Medicaid provider
653 network. The agency shall determine instances in which allowing
654 Medicaid beneficiaries to purchase durable medical equipment and
655 other goods is less expensive to the Medicaid program than long-
656 term rental of the equipment or goods. The agency may establish
657 rules to facilitate purchases in lieu of long-term rentals in
658 order to protect against fraud and abuse in the Medicaid program
659 as defined in s. 409.913. The agency may seek federal waivers
660 necessary to administer these policies.
661 (16)
662 (b) The responsibility of the agency under this subsection
663 shall include the development of capabilities to identify actual
664 and optimal practice patterns; patient and provider educational
665 initiatives; methods for determining patient compliance with
666 prescribed treatments; fraud, waste, and abuse prevention and
667 detection programs; and beneficiary case management programs.
668 1. The practice pattern identification program shall
669 evaluate practitioner prescribing patterns based on national and
670 regional practice guidelines, comparing practitioners to their
671 peer groups. The agency and its Drug Utilization Review Board
672 shall consult with the Department of Health and a panel of

673 practicing health care professionals consisting of the
674 following: the Speaker of the House of Representatives and the
675 President of the Senate shall each appoint three physicians
676 licensed under chapter 458 or chapter 459; and the Governor
677 shall appoint two pharmacists licensed under chapter 465 and one
678 dentist licensed under chapter 466 who is an oral surgeon. Terms
679 of the panel members shall expire at the discretion of the
680 appointing official. The advisory panel shall be responsible for
681 evaluating treatment guidelines and recommending ways to
682 incorporate their use in the practice pattern identification
683 program. Practitioners who are prescribing inappropriately or
684 inefficiently, as determined by the agency, may have their
685 prescribing of certain drugs subject to prior authorization or
686 may be terminated from all participation in the Medicaid
687 program.
688 2. The agency shall also develop educational interventions
689 designed to promote the proper use of medications by providers
690 and beneficiaries.
691 3. The agency shall implement a pharmacy fraud, waste, and
692 abuse initiative that may include a surety bond or letter of
693 credit requirement for participating pharmacies, enhanced
694 provider auditing practices, the use of additional fraud and
695 abuse software, recipient management programs for beneficiaries
696 inappropriately using their benefits, and other steps that will
697 eliminate provider and recipient fraud, waste, and abuse. The
698 initiative shall address enforcement efforts to reduce the
699 number and use of counterfeit prescriptions.
700 4. ~~By September 30, 2002,~~ The agency <u>may</u> ~~shall~~ contract

701 with an entity in the state to provide electronic access to
702 Medicaid prescription refill data and information relating to
703 the Medicaid Preferred Drug List to Medicaid providers ~~implement~~
704 ~~a wireless handheld clinical pharmacology drug information~~
705 ~~database for practitioners~~. The initiative shall be designed to
706 enhance the agency's efforts to reduce fraud, abuse, and errors
707 in the prescription drug benefit program and to otherwise
708 further the intent of this paragraph.
709 5. By April 1, 2006, the agency shall contract with an
710 entity to design a database of clinical utilization information
711 or electronic medical records for Medicaid providers. This
712 system must be web-based and allow providers to review on a
713 real-time basis the utilization of Medicaid services, including,
714 but not limited to, physician office visits, inpatient and
715 outpatient hospitalizations, laboratory and pathology services,
716 radiological and other imaging services, dental care, and
717 patterns of dispensing prescription drugs in order to coordinate
718 care and identify potential fraud and abuse.
719 6. The agency may apply for any federal waivers needed to
720 administer this paragraph.
721 (39)(a) The agency shall implement a Medicaid prescribed-
722 drug spending-control program that includes the following
723 components:
724 1. A Medicaid preferred drug list, which shall be a
725 listing of cost-effective therapeutic options recommended by the
726 Medicaid Pharmacy and Therapeutics Committee established
727 pursuant to s. 409.91195 and adopted by the agency for each
728 therapeutic class on the preferred drug list. At the discretion

729 of the committee, and when feasible, the preferred drug list
730 should include at least two products in a therapeutic class. The
731 agency may post the preferred drug list and updates to the
732 preferred drug list on an Internet website without following the
733 rulemaking procedures of chapter 120. Antiretroviral agents are
734 excluded from the preferred drug list. The agency shall also
735 limit the amount of a prescribed drug dispensed to no more than
736 a 34-day supply unless the drug products' smallest marketed
737 package is greater than a 34-day supply, or the drug is
738 determined by the agency to be a maintenance drug in which case
739 a 100-day maximum supply may be authorized. The agency is
740 authorized to seek any federal waivers necessary to implement
741 these cost-control programs and to continue participation in the
742 federal Medicaid rebate program, or alternatively to negotiate
743 state-only manufacturer rebates. The agency may adopt rules to
744 implement this subparagraph. The agency shall continue to
745 provide unlimited contraceptive drugs and items. The agency must
746 establish procedures to ensure that:
747 a. There is a response to a request for prior consultation
748 by telephone or other telecommunication device within 24 hours
749 after receipt of a request for prior consultation; and
750 b. A 72-hour supply of the drug prescribed is provided in
751 an emergency or when the agency does not provide a response
752 within 24 hours as required by sub-subparagraph a.
753 2. Reimbursement to pharmacies for Medicaid prescribed
754 drugs shall be set at the lowest ~~lesser~~ of: the average
755 wholesale price (AWP) minus 16.4 percent, the wholesaler
756 acquisition cost (WAC) plus 3.75 ~~4.75~~ percent, the federal upper

757 limit (FUL), the state maximum allowable cost (SMAC), or the
758 usual and customary (UAC) charge billed by the provider.
759 3. The agency shall develop and implement a process for
760 managing the drug therapies of Medicaid recipients who are using
761 significant numbers of prescribed drugs each month. The
762 management process may include, but is not limited to,
763 comprehensive, physician-directed medical-record reviews, claims
764 analyses, and case evaluations to determine the medical
765 necessity and appropriateness of a patient's treatment plan and
766 drug therapies. The agency may contract with a private
767 organization to provide drug-program-management services. The
768 Medicaid drug benefit management program shall include
769 initiatives to manage drug therapies for HIV/AIDS patients,
770 patients using 20 or more unique prescriptions in a 180-day
771 period, and the top 1,000 patients in annual spending. The
772 agency shall enroll any Medicaid recipient in the drug benefit
773 management program if he or she meets the specifications of this
774 provision and is not enrolled in a Medicaid health maintenance
775 organization.
776 4. The agency may limit the size of its pharmacy network
777 based on need, competitive bidding, price negotiations,
778 credentialing, or similar criteria. The agency shall give
779 special consideration to rural areas in determining the size and
780 location of pharmacies included in the Medicaid pharmacy
781 network. A pharmacy credentialing process may include criteria
782 such as a pharmacy's full-service status, location, size,
783 patient educational programs, patient consultation, disease
784 management services, and other characteristics. The agency may

785 impose a moratorium on Medicaid pharmacy enrollment when it is
786 determined that it has a sufficient number of Medicaid-
787 participating providers. The agency must allow dispensing
788 practitioners to participate as a part of the Medicaid pharmacy
789 network regardless of the practitioner's proximity to any other
790 entity that is dispensing prescription drugs under the Medicaid
791 program. A dispensing practitioner must meet all credentialing
792 requirements applicable to his or her practice, as determined by
793 the agency.
794 5. The agency shall develop and implement a program that
795 requires Medicaid practitioners who prescribe drugs to use a
796 counterfeit-proof prescription pad for Medicaid prescriptions.
797 The agency shall require the use of standardized counterfeit-
798 proof prescription pads by Medicaid-participating prescribers or
799 prescribers who write prescriptions for Medicaid recipients. The
800 agency may implement the program in targeted geographic areas or
801 statewide.
802 6. The agency may enter into arrangements that require
803 manufacturers of generic drugs prescribed to Medicaid recipients
804 to provide rebates of at least 15.1 percent of the average
805 manufacturer price for the manufacturer's generic products.
806 These arrangements shall require that if a generic-drug
807 manufacturer pays federal rebates for Medicaid-reimbursed drugs
808 at a level below 15.1 percent, the manufacturer must provide a
809 supplemental rebate to the state in an amount necessary to
810 achieve a 15.1-percent rebate level.
811 7. The agency may establish a preferred drug list as
812 described in this subsection, and, pursuant to the establishment

813 of such preferred drug list, it is authorized to negotiate
814 supplemental rebates from manufacturers that are in addition to
815 those required by Title XIX of the Social Security Act and at no
816 less than 14 percent of the average manufacturer price as
817 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
818 the federal or supplemental rebate, or both, equals or exceeds
819 29 percent. There is no upper limit on the supplemental rebates
820 the agency may negotiate. The agency may determine that specific
821 products, brand-name or generic, are competitive at lower rebate
822 percentages. Agreement to pay the minimum supplemental rebate
823 percentage will guarantee a manufacturer that the Medicaid
824 Pharmaceutical and Therapeutics Committee will consider a
825 product for inclusion on the preferred drug list. However, a
826 pharmaceutical manufacturer is not guaranteed placement on the
827 preferred drug list by simply paying the minimum supplemental
828 rebate. Agency decisions will be made on the clinical efficacy
829 of a drug and recommendations of the Medicaid Pharmaceutical and
830 Therapeutics Committee, as well as the price of competing
831 products minus federal and state rebates. The agency is
832 authorized to contract with an outside agency or contractor to
833 conduct negotiations for supplemental rebates. For the purposes
834 of this section, the term "supplemental rebates" means cash
835 rebates. Effective July 1, 2004, value-added programs as a
836 substitution for supplemental rebates are prohibited. The agency
837 is authorized to seek any federal waivers to implement this
838 initiative.
839 8. The Agency for Health Care Administration shall expand
840 home delivery of pharmacy products. <u>The agency is authorized to</u>

841 amend the state plan and issue a procurement, as necessary, in
842 order to implement this program. The procurements shall include
843 agreements with a pharmacy or pharmacies located in the state to
844 provide mail order delivery services at no cost to the
845 recipients who elect to receive home delivery of pharmacy
846 products. The procurement shall focus on serving recipients with
847 chronic diseases for which pharmacy expenditures represent a
848 significant portion of Medicaid pharmacy expenditures or which
849 impact a significant portion of the Medicaid population. ~~To~~
850 ~~assist Medicaid patients in securing their prescriptions and~~
851 ~~reduce program costs, the agency shall expand its current mail-~~
852 ~~order-pharmacy diabetes-supply program to include all generic~~
853 ~~and brand-name drugs used by Medicaid patients with diabetes.~~
854 ~~Medicaid recipients in the current program may obtain~~
855 ~~nondiabetes drugs on a voluntary basis. This initiative is~~
856 ~~limited to the geographic area covered by the current contract.~~
857 The agency may seek and implement any federal waivers necessary
858 to implement this subparagraph.
859 9. The agency shall limit to one dose per month any drug
860 prescribed to treat erectile dysfunction.
861 10.a. The agency may implement a Medicaid behavioral drug
862 management system. The agency may contract with a vendor that
863 has experience in operating behavioral drug management systems
864 to implement this program. The agency is authorized to seek
865 federal waivers to implement this program.
866 b. The agency, in conjunction with the Department of
867 Children and Family Services, may implement the Medicaid
868 behavioral drug management system that is designed to improve

869 the quality of care and behavioral health prescribing practices
870 based on best practice guidelines, improve patient adherence to
871 medication plans, reduce clinical risk, and lower prescribed
872 drug costs and the rate of inappropriate spending on Medicaid
873 behavioral drugs. The program may include the following
874 elements:
875 (I) Provide for the development and adoption of best
876 practice guidelines for behavioral health-related drugs such as
877 antipsychotics, antidepressants, and medications for treating
878 bipolar disorders and other behavioral conditions; translate
879 them into practice; review behavioral health prescribers and
880 compare their prescribing patterns to a number of indicators
881 that are based on national standards; and determine deviations
882 from best practice guidelines.
883 (II) Implement processes for providing feedback to and
884 educating prescribers using best practice educational materials
885 and peer-to-peer consultation.
886 (III) Assess Medicaid beneficiaries who are outliers in
887 their use of behavioral health drugs with regard to the numbers
888 and types of drugs taken, drug dosages, combination drug
889 therapies, and other indicators of improper use of behavioral
890 health drugs.
891 (IV) Alert prescribers to patients who fail to refill
892 prescriptions in a timely fashion, are prescribed multiple same-
893 class behavioral health drugs, and may have other potential
894 medication problems.
895 (V) Track spending trends for behavioral health drugs and
896 deviation from best practice guidelines.

897 (VI) Use educational and technological approaches to
898 promote best practices, educate consumers, and train prescribers
899 in the use of practice guidelines.
900 (VII) Disseminate electronic and published materials.
901 (VIII) Hold statewide and regional conferences.
902 (IX) Implement a disease management program with a model
903 quality-based medication component for severely mentally ill
904 individuals and emotionally disturbed children who are high
905 users of care.
906 11.a. The agency shall implement a Medicaid prescription
907 drug management system. The agency may contract with a vendor
908 that has experience in operating prescription drug management
909 systems in order to implement this system. Any management system
910 that is implemented in accordance with this subparagraph must
911 rely on cooperation between physicians and pharmacists to
912 determine appropriate practice patterns and clinical guidelines
913 to improve the prescribing, dispensing, and use of drugs in the
914 Medicaid program. The agency may seek federal waivers to
915 implement this program.
916 b. The drug management system must be designed to improve
917 the quality of care and prescribing practices based on best
918 practice guidelines, improve patient adherence to medication
919 plans, reduce clinical risk, and lower prescribed drug costs and
920 the rate of inappropriate spending on Medicaid prescription
921 drugs. The program must:
922 (I) Provide for the ~~development and~~ adoption of best
923 practice guidelines for the prescribing and use of drugs in the
924 Medicaid program, including translating best practice guidelines

925 into practice; reviewing prescriber patterns and comparing them
926 to indicators that are based on national standards and practice
927 patterns of clinical peers in their community, statewide, and
928 nationally; and determine deviations from best practice
929 guidelines.
930 (II) Implement processes for providing feedback to and
931 educating prescribers using best practice educational materials
932 and peer-to-peer consultation.
933 (III) Assess Medicaid recipients who are outliers in their
934 use of a single or multiple prescription drugs with regard to
935 the numbers and types of drugs taken, drug dosages, combination
936 drug therapies, and other indicators of improper use of
937 prescription drugs.
938 (IV) Alert prescribers to patients who fail to refill
939 prescriptions in a timely fashion, are prescribed multiple drugs
940 that may be redundant or contraindicated, or may have other
941 potential medication problems.
942 ~~(V) Track spending trends for prescription drugs and~~
943 ~~deviation from best practice guidelines.~~
944 ~~(VI) Use educational and technological approaches to~~
945 ~~promote best practices, educate consumers, and train prescribers~~
946 ~~in the use of practice guidelines.~~
947 ~~(VII) Disseminate electronic and published materials.~~
948 ~~(VIII) Hold statewide and regional conferences.~~
949 ~~(IX) Implement disease management programs in cooperation~~
950 ~~with physicians and pharmacists, along with a model quality-~~
951 ~~based medication component for individuals having chronic~~
952 ~~medical conditions.~~

953 12. The agency is authorized to contract for drug rebate
954 administration, including, but not limited to, calculating
955 rebate amounts, invoicing manufacturers, negotiating disputes
956 with manufacturers, and maintaining a database of rebate
957 collections.
958 13. The agency may specify the preferred daily dosing form
959 or strength for the purpose of promoting best practices with
960 regard to the prescribing of certain drugs as specified in the
961 General Appropriations Act and ensuring cost-effective
962 prescribing practices.
963 14. The agency may require prior authorization for
964 Medicaid-covered prescribed drugs. The agency may, but is not
965 required to, prior-authorize the use of a product:
966 a. For an indication not approved in labeling;
967 b. To comply with certain clinical guidelines; or
968 c. If the product has the potential for overuse, misuse,
969 or abuse.
970
971 The agency may require the prescribing professional to provide
972 information about the rationale and supporting medical evidence
973 for the use of a drug. The agency may post prior authorization
974 criteria and protocol and updates to the list of drugs that are
975 subject to prior authorization on an Internet website without
976 amending its rule or engaging in additional rulemaking.
977 15. The agency, in conjunction with the Pharmaceutical and
978 Therapeutics Committee, may require age-related prior
979 authorizations for certain prescribed drugs. The agency may
980 preauthorize the use of a drug for a recipient who may not meet

981 the age requirement or may exceed the length of therapy for use
982 of this product as recommended by the manufacturer and approved
983 by the Food and Drug Administration. Prior authorization may
984 require the prescribing professional to provide information
985 about the rationale and supporting medical evidence for the use
986 of a drug.
987 16. The agency shall implement a step-therapy prior
988 authorization approval process for medications excluded from the
989 preferred drug list. Medications listed on the preferred drug
990 list must be used within the previous 12 months prior to the
991 alternative medications that are not listed. The step-therapy
992 prior authorization may require the prescriber to use the
993 medications of a similar drug class or for a similar medical
994 indication unless contraindicated in the Food and Drug
995 Administration labeling. The trial period between the specified
996 steps may vary according to the medical indication. The step-
997 therapy approval process shall be developed in accordance with
998 the committee as stated in s. 409.91195(7) and (8). A drug
999 product may be approved without meeting the step-therapy prior
1000 authorization criteria if the prescribing physician provides the
1001 agency with additional written medical or clinical documentation
1002 that the product is medically necessary because:
1003 a. There is not a drug on the preferred drug list to treat
1004 the disease or medical condition which is an acceptable clinical
1005 alternative;
1006 b. The alternatives have been ineffective in the treatment
1007 of the beneficiary's disease; or
1008 c. Based on historic evidence and known characteristics of

1009 the patient and the drug, the drug is likely to be ineffective,
1010 or the number of doses have been ineffective.
1011
1012 The agency shall work with the physician to determine the best
1013 alternative for the patient. The agency may adopt rules waiving
1014 the requirements for written clinical documentation for specific
1015 drugs in limited clinical situations.
1016 17. The agency shall implement a return and reuse program
1017 for drugs dispensed by pharmacies to institutional recipients,
1018 which includes payment of a $5 restocking fee for the
1019 implementation and operation of the program. The return and
1020 reuse program shall be implemented electronically and in a
1021 manner that promotes efficiency. The program must permit a
1022 pharmacy to exclude drugs from the program if it is not
1023 practical or cost-effective for the drug to be included and must
1024 provide for the return to inventory of drugs that cannot be
1025 credited or returned in a cost-effective manner. The agency
1026 shall determine if the program has reduced the amount of
1027 Medicaid prescription drugs which are destroyed on an annual
1028 basis and if there are additional ways to ensure more
1029 prescription drugs are not destroyed which could safely be
1030 reused. The agency's conclusion and recommendations shall be
1031 reported to the Legislature by December 1, 2005.
1032 Section 10. Notwithstanding s. 430.707, Florida Statutes,
1033 and subject to federal approval of the application to be a site
1034 for the Program of All-inclusive Care for the Elderly, the
1035 Agency for Health Care Administration shall contract with one
1036 private health care organization, the sole member of which is a

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

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1037 private, not-for-profit corporation that owns and manages health
1038 care organizations which provide comprehensive long-term care
1039 services, including nursing home, assisted living, independent
1040 housing, home care, adult day care, and care management, with a
1041 board-certified, trained geriatrician as the medical director.
1042 This organization shall provide these services to frail and
1043 elderly persons who reside in Palm Beach County. The
1044 organization shall be exempt from the requirements of chapter
1045 641, Florida Statutes. The agency, in consultation with the
1046 Department of Elderly Affairs and subject to an appropriation,
1047 shall approve up to 150 initial enrollees in the Program of All-
1048 inclusive Care for the Elderly established by this organization
1049 to serve elderly persons who reside in Palm Beach County.
1050 Section 11. This act shall take effect July 1, 2011.