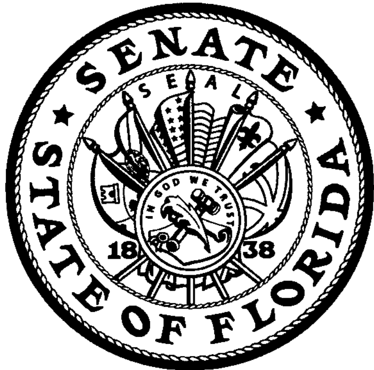

Conference Committee on House Health Care Appropriations / Senate Health and Human Services Appropriations

<u>House Offer #1</u>
Conforming Bill
HB 5101

Monday, February 29, 2016
9:00 PM
212 Knott

	HB 5101	House Offer #1	SB 2508
1	<u>**House Revision**</u> 322.142 Color photographic or digital imaged licenses.— (4) The department may maintain a film negative or print file. The department shall maintain a record of the digital image and signature of the licensees, together with other data required by the department for identification and retrieval. Reproductions from the file or digital record are exempt from the provisions of s. 119.07(1) and may be made and issued only: <u>(m) To the Agency for Health Care Administration pursuant to an interagency agreement to prevent health care fraud. If the Agency for Health Care Administration enters into an agreement with a private entity to carry out duties relating to health care fraud prevention, such contracts shall include, but not be limited to, the following provisions:</u> <u>1. Provisions requiring internal controls and audit processes to identify access, use, and unauthorized access of information.</u> <u>2. A requirement to report unauthorized access or use to the Agency for Health Care Administration within one business day of the discovery of the unauthorized access or use.</u> <u>3. Provisions for liquidated damages for unauthorized access or use of no less than $5,000 per occurrence.</u>	**House Revised**	**Section 1.** (s. 322.143, F.S.) Provides that, for the purpose of combatting health care fraud, the Dept of Highway Safety and Motor Vehicles will provide photographic access, pursuant to a written agreement, with hospitals, insurance companies, or their software providers, for the purpose of verifying a patient's identity or Medicaid eligibility by swiping an individual's driver's license or identification card
2		**Senate**	**Section 2.** (s. 395.602(2)(e), F.S.) Provides that a hospital classified as a sole community hospital which has up to 175 licensed beds is included in the definition of "rural hospital.".
2a	**New Section.** (s.408.036(3), F.S.) Revises statute to provide a specific CON exemption for a new hospital under certain circumstances. (3) EXEMPTIONS.—Upon request, the following projects are subject to exemption	**House New**	

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	from the provisions of subsection (1): (u) For the establishment of a health care facility or project that meets all of the following criteria: 1. The applicant is an existing health care facility which has provided in excess of 75,000 Medicaid patient days each year for the previous five years; 2. The proposed new facility is in the same health planning district, or county, if the health planning district has multiple counties, as the applicant and does not exceed 125 beds; and 3. The applicant agrees to delicense a comparable number of beds at an existing facility or facilities in the same health planning district for a period of five years. A hospital that constructs a facility under this provision may not apply for an additional CON exemption for a minimum of five years.		
3	**Section 1.** (s. 409.285, F.S) 409.285 Opportunity for hearing and appeal. (1) If an application for public assistance is not acted upon within a reasonable time after the filing of the application, or is denied in whole or in part, or if an assistance payment is modified or canceled, the applicant or recipient may appeal the decision to the Department of Children and Families in the manner and form prescribed by the department. (a)(2) The hearing authority may be the Secretary of Children and Families, a panel of department officials, or a hearing officer appointed for that purpose. The hearing authority is responsible for a final administrative decision in the name of the department on all issues that have been the subject of a hearing. With regard to the department, the decision of the hearing authority is final and binding. The department is responsible for seeing that the decision is carried out promptly. (b)(3) The department may adopt rules to administer this subsection section. Rules for the Temporary Assistance for Needy Families block grant programs must be similar to the federal requirements for Medicaid programs. (2) Appeals related to Medicaid programs directly administered by the Agency for	**House Modified**	**Section 3.** (s. 409.285, F.S.) Revises parameters for Medicaid fair hearings. Provides that appeals related to Medicaid programs administered by AHCA must be directed to AHCA, not DCF. Specifies AHCA's hearing authority. Provides that AHCA fair hearings do not need to be conducted by DOAH. Authorizes AHCA to adopt rules. Provides that appeals related to the APD's home and community based waiver are subject to APD's appeals process under s. 393.125, F.S.

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	Health Care Administration, including appeals related to Florida s Statewide Medicaid Managed Care program and associated federal waivers, filed on or after March 1, 2017, must be directed to the Agency for Health Care Administration in the manner and form prescribed by the agency. The department and the Agency for Health Care Administration shall establish a transition process to transfer administration of these appeals from the department to the agency by March 1, 2017. (a) The hearing authority for appeals heard by the Agency for Health Care Administration may be the secretary of the agency, a panel of agency officials, or a hearing officer appointed for that purpose. The hearing authority is responsible for a final administrative decision in the name of the agency on all issues that have been the subject of a hearing. A decision of the hearing authority is final and binding on the agency. The agency is responsible for seeing that the decision is promptly carried out. (b) Notwithstanding ss. 120.569 and 120.57, hearings conducted by the Agency for Health Care Administration pursuant to this subsection are subject to federal regulations and requirements relating to Medicaid appeals, are exempt from the uniform rules of procedure under s. 120.54(5), and do not need to be conducted by an administrative law judge assigned by the Division of Administrative Hearings. (c) The Agency for Health Care Administration shall seek federal approval necessary to implement this subsection and may adopt rules necessary to administer this subsection. (3) Appeals related to Medicaid programs administered by the Agency for Persons with Disabilities are subject to s. 393.125.		
4		**Senate**	**Section 4.** (s. 409.811, F.S.) Amends definitions to permit certain non-citizen children to receive federal financial premium assistance under Medicaid or the Children's Health Insurance Program (CHIP). First of four statutory sections identical to those contained in SB 248 and HB 89.
5		**Senate**	**Section 5.** (s. 409.814, F.S.) Replace a reference to "qualified alien" with "lawfully residing child" when referring to children who are not eligible for Title XXI funded premium assistance. Also clarifies that Kidcare program eligibility is not being extended to undocumented immigrants. Second of four statutory sections identical to those contained in SB 248 and HB 89.
6		**Senate**	**Section 6.** (s. 409.904, F.S.) Provides that a child younger than 19 years of age who is a lawfully residing child as defined in s. 409.811, F.S., is eligible for Medicaid under s.

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			409.903, F.S. Also clarifies that Medicaid eligibility is not being extended to undocumented immigrants. Third of four statutory sections identical to those contained in SB 248 and HB 89.
7	**Section 2.** (409.905, F.S.) Deletes statutes requiring a cost-based reimbursement methodology for hospital outpatient services and requires AHCA to implement a prospective payment system for those services, effective July 1, 2017, and July 1 of each fiscal year thereafter.	**House Revised**	
8		**Senate**	**Section 7.** (s. 409.905, F.S.) Deletes the requirement for AHCA to limit payment for hospital emergency department visits for non-pregnant Medicaid recipients 21 years of age or older to six visits per fiscal year.
9		**Senate**	**Section 8.** (s. 409.906, F.S.), Requires AHCA to seek federal approval to pay for flexible services for persons with severe mental illness or substance abuse disorders, including, but not limited to, temporary housing assistance. Payment for such services may be made as enhanced rates or incentive payments to managed care plans within Statewide Medicaid Managed Care.
10		**House Revised-see attached**	**Section 9.** (s. 409.9064, F.S.) Requires AHCA to seek federal approval of a section 1915(i) state plan option for home and community-based services for individuals diagnosed with Phelan-McDermid Syndrome. Requires that financial eligibility for Medicaid benefits under such a state plan option will be determined in the same manner as the home and community-based services waiver currently administered by APD
11		**Senate**	**Section 10.** (s. 409.907, F.S.) Authorizes AHCA to certify that a Medicaid provider is out of business and that any overpayments made to the provider cannot be collected under state law.
12		**Senate**	**Section 11.** (s. 409.9072, F.S.) Authorizes AHCA to reimburse private schools and charter schools for providing Medicaid school-based services identical to those offered under the Medicaid certified school match program and under the same eligibility criteria as children eligible for services under that program. For reimbursements to private and charter schools under this provision, AHCA is directed to apply the reimbursement schedule developed for providers within the certified school match program.

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13	**Section 8.** (s. 409.908, F.S.) Deletes statutory provisions allowing hospitals that provide services to a disproportionate share of low-income Medicaid recipients, or are RPICC hospitals, or that receive teaching hospital DSH dollars, to receive additional Medicaid reimbursement. Also deletes the provision requiring the total amount of payment for DSH hospitals to be fixed in the GAA. Also deletes the requirement that the computation of these payments must be in compliance with all federal regulations and the methodologies described in ss. 409.911 and 409.9113, F.S.	**Senate-no language**	
13a	**Section 8.** (s. 409.908(1)(a)(2), F.S.) Amends statute to exempt Class III Psychiatric Hospitals from DRG Inpatient prospective payments. (a) Reimbursement for inpatient care is limited as provided in s. 409.905(5), except as otherwise provided in this subsection. 1. If authorized by the General Appropriations Act, the agency may modify reimbursement for specific types of services or diagnoses, recipient ages, and hospital provider types. 2. The agency may establish an alternative methodology to the DRG-based prospective payment system to set reimbursement rates for: a. State-owned psychiatric hospitals. b. Newborn hearing screening services. c. Transplant services for which the agency has established a global fee. d. Recipients who have tuberculosis that is resistant to therapy who are in need of long-term, hospital-based treatment pursuant to s. 392.62. e. Class III psychiatric hospitals.	**House New**	
13b	**Section 8.** (s. 409.908(5), F.S.) Amends statute to require AHCA to implement a prospective payment system for ambulatory surgical centers, effective July 1, 2017, and July 1 of each fiscal year thereafter. (5) Effective July 1, 2017, an ambulatory surgical center shall be reimbursed pursuant to a prospective payment methodology. The agency shall implement a prospective payment methodology for establishing reimbursement rates for ambulatory surgical centers. Rates shall be calculated annually and take effect July 1, 2017, each year thereafter. The methodology shall categorize the amount and type of services used in various ambulatory visits which group together procedures and medical visits that share similar characteristics and resource utilization the lesser of the amount billed by the provider or the	**House-new**	

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	Medicare-established allowable amount for the facility.		
14		**House-no language**	**Section 12.** (s. 409.908, F.S.) Removes nursing homes from the list of providers for which AHCA is required to set rates at levels that ensure no increase in statewide expenditures resulting from changes in unit costs, effective July 1, 2017.
15	**Section 3.** (s. 409.909, F.S.) Conforms the Statewide Medicaid Residency Program to the implementation of the prospective payment system for hospital outpatient services under section 2 of the House bill with an effective date of July 1, 2017.	**House-Revised**	
16		**Senate**	**Section 13.** (s. 409.909, F.S.) Adds psychiatry to the list of primary care specialties as specified within the Statewide Medicaid Residency Program.
16a	**New Section.** (s.409.909(2)(c), F.S.) Amends statute to include Federally Qualified Health Centers holding certain accreditations to be included within the Statewide Medicaid Residency Program. (c) "Qualifying institutions" means a federally Qualified Health Center holding ACGME institutional accreditation. (d) "Resident" means a medical intern, fellow, or resident enrolled in a program accredited by the Accreditation Council for Graduate Medical Education, the American Association of Colleges of Osteopathic Medicine, or the American Osteopathic Association at the beginning of the state fiscal year during which the allocation fraction is calculated, as reported by the hospital to the agency. (3) The agency shall use the following formula to calculate a participating hospital's and qualifying institution's allocation fraction: HAF=[0.9 x (HFTE/TFTE)] + [0.1 x (HMP/TMP)] Where: HAF=A hospital's and qualifying institution's allocation fraction.	**House New**	

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	HFTE=A hospital's and qualifying institution's total number of FTE residents. TFTE=The total FTE residents for all participating hospitals and qualifying institutions. HMP=A hospital's and qualifying institution's Medicaid payments. TMP=The total Medicaid payments for all participating hospitals and qualifying institutions. (4) A hospital's and qualifying institution's annual allocation shall be calculated by multiplying the funds appropriated for the Statewide Medicaid Residency Program in the General Appropriations Act by that hospital's and qualifying institution's allocation fraction. If the calculation results in an annual allocation that exceeds two times the average per FTE resident amount for all hospitals and qualifying institutions, the hospital's and qualifying institution's annual allocation shall be reduced to a sum equaling no more than two times the average per FTE resident. The funds calculated for that hospital and qualifying institution in excess of two times the average per FTE resident amount for all hospitals and qualifying institutions shall be redistributed to participating hospitals and qualifying institutions whose annual allocation does not exceed two times the average per FTE resident amount for all hospitals and qualifying institutions, using the same methodology and payment schedule specified in this section.		
16b	**New Section.** (s.409.909(5)(a), F.S.) Amends statute to clarify the timeframe for accreditation approvals for hospitals applying for the Graduate Medical Education Startup Bonus Program. (a) Hospitals applying for a startup bonus must submit to the agency by March 1 their Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution approval validating the new resident positions approved on or after March 2 of the prior fiscal year through March 1 of the current fiscal year for the physician specialties identified in a statewide supply-and-demand deficit as provided in the current fiscal year General Appropriations Act.~~in physician specialties in statewide supply-and-demand deficit in the current fiscal year~~. An applicant hospital may validate a	**House New**	

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	change in the number of residents by comparing the number in the prior period Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution approval to the number in the current year.		
17	**Section 7.** Repeals s. 409.911, F.S., relating to the DSH program.	**No Language**	**Section 14.** (s. 409.911, F.S.) Requires AHCA to use the average of the 2007, 2008, and 2009 audited disproportionate share hospital (DSH) data to determine each hospital's Medicaid days and charity care for the 2016-2017 fiscal year. Also provides that, notwithstanding the provisions of s. 409.911, F.S., to the contrary, for the 2016-2017 fiscal year, AHCA must distribute moneys to hospitals providing a disproportionate share of Medicaid or charity care services as provided in the 2016-2017 General Appropriations Act (GAA).
18	**Section 7.** Repeals s. 409.9113, F.S., relating to the teaching hospital DSH program.	**No Language**	**Section 15.** (s. 409.9113, F.S.) Provides that, notwithstanding the provisions of s. 409.9113, F.S., to the contrary, for the 2016-2017 fiscal year, AHCA must make disproportionate share payments to teaching hospitals as provided in the 2016-2017 GAA.
19	**Section 4.** (409.9115, F.S.) Defers to the GAA instead of s. 409.911, F.S., to determine the total amount earned by a mental health hospital in the calculation of DSH earnings for the mental health DSH program.	**No language**	**Section 16.** (s. 409.9115, F.S.) Provides that, notwithstanding the provisions of s. 409.9115, F.S., to the contrary, for the 2016-2017 fiscal year, and for hospitals that qualify, AHCA must distribute funds for the DSH program for mental health hospitals under the same manner as in the 2015-2016 fiscal year.
20	**Section 5.** (409.9116, F.S.) Removes reference to s. 409.911, F.S., from statutory language relating to rural hospital DSH.	**No Language**	
21	**Section 7.** Repeals s. 409.9118, F.S., relating to the specialty hospital DSH program.	**No Language**	
22	**Section 7.** Repeals s. 409.9119, F.S., relating to the children's hospital DSH program.	**No Language**	**Section 17.** (s. 409.9119, F.S.) Provides that, notwithstanding the provisions of s. 409.9119, F.S., to the contrary, for the 2016-2017 fiscal year, and for hospitals that fully comply with requirements under the DSH program for specialty children's hospitals under s. 409.9119(3), F.S., AHCA must make DSH payments to children's specialty hospitals as provided in the 2016-2017 GAA.
23		**Senate**	**Section 18.** (s. 409.9128, F.S.) Conforms the statute to federal law regarding reimbursement by a Medicaid managed care plan to a non-contracted provider for emergency services, by virtue of a cross-reference to s. 409.967, F.S., as amended by the bill.

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24		**Senate**	**Section 19.** (s. 409.967, F.S.) Conforms Statewide Medicaid Managed Care to federal law regarding reimbursement by a Medicaid managed care plan to a non-contracted provider for emergency services. Also requires AHCA to post on its website annually, or more frequently as needed, the data necessary for Medicaid managed care plans and hospitals to abide with the law.
25		**Senate**	**Section 20.** (s. 409.968, F.S.) Requires AHCA to establish a payment methodology to fund managed care plans within Statewide Medicaid Managed Care for flexible services for persons with severe mental illness and substance abuse disorders, including, but not limited to, temporary housing assistance. After receiving such payments for at least one year, a managed care plan must document the results of its efforts to maintain the target population in stable housing up to the maximum duration allowed under federal approval. *(Also see section 8 of the Senate bill.)*
26		**House accepts Senate language on the first two paragraphs.** **House accepts a portion of the third paragraph; however, House does NOT accept the highlighted provisions relating to deleting the provision requiring that such payments to hospitals cannot exceed 120% of the rate AHCA would have paid.**	**Section 21.** (s. 409.975, F.S.) Clarifies within Medicaid's Managed Medical Assistance component of SMMC, that the term "essential provider" includes providers determined to be essential Medicaid providers under s. 409.975(1)(a), F.S., and providers specified as statewide essential providers under s. 409.975(1)(b), F.S., for the purpose of applying the criteria for excluding an essential provider from a managed care plan network under s. 409.975(1)(c), F.S. Provides a cross-reference to s. 409.967, F.S., as amended by the bill, regarding payments required of a managed care plan within the Statewide Medicaid Managed Care program to a non-contracted provider that has rendered emergency services to a member of the managed care plan. Deletes the provision in s. 409.975(6), F.S., currently requiring that for rates, methods, and terms of payment negotiated after an MMA contract between AHCA and a managed care plan has been executed, the managed care plan must pay hospitals within its provider networks, at a minimum, the rate that AHCA would have paid on the first day of the contract between the provider and the plan. And, deletes the provision requiring that such payments to hospitals cannot exceed 120 percent of the rate AHCA would have paid on the first day of the contract between the provider and the plan, unless specifically approved by AHCA.

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27		**Senate**	**Section 22.** (s. 624.91, F.S.) Amends the Florida Healthy Kids Corporation Act to conform to changes made under sections 4, 5, and 6 of the Senate bill and to update references to modified or deleted terms. Fourth of four statutory sections identical to those contained in SB 248 and HB 89.
28		**Senate**	**Section 23.** (641.513, F.S.) Provides that the amount of reimbursement paid by a health maintenance organization (HMO) to a non-contracted provider for emergency services provided to a member of the HMO who is a Medicaid recipient, will be determined under ch. 409. The bill also provides that the amount of reimbursement for emergency services provided to subscribers who are enrolled in an HMO pursuant to the Florida Healthy Kids program by a provider for whom no contract exists between the provider and the HMO, will be the lesser of: the provider's charges; the usual and customary provider charges for similar services in the community where the services were provided; the charge mutually agreed to by the managed care plan and the provider within 60 days after submittal of the claim; or the Medicaid rate.
29	**Section 9.** (s. 1009.66, F.S.) Provides that specialty children's hospitals that employ nurses participating in the Nursing Student Loan Forgiveness Program are no longer exempt from the requirement that employers of such nurses provide a dollar-for-dollar match for funds used for loan forgiveness. Also removes specialty children's hospitals from the prioritization list on which applicant awards for loan forgiveness are based.	**Senate-no language**	
30	**Section 10.** (s. 1009.67, F.S.) Removes specialty children's hospitals from a list of facilities that are eligible for credit for repayment of a scholarship within the nursing scholarship program.	**Senate-no language**	
31	**Section 6.** Amends section 18 of chapter 2012-33, L.O.F., to authorize a current Program of All-Inclusive Care for the Elderly (PACE) organization that is authorized to provide PACE services for up to 150 frail elders in Broward County under ch. 2012-33, L.O.F., to also use those PACE slots for frail elders residing in Miami-Dade County, subject to federal approval and a contract amendment with AHCA.	**House**	**Section 24.** Authorizes a current Program of All-Inclusive Care for the Elderly (PACE) organization that is authorized to provide PACE services for up to 150 frail elders in Broward County under ch. 2012-33, L.O.F., to also use those PACE slots for frail elders residing in Miami-Dade County, subject to federal approval and a contract amendment with AHCA.
32		**Senate**	**Section 25.** Directs AHCA, subject to federal approval to become a PACE site, to contract with one private, not-for-profit hospice organization located in Escambia County that owns and manages health care organizations licensed in Hospice Service Areas 1, 2A, and 2B which provide comprehensive services, including, but not limited to, hospice and palliative care, to frail elders residing in the specified hospice service areas. Provides that the PACE organization will be exempt from the requirements of ch. 641, F.S. Authorizes up to 100 initial enrollee slots, subject to an appropriation by

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			the Legislature.
32a	**New Section.** Subject to federal approval of the application to be a site for the Program of All-inclusive Care for the Elderly (PACE) program, the Agency for Health Care Administration shall contract with a not-for-profit organization that has been jointly formed by a lead agency that has been designated pursuant to s. 430.205, Florida Statutes, and that is licensed as a nursing home diversion program provider, and by a not-for-profit hospice provider that has been licensed for more than 30 years to serve individuals and families in Clay, Duval, St. Johns, Baker, and Nassau Counties. The not-for-profit organization shall leverage existing community-based care providers and healthcare organizations to provide PACE services to frail elders who reside in Clay, Duval, St. Johns, Baker, and Nassau Counties. The organization is exempt from the requirements of chapter 641, Florida Statutes. The agency, in consultation with the Department of Elderly Affairs, and subject to an appropriation, shall approve up to 300 initial enrollees in the PACE established by this organization to serve frail elders who reside in Clay, Duval, St. Johns, Baker, and Nassau Counties.	**House**	
32b	**New Section.** Subject to federal approval of the application to be a site for the Program of All-inclusive Care for the Elderly (PACE) program, the Agency for Health Care Administration shall contract with one private, not-for-profit hospice organization located in Lake County that operates health care organizations licensed in Hospice Areas 7B and 3E, which provides comprehensive services, including hospice and palliative care, to frail elders who reside in these service areas. The organization is exempt from the requirements of chapter 641, Florida Statutes. The agency in consultation with the Department of Elderly Affairs and subject to an appropriation, shall approve up to 150 initial enrollees in the Program of All Inclusive Care for the Elderly established by this organization to serve frail elders who reside in Hospice Service Areas 7B and 3E.	**House**	
32c	**New Section.** Subject to federal approval of the application to be a site for the Program of All-inclusive Care for the Elderly (PACE), the Agency for Health Care Administration shall contract with one not-for-profit organization that has more than 30 years' experience as a licensed hospice and is currently a licensed hospice serving individuals and families in Hillsborough and Pinellas Counties. This not-for-profit organization shall provide PACE services to frail elders who reside in Hillsborough County. The organization is exempt from the requirements of chapter 641, Florida Statutes. The agency, in consultation with the Department of Elderly Affairs and	**House**	

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	subject to the appropriation of funds by the Legislature, shall approve up to 150 initial enrollees in the Program of All-inclusive Care for the Elderly established by this organization to serve frail elders who reside in Hillsborough.		
33	**Section 11.** The bill takes effect July 1, 2016.	**Identical**	**Section 26.** Except as otherwise provided, the bill takes effect July 1, 2016.

Section XX. Subsection (9) of section 393.063, Florida Statutes, is amended, present subsections (25) through (41) are redesignated as subsections (26) through (42), respectively, and a new subsection (25) is added to that section, to read:

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

(9) "Developmental disability" means a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.

(25) "Phelan-McDermid syndrome" means a disorder caused by the loss of the terminal segment of the long arm of chromosome 22, which occurs near the end of the chromosome at a location designated q13.3, typically leading to developmental delay, intellectual disability, dolicocephaly, hypotonia, or absent or delayed speech.

Section 3. Paragraphs (a) and (b) of subsection (5) and present (7) of section 393.065, Florida Statutes, are amended, subsection (6) is renumbered as subsection (8), and new subsections (6), (7), and (9) are added to that section, to read:

393.065 Application and eligibility determination.—

(5) ~~Except as otherwise directed by law, beginning July 1, 2010,~~ The agency shall assign and provide priority to clients waiting for waiver services in the following order:

(a) Category 1, which includes clients deemed to be in crisis as described in rule, shall be given first priority in moving from the waiting list to the waiver.

(b) Category 2, which includes individuals on the waiting ~~children on the wait~~ list who are:

1. From the child welfare system with an open case in the Department of Children and Families' statewide automated child welfare information system and who are either:

a. Transitioning out of the child welfare system at the finalization of an adoption, a reunification with family members, a permanent placement with a relative, or a guardianship with a nonrelative; or

b. At least 18 years old but not yet 22 years old and who need both waiver services and extended foster care services; or

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

For individuals who are at least 18 years old but not yet 22 years old and who are eligible under sub-subparagraph 1.b., the agency shall provide waiver services, including residential habilitation, and the community-based care lead agency shall fund room and board at the rate established in s. 409.145(4) and provide case management and related services as defined in s. 409.986(3)(e). Individuals may receive both waiver services and services under s. 39.6251. Services may not duplicate services available through the Medicaid state plan.

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

(7) The agency shall allow an individual with a diagnosis of Phelan-McDermid syndrome who meets the eligibility

requirements under subsection (1) to receive home and community-based services.

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

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

Section 8. Effective June 30, 2016, or if this act fails to become law until after that date, operating retroactively to June 30, 2016, sections 24 and 26 of chapter 2015-222, Laws of Florida, are repealed.

Section 9. Subsection (15) of section 393.067, Florida Statutes, is reenacted to read:

393.067 Facility licensure.—

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

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

393.18 Comprehensive transitional education program.—A comprehensive transitional education program is a group of jointly operating centers or units, the collective purpose of which is to provide a sequential series of educational care, training, treatment, habilitation, and rehabilitation services to persons who have developmental disabilities and who have severe or moderate maladaptive behaviors. However, this section does not require such programs to provide services only to

persons with developmental disabilities. All such services shall be temporary in nature and delivered in a structured residential setting, having the primary goal of incorporating the principle of self-determination in establishing permanent residence for persons with maladaptive behaviors in facilities that are not associated with the comprehensive transitional education program. The staff shall include behavior analysts and teachers, as appropriate, who shall be available to provide services in each component center or unit of the program. A behavior analyst must be certified pursuant to s. 393.17.

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

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

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

(c) Community transition residence.—This component is a residential center providing educational programs and any support services, training, and care that are needed to assist

persons with maladaptive behaviors to avoid regression to more restrictive environments while preparing them for more independent living. Continuous-shift staff shall be required for this component.

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

(e) Independent living education center.—This component is a facility providing a family living environment for persons with maladaptive behaviors in a largely unrestricted setting and includes education and monitoring that is appropriate to support the development of independent living skills.

(2) Components of a comprehensive transitional education program are subject to the license issued under s. 393.067 to a comprehensive transitional education program and may be located on a single site or multiple sites.

(3) Comprehensive transitional education programs shall develop individual education plans for each person with maladaptive behaviors who receives services from the program. Each individual education plan shall be developed in accordance with the criteria specified in 20 U.S.C. ss. 401 et seq., and 34 C.F.R. part 300.

(4) For comprehensive transitional education programs, the total number of residents who are being provided with services may not in any instance exceed the licensed capacity of 120 residents and each residential unit within the component centers of the program authorized under this section may not in any instance exceed 15 residents. However, a program that was authorized to operate residential units with more than 15

residents before July 1, 2015, may continue to operate such units.