# Health Care Appropriations Subcommittee

# Meeting Packet

March 27, 2013
4:30 PM—6:30 PM
Webster Hall

**Will Weatherford**
**Speaker**

**Matt Hudson**
**Chair**

# The Florida House of Representatives

**Appropriations Committee**

**Health Care Appropriations Subcommittee**

**Will Weatherford**
**Speaker**

**Matt Hudson**
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AGENDA
March 27, 2013
Webster Hall (212 Knott)

I. Call to Order/Roll Call

II. Chair's Proposed Budget for FY 2013-14

III. PCB HCAS 13-01—Medicaid

IV. PCB HCAS 13-02—Community-Based Care

V. CS/HB 411—Children's Initiatives by Fullwood

VI. CS/HB 701—Electronic Benefit Transfer by Smith

VII. HB 7103—Cross-Over Youth by Harrell

VIII. Closing Remarks and Adjournment

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## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** PCB HCAS 13-01 Medicaid
**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 conforms statutes to the funding decisions included in the proposed General Appropriations Act (GAA) for Fiscal Year 2013-2014. The bill:

- Repeals the Community Hospital Education Act.
- Establishes a new statute to provide a methodology to distribute Graduate Medical Education funding through the new Statewide Medicaid Graduate Medical Education Program.
- Modifies definition of rural hospital for reimbursement purposes.
- Defines how hospital inpatient rates will be calculated under a prospective payment system.
- Modifies current statute to provide deadlines related to intergovernmental transfer (IGT) letters of agreement and for source data and rate calculation corrections related to hospital inpatient and outpatient reimbursements.
- Modifies current statute to eliminate language related to the diagnosis-related group (DRG) study.
- Defines how hospital outpatient base rates will be set under a cost-reimbursement system and provides statutory deadlines for rate adjustments.
- Modifies statutes to convert hospital inpatient rates to a DRG payment system.
- Revises the years of audited data used in determining Medicaid and charity care days for hospitals in the Disproportionate Share Hospital (DSH) program.
- Continues Medicaid DSH distributions for nonstate government owned or operated hospitals eligible for payment on July 1, 2011.
- Revises the Medicaid DSH distribution criteria for Specialty Hospitals related to Tuberculosis patient services.

The bill provides an effective date of July 1, 2013.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Community Hospital Education Act**

The Community Hospital Education Program was created to support primary care residency programs and access to care for communities. The program is funded through a general appropriation by the Legislature each year, which is then used in the Medicaid program to draw down additional federal funding to disperse to hospitals with participating programs. In recent years, the funding has been disbursed through hospital inpatient per diem rates to support graduate medical education.

The bill repeals the Community Hospital Education Program and replaces it with the Statewide Medicaid Graduate Medical Education Program.

**Graduate Medical Education**

Graduate Medical Education (GME) is the period of training following graduation from a medical school when physicians refine the clinical skills necessary to practice in a specific medical field (surgery, dermatology, family practice, etc.). GME or "residency" programs for allopathic and osteopathic physicians include internships, residency training and fellowships, and can range from three to six years or more in length of time.[1]

Graduate Medical Education is important because:[2]

- GME training has a direct impact on the quality and adequacy of the state's physician specialty and sub-specialty workforce and the geographic distribution of physicians.
- The support and expansion of residency programs in critical need areas could result in more primary care practitioners and specialists practicing in Florida.
- Medical residents are more likely to practice in the state where they completed their graduate medical education training than where they went to medical school.
- Quality, prestigious programs will attract the best students, who will stay as practicing physicians.
- Medical residents act as "Safety Nets" to care for indigent, uninsured and underserved patients in the state.
- Supporting residency programs helps ensure Florida's ability to train and retain the caliber of medical doctors the state's citizens and visitors deserve.
- Among the currently practicing physicians in Florida, the top five specialties were:
    - Family Medicine (14.6%),
    - Medical Specialist (14.2%),
    - Surgical Specialist (13.4%),
    - Internal Medicine (12.8%), and
    - Anesthesiology (6.2%).
- 13.2 percent of the physicians from the 2009 survey indicated that they plan to retire in the next 5 years.

Currently, hospitals are reimbursed for their GME costs through their Medicaid Hospital Inpatient reimbursement per diem rates. This is accomplished through a cost-based reimbursement system.

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[1] Florida Department of Health, *Annual Report on Graduate Medical Education in Florida*, January 2010, available at: http://www.doh.state.fl.us/Workforce/GME_Annual_Report_2010.pdf

[2] *Id*

The costs directly related to each hospital's residency program are included in the cost reports that the hospitals submit to AHCA. The cost reports are used to set a Hospital Inpatient per diem rate and they receive reimbursement for the GME costs as a percentage of their Medicaid days.

The bill creates a new section of statute entitled "Statewide Medicaid Graduate Medical Education Program." This new program authorizes the AHCA to make payments to hospitals for their costs associated with graduate medical education and for tertiary health care services provided to Medicaid beneficiaries. The bill provides an allocation fraction to be used for distributing funds to participating hospitals and defines the primary factors that will be used in each hospital's factor.

The primary factors of the funding allocation are as follows:

- The number of full-time residents enrolled in a hospital's graduate medical education program as reported in the hospital's most recently filed Medicare/Medicaid cost report to the AHCA.
- The direct medical education costs divided by total facility costs as reported in the hospital's most recently filed Medicare/Medicaid cost report to the AHCA multiplied by the sum of the hospital's total Medicaid inpatient reimbursements.

The bill requires AHCA, on or before October 1 of each year, to calculate each hospital's funding allocation by applying the following allocation fraction:

$$THAF = [(HFTE/TFTE) \times 0.5] + [(HGMP/TGMP) \times 0.5]$$

Where:

THAF = A hospital's total allocation fraction.

HFTE = A hospital's total number of full-time equivalent residents.

TFTE = The sum of all participating hospitals' full-time equivalent residents.

HGMP = A hospital's total Graduate Medical Education Medicaid payments.

TGMP = The sum of all participating hospitals' total Graduate Medical Education Medicaid payments.

The result of this fraction produces each hospital's total allocation factor that is multiplied by the total amount of Graduate Medical Education funding available to determine each hospital's funding amount.

The bill also authorizes the AHCA to adopt any rules needed to administer the program.

**Rural Hospitals**

Currently s. 408.07 F.S., defines "rural hospital" as an acute care hospital having 100 or fewer licensed beds and an emergency room, which is:

- The sole provider within a county with a population density of no greater than 100 persons per square mile;
- An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;
- A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or fewer per square mile;
- A hospital with a service area that has a population of 100 persons or fewer per square mile. The term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the AHCA; or

- A critical access hospital.

Rural hospitals are eligible to receive funding through the Disproportionate Share Hospital Program under s. 409.9116, Florida Statutes. A hospital that received funds under this statute for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2015.

The bill amends s. 395.602, F.S., to include language that specifies if a hospital received Rural Disproportionate Share Hospital Program funding for a quarter beginning no later than July 1, 2002, or was a hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal years, it will continue to receive funding through June 30, 2015, if the hospital continues to have 100 or fewer licensed beds and an emergency room.

**Intergovernmental Transfers**

Certain exemptions to hospital inpatient and outpatient reimbursement per diem rates are funded through county and other local tax dollars that are transferred to the state and used to draw federal match. Local dollars transferred to the state and used in this way are known as "intergovernmental transfers" or IGTs. IGTs are also used to augment hospital payments in other ways, specifically through the Low Income Pool. All IGTs are contingent upon the willingness of counties and other local taxing authorities to transfer funds to the state in order to draw down federal match. The local taxing authorities commit to sending these funds to the state in the form of an executed Letter of Agreement with the AHCA. In order for AHCA to make timely payments to hospitals, the AHCA must know which local governments will be submitting IGTs and the amount of the funds prior to using the funds to draw the federal match.

The bill amends statute to require the local governments to submit to the AHCA the final executed letter of agreement containing the total amount of the IGTs authorized by the entity, no later than October 15 of each year.

**Hospital Rate-setting**

In 2011, the Legislature directed the AHCA to establish a deadline of September 30 which hospital rates could not be adjusted until the next fiscal year. The following year, the Legislature extended the statutory deadline for rate adjustments from September 30 to October 31 and extended the statutory deadline for the reconciliation of errors in cost reporting and rate calculations from September 30 to October 31.

The bill amends statute to extend the discovery deadline of source data or rate calculation errors from October 31 to November 7. Errors discovered by November 7 will be corrected by the AHCA by November 15; however, errors discovered after November 7 will be corrected in the next fiscal year.

**Diagnosis Related Group (DRG) System for Hospital Reimbursement**

DRG is a type of prospective payment system for reimbursing hospital inpatient services that provides an alternative to cost-based per diem reimbursement. DRGs classify an inpatient stay into a group based on the patient's diagnoses, sex, age, and other factors which can include costs of labor, hospital case mix, and overall wellness or acuity of the population. When demographics and external factors that affect cost are considered, groups of related diagnoses are designed to provide a stable and fairly predictable indication of the resources needed for treating a particular patient. This type of system is used in Medicare and seeks to tailor reimbursement more closely to actual costs of treatment for each individual patient.

There are 38 states that currently use or are considering transitioning to a DRG reimbursement methodology for its Medicaid programs. Among the states that use a DRG reimbursement

methodology, the most prevalent DRG reimbursement methodologies are All Patient Refined DRGs (APR-DRGs) and the Medicare DRGs (MS-DRGs). There are differences between these two DRG systems, however the major difference is that MS-DRGs are intended for use on Medicare population (age 65 and older or aged 65 and under with a disability) and the APR-DRGs are more appropriate for all patients (based on Nationwide Inpatient Sample). Additionally, the APR-DRG system has a higher number of DRGs and more relative weights to address the needs on non-Medicare populations, such as pediatric, newborn, and maternity patients.[3]

During the 2012 Session, the Legislature revised the agency's time frame for developing a plan to transition the state's cost-based reimbursement system for hospital inpatient services to a DRG system. During FY 2012-13, the AHCA contracted with a consultant, Navigant Healthcare, to develop and plan the transition from cost-based reimbursement to the use of DRGs. The final plan was released on December 21, 2012.

*Hospital Provider Types*
In its findings, Navigant recommended the use of the APR-DRG system and the following types of providers to be included in the DRG payment methodology:

- General acute care
- Rural hospitals, including critical access hospitals
- Children's hospitals
- Cancer hospitals
- Teaching hospitals
- In-state / out-of-state / border hospitals
- Long term acute care
- Rehabilitation hospitals and distinct part units
- Psychiatric specialty distinct part units

The only provider types excluded from Navigant's recommended DRG payment method are the state psychiatric facilities, as these facilities currently bill long-term care claims and have lengths of stay that suggest they are not true acute care admissions.

*Hospital Services*
Navigant recommended all inpatient services at hospitals included in the DRG payment method be reimbursed via DRGs with two notable exceptions, newborn hearing screening and transplants currently paid via a global fee. Newborn hearing screening is currently reimbursed separately from hospital per diems. Similarly, many transplants are currently paid outside the per diem method using a global fee that covers all related services for a one-year period. Navigant recommended that the AHCA maintain its current reimbursement policy for both of these services.

*Provider Base Rates*
Navigant recommended a single common base rate to be used for all hospitals. They recommended that the base rate only include the portion of the rate funded from state general revenue and the Public Medical Assistance Trust Fund. Distributions of funds from intergovernmental transfers were recommended to be made outside of the DRG payment methodology and not to be included in the base rate. Additionally, Navigant recommended against applying a wage area adjustment to the base rate.

*Policy Adjustors*
Policy adjustors are multipliers applied to specific claims for the purpose of increasing or decreasing payment. Generally, policy adjustors are applied for specific types of care, either for all recipients receiving that care or for subsets of recipients. Four types of policy adjustors are commonly used:

[3] Navigant Healthcare, *DRG Conversion Implementation Plan Final*, December 21, 2012, available at: http://ahca.myflorida.com/Medicaid/cost_reim/index.shtml

- Service adjustors
- Age/service adjustors
- Provider/service adjustors
- Provider adjustors

The adjustors extend beyond DRG relative weights and represent a decision to direct funds to a particular group of patients who are otherwise clinically similar. States that have transitioned to a DRG system, have often provided increased funding to allow for policy adjustors, as the use of policy adjustors can cause hospital base rates to be reduced having the effect of shifting funds from one area to another.

Navigant's recommendations related to policy adjustors are listed below:

- Services adjustor – Recommended for rehabilitation services due to the level of variation in hospital resources needed for these services. DRGs are unable to accurately predict relative hospital cost.
- Age/service adjustors – None recommended.
- Provider/service adjustors – None recommended.
- Provider adjustors – Recommended for three types of providers:
    - Rural Hospitals – due to the historical special consideration given by the Florida Legislature through exemptions from rate cuts and general revenue appropriations to keep per diems for rural hospitals relatively high.
    - Long Term Acute Care Hospitals (LTAC) – to maintain these providers' overall reimbursement compared to historical per diem rates. DRGs are not an accurate predictor of costs for the types of stays common at these facilities.
    - High Medicaid, High Outlier Hospitals – due to the combination of high occurrences of outlier cases with high Medicaid utilization. Recommend an adjustor for any hospital with Medicaid utilization at or above 50 percent and a projected outlier payment percentage at or above 30 percent.

The bill amends current statute to provide that AHCA has the authority to modify the reimbursement for specific types of services or diagnoses, patient ages, and hospital provider types only when authorized by the General Appropriations Act (GAA). The GAA includes an additional $76.6 million to assist with the transition to DRG system of reimbursement.

The AHCA does not have the authority to modify reimbursement for any individual hospital providing specialized services if those services are already reflected in the existing DRGs used to set the reimbursement.

The bill amends current statute to allow the AHCA to establish alternative reimbursement methodologies for specific provider types and services, including state-owned psychiatric hospitals, newborn hearing screening services, transplant services for which the AHCA has established a global fee and patients with tuberculosis who are in need of long-term hospital based services. Additionally, the bill excludes payment of Graduate Medical Education through the DRG payment system, as reimbursement of these costs will be made through the Statewide Medicaid Graduate Medical Education Program.

Finally, the bill amends statute to authorize the AHCA to modify reimbursement according to methodologies listed specifically in the GAA.

**Disproportionate Share Program (DSH)**

Each year the Low-Income Pool 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 implement the changes in DSH program funding for Fiscal Year 2013-2014. The bill:

- Revises the years of audited data to be used in calculating disproportionate share payments to hospitals for Fiscal Year 2013-2014 to use the 2005, 2006, and 2007 years; and
- Continues disproportionate share payments for any non-state government owned or operated hospital eligible for payment on July 1, 2011 for Fiscal Year 2013-2014.

**Disproportionate Share Program (DSH) for Specialty Hospitals**

Sections 81 through 83, chapter 2012-184, L.O.F., directed the Department of Health (DOH) to develop and implement a transition plan for the closure of A.G. Holley State Hospital. The department's plan included specific steps to end voluntary admissions, transfer patients to alternate facilities, communicate with families, providers, other affected parties, and the general public, and enter into necessary contracts with providers.

The law directed the DOH to contract for the operation of a treatment program for individuals with active tuberculosis. Prior to the closure of AG Holley, the DOH entered into contracts with two Florida hospitals, Shands Jacksonville and Jackson Health System in Miami to provide care to newly court ordered tuberculosis patients and those patients requiring hospitalization previously treated at AG Holley. AG Holley officially closed on July 2, 2012.

The bill amends current statute to authorize disproportionate share program funding to hospitals that receive inpatient patients who have active tuberculosis or a history of noncompliance with treatment of tuberculosis and who retain a contract with the DOH to accept clients for admission and inpatient treatment.

B. SECTION DIRECTORY:

**Section 1:** Repeals s. 381.0403 F.S., relating to the Community Hospital Education Program.

**Section 2:** Amends s. 395.602, F.S., relating to the timeframe for the designation of rural hospitals.

**Section 3:** Amends s. 409.905, F.S., relating to the methodology for establishing prospective payment hospital inpatient rates and cost-based outpatient base rates; specifying dates by which local governmental entities must submit letters of agreement for intergovernmental transfers; specifying dates by which AHCA may correct errors in rate calculations; and deletes a requirement to develop a plan to convert Medicaid hospital inpatient rates into a DRG methodology.

**Section 4:** Amends s. 409.908, F.S., to convert current Medicaid hospital inpatient reimbursement to a DRG methodology.

**Section 5:** Amends s. 409.911, F.S., to revise the years of audited data used for hospitals in the disproportionate share program and continues Medicaid disproportionate share distributions for nonstate government-owned or operated hospitals eligible for payment on a specified date.

**Section 6:** Creates s. 409.9111, F.S., the Statewide Medicaid Graduate Medical Education Program.

**Section 7:** Amends s. 409.9118, F.S., to revise the disproportionate share program distribution criteria for specialty hospitals related to tuberculosis patient services.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

$205,507,108 in federal Medicaid funds will be generated through the implementation of the DSH programs.

2. Expenditures:

The GAA contains the following appropriation:

| | FY 2013-14 |
|---|---|
| **GRADUATE MEDICAL EDUCATION** | |
| General Revenue | $ 33,056,000 |
| Medical Care Trust Fund | $ 46,924,644 |
| **Total** | **$ 79,980,644** |
| **DIAGNOSIS RELATED GROUPS (DRG)** | |
| Medical Care Trust Fund | $ 1,000,000 |
| **Total** | **$ 1,000,000** |
| **INPATIENT HOSPITAL REIMBURSEMENT** | |
| General Revenue | $ 31,835,516 |
| Medical Care Trust Fund | $ 44,706,842 |
| Refugee Assistance Trust Fund | $ 97,301 |
| **Total** | **$ 76,639,659** |
| **REGULAR DISPROPORTIONATE SHARE (DSH)** | |
| General Revenue | $ 750,000 |
| Grants and Donations Trust Fund | $ 95,243,343 |
| Medical Care Trust Fund | $132,998,411 |
| **Total** | **$228,991,754** |
| **MENTAL HEALTH HOSPITAL DSH** | |
| Medical Care Trust Fund | $ 70,126,164 |
| **Total** | **$ 70,126,164** |
| **TUBERCULOSIS DSH** | |
| Medical Care Trust Fund | $ 2,382,533 |
| **Total** | **$ 2,382,533** |
| **TOTAL BUDGETARY IMPACT** | |
| **General Revenue** | **$ 65,641,516** |
| **Grants and Donations Trust Fund** | **$ 95,243,343** |
| **Medical Care Trust Fund** | **$298,138,594** |
| **Refugee Assistance Trust Fund** | **$ 97,301** |
| **GRAND TOTAL** | **$459,120,754** |

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None

2. Expenditures:

Local governments and other local political subdivisions may provide $95,243,343 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 reimbursement toward the cost of providing care to uninsured individuals.

D. FISCAL COMMENTS:

The AHCA will distribute a total of $301,500,451 through the federal Disproportionate Share Hospital (DSH) program to hospitals providing a disproportionate share of Medicaid or charity care services.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None

2. Other:

B. RULE-MAKING AUTHORITY:

The bill authorizes the AHCA to adopt any rules needed to administer the Statewide Medicaid Graduate Medical Education Program.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to Medicaid; repealing s. 381.0403, F.S., relating to the Community Hospital Education Act; amending s. 395.602, F.S.; modifying the timeframe and requirements for the designation of a rural hospital; amending s. 409.905, F.S.; providing a prospective payment methodology for establishing hospital reimbursement rates; specifying dates by which local governmental entities must submit letters of agreement for intergovernmental transfers; deleting a requirement to develop a plan to convert Medicaid inpatient hospital rates to diagnosis-related groups; specifying dates by which the Agency for Health Care Administration must correct errors in rate calculations for inpatient and outpatient reimbursement rates; amending s. 409.908, F.S.; revising the current hospital inpatient reimbursement system to a diagnosis-related group system; amending s. 409.911, F.S.; revising the years of audited data used to determine Medicaid and charity care days for hospitals in the disproportionate share program; continuing Medicaid disproportionate share program distributions for nonstate government-owned or operated hospitals eligible for payment on a specified date; creating s. 409.9111, F.S.; establishing the Statewide Medicaid Graduate Medical Education program; requiring hospitals participating in the program to provide certain information to the agency; requiring

the agency to allocate funds to hospitals based on certain criteria; providing a formula for calculating a participating hospital's allocation; authorizing the Agency for Health Care Administration to adopt rules; amending s. 409.9118, F.S.; revising the Medicaid disproportionate share program distribution criteria for specialty hospitals related to tuberculosis patient services; providing an effective date.

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

Section 1. Section 381.0403, Florida Statutes, is repealed.

Section 2. Paragraph (e) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

(2) DEFINITIONS.—As used in this part:

(e) "Rural hospital" means an acute care hospital licensed under this chapter, having 100 or fewer licensed beds and an emergency room, which is:

1. The sole provider within a county with a population density of no greater than 100 persons per square mile;

2. An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict

whose boundaries encompass a population of 100 persons or fewer per square mile;

4. A hospital in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax pursuant to law and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency pursuant to chapter 125, and has 120 beds or less that serves an agricultural community with an emergency room utilization of no less than 20,000 visits and a Medicaid inpatient utilization rate greater than 15 percent;

5. A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the Agency for Health Care Administration; or

6. A hospital designated as a critical access hospital, as defined in s. 408.07(15).

Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2015, if the hospital continues to have 100 or fewer licensed

beds and an emergency room, or meets the criteria of subparagraph 4. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation to the Agency for Health Care Administration. A hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal years is deemed to continue to be a rural hospital from the date of designation through June 30, 2015, if the hospital continues to have 100 or fewer licensed beds and an emergency room.

Section 3. Paragraphs (c) through (f) of subsection (5) and subsection (6) of section 409.905, Florida Statutes, are amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act. Effective August 1, 2012, the agency shall limit payment for hospital emergency department visits for a nonpregnant Medicaid recipient 21 years of age or older to six visits per fiscal year.

(c) The agency shall implement a prospective payment methodology for establishing ~~base~~ reimbursement rates for inpatient hospital services ~~each hospital based on allowable costs, as defined by the agency~~. The reimbursement rate ~~Rates~~ shall be calculated annually and take effect July 1 of each year ~~based on the most recent complete and accurate cost report submitted by each hospital~~. The agency's methodology shall categorize each inpatient admission into diagnosis-related groups and assign a relative payment weight to the base rate according to the average relative amount of hospital resources used to treat a patient in a specific diagnosis-related group category. The agency may adopt the most recent relative weights calculated and made available by the Nationwide Inpatient Sample maintained by the Agency for Healthcare Research and Quality. The agency may adopt alternative weights if the agency finds that Florida-specific weights deviate with statistical significance from national weights for high volume diagnosis-

related groups. The agency shall establish a single, uniform base rate for all hospitals unless specifically exempt pursuant to s. 409.908(1).

1. Adjustments may not be made to the rates after October 31 of the state fiscal year in which the rates take effect, except as defined in subparagraph 2. and for cases of insufficient collections of intergovernmental transfers authorized under s. 409.908(1) or the General Appropriations Act. In such cases, the agency shall submit a budget amendment or amendments under chapter 216 requesting approval of rate reductions by amounts necessary for the aggregate reduction to equal the dollar amount of intergovernmental transfers not collected and the corresponding federal match. Notwithstanding the $1 million limitation on increases to an approved operating budget contained in ss. 216.181(11) and 216.292(3), a budget amendment exceeding that dollar amount is subject to notice and objection procedures set forth in s. 216.177. Local governmental entities must submit to the agency, by no later than October 15 of each year, a final executed letter of agreement containing the total amount of intergovernmental transfers authorized by the entity for consideration in the reimbursement methodology.

2. Errors in source data ~~cost reporting~~ or calculation of rates discovered by November 7 must be corrected by the agency subsequent to November 15. Errors in source data or calculation of rates discovered after November 7 ~~after October 31~~ must be reconciled in a subsequent rate period. The agency may not make any adjustment to a hospital's reimbursement ~~rate~~ more than 5 years after a hospital is notified of an audited rate

established by the agency. The requirement that the agency may not make any adjustment to a hospital's reimbursement ~~rate~~ more than 5 years after a hospital is notified of an audited rate established by the agency is remedial and applies to actions by providers involving Medicaid claims for hospital services. Hospital rates are subject to such limits or ceilings as may be established in law or described in the agency's hospital reimbursement plan. Specific exemptions to the limits or ceilings may be provided in the General Appropriations Act.

(d) The agency shall implement a comprehensive utilization management program for hospital neonatal intensive care stays in certain high-volume participating hospitals, select counties, or statewide, and replace existing hospital inpatient utilization management programs for neonatal intensive care admissions. The program shall be designed to manage appropriate admissions and discharges ~~the lengths of stay~~ for children being treated in neonatal intensive care units and must seek ~~the earliest~~ medically appropriate discharge to the child's home or other less costly treatment setting. The agency may competitively bid a contract for the selection of a qualified organization to provide neonatal intensive care utilization management services. The agency may seek federal waivers to implement this initiative.

(e) The agency may develop and implement a program to reduce the number of hospital readmissions among the non-Medicare population eligible in areas 9, 10, and 11.

~~(f) The agency shall develop a plan to convert Medicaid inpatient hospital rates to a prospective payment system that~~

~~categorizes each case into diagnosis-related groups (DRG) and assigns a payment weight based on the average resources used to treat Medicaid patients in that DRG. To the extent possible, the agency shall propose an adaptation of an existing prospective payment system, such as the one used by Medicare, and shall propose such adjustments as are necessary for the Medicaid population and to maintain budget neutrality for inpatient hospital expenditures.~~

~~1. The plan must:~~

~~a. Define and describe DRGs for inpatient hospital care specific to Medicaid in this state;~~

~~b. Determine the use of resources needed for each DRG;~~

~~c. Apply current statewide levels of funding to DRGs based on the associated resource value of DRGs. Current statewide funding levels shall be calculated both with and without the use of intergovernmental transfers;~~

~~d. Calculate the current number of services provided in the Medicaid program based on DRGs defined under this subparagraph;~~

~~e. Estimate the number of cases in each DRG for future years based on agency data and the official workload estimates of the Social Services Estimating Conference;~~

~~f. Calculate the expected total Medicaid payments in the current year for each hospital with a Medicaid provider agreement, based on the DRGs and estimated workload;~~

~~g. Propose supplemental DRG payments to augment hospital reimbursements based on patient acuity and individual hospital characteristics, including classification as a children's~~

~~hospital, rural hospital, trauma center, burn unit, and other characteristics that could warrant higher reimbursements, while maintaining budget neutrality; and~~

~~h. Estimate potential funding for each hospital with a Medicaid provider agreement for DRGs defined pursuant to this subparagraph and supplemental DRG payments using current funding levels, calculated both with and without the use of intergovernmental transfers.~~

~~2. The agency shall engage a consultant with expertise and experience in the implementation of DRG systems for hospital reimbursement to develop the DRG plan under subparagraph 1.~~

~~3. The agency shall submit the DRG plan, identifying all steps necessary for the transition and any costs associated with plan implementation, to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than January 1, 2013. The plan shall include a timeline necessary to complete full implementation by July 1, 2013. If, during implementation of this paragraph, the agency determines that these timeframes might not be achievable, the agency shall report to the Legislative Budget Commission the status of its implementation efforts, the reasons the timeframes might not be achievable, and proposals for new timeframes.~~

(6) HOSPITAL OUTPATIENT SERVICES.—

(a) The agency shall pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a recipient in the outpatient portion of a hospital licensed under part I of chapter 395, and provided under the direction of a licensed physician or licensed dentist, except that payment for

such care and services is limited to $1,500 per state fiscal year per recipient, unless an exception has been made by the agency, and with the exception of a Medicaid recipient under age 21, in which case the only limitation is medical necessity.

(b) The agency shall implement a methodology for establishing base reimbursement rates for each hospital based on allowable costs, as defined by the agency. Rates shall be calculated annually and take effect July 1 of each year. The agency may periodically adjust the outpatient reimbursement rate using aggregate cost report data based on the most recent complete and accurate cost reports submitted by each hospital.

1. Adjustments may not be made to the rates after October 31 of the state fiscal year in which the rates take effect, except as defined in subparagraph 2., and for cases of insufficient collections of intergovernmental transfers authorized under s. 409.908(1) or the General Appropriations Act. In such cases, the agency shall submit a budget amendment or amendments under chapter 216 requesting approval of rate reductions by amounts necessary for the aggregate reduction to equal the dollar amount of intergovernmental transfers not collected and the corresponding federal match. Notwithstanding the $1 million limitation on increases to an approved operating budget contained in ss. 216.181(11) and 216.292(3), a budget amendment exceeding the $1 million limitation is subject to notice and objection procedures set forth in s. 216.177. Local governmental entities must submit to the agency, by no later than October 15 of each year, a final executed letter of agreement containing the total amount of intergovernmental

transfers authorized by the entity for consideration in the reimbursement methodology.

2. Any amendment to previously submitted cost reports must be submitted by a hospital no later than September 1 in order for the amended report to be considered by the agency, for the final rates set by October 31 of the current state fiscal year in which the rates take effect. Any errors in the calculation of rates discovered by November 7 must be corrected by the agency by November 15. Any errors in cost reporting or calculation of rates discovered after November 7 must be reconciled in a subsequent rate period. The agency may not make any adjustment to a hospital's reimbursement rate more than 5 years after a hospital is notified of an audited rate established by the agency. The requirement that the agency may not make any adjustment to a hospital's reimbursement rate more than 5 years after a hospital is notified of an audited rate established by the agency is remedial and applies to actions by providers involving Medicaid claims for hospital services. Hospital rates are subject to such limits or ceilings as may be established in law or described in the agency's hospital reimbursement plan. Specific exemptions to the limits or ceilings may be provided in the General Appropriations Act.

Section 4. Paragraph (a) of subsection (1) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in

policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited as

provided for in s. 409.905(5), except as otherwise provided in this subsection. ~~for:~~

1. When authorized by the General Appropriations Act, the agency may modify reimbursement rates for specific types of services or diagnoses, patient ages, and hospital provider types.

a. Unless otherwise provided in this section, the agency may not modify reimbursement rates for any individual hospital providing specialized services if those services are accounted for or reflected in the existing diagnosis-related groups used by the agency. The agency may modify reimbursement rates for specialized diagnosis-related group categories.

b. The agency may not modify reimbursement rates for statutory teaching hospitals as defined in s. 408.07(45) or the costs associated with graduate medical education if hospitals licensed under part I of chapter 395 receive funding through the Statewide Medicaid Graduate Medical Education program under s. 409.9111 or the disproportionate share program for teaching hospitals under s. 409.9113.

2. The agency may establish an alternative system of reimbursement for the diagnosis-related group-based prospective payment system for:

a. State-owned psychiatric hospitals.

b. Newborn hearing screening services.

c. Transplant services for which the agency may establish a global fee.

d. Patients with tuberculosis who have been resistant to therapy and are in need of long-term hospital-based treatment

pursuant to a contract established under s. 392.62.

3. The agency shall modify reimbursement according to other methodologies recognized in the General Appropriations Act.

~~1. The raising of rate reimbursement caps, excluding rural hospitals.~~

~~2. Recognition of the costs of graduate medical education.~~

~~3. Other methodologies recognized in the General Appropriations Act.~~

~~During the years funds are transferred from the Department of Health, any reimbursement supported by such funds shall be subject to certification by the Department of Health that the hospital has complied with s. 381.0403.~~ The agency is authorized to receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds, through the Medicaid inpatient reimbursement methodologies. Funds received from state entities or local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act, to the extent that the identified local health care provider that is otherwise entitled to and is contracted to receive such local funds is the benefactor under the state's Medicaid program as determined under the General Appropriations Act and pursuant to an

agreement between the Agency for Health Care Administration and the local governmental entity. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form shall identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. The agency shall prepare an annual statement of impact which documents the specific activities undertaken during the previous fiscal year pursuant to this paragraph, to be submitted to the Legislature no later than January 1, annually.

Section 5. Paragraph (a) of subsection (2) and paragraph (d) of subsection (4) of section 409.911, Florida Statutes, are amended to read:

409.911 Disproportionate share program.—Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(2) The Agency for Health Care Administration shall use the following actual audited data to determine the Medicaid days and charity care to be used in calculating the disproportionate share payment:

(a) The average of the 2005 ~~2004~~, 2006 ~~2005~~, and 2007 ~~2006~~

audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2013-2014 ~~2012-2013~~ state fiscal year.

(4) The following formulas shall be used to pay disproportionate share dollars to public hospitals:

(d) Any nonstate government owned or operated hospital eligible for payments under this section on July 1, 2011, remains eligible for payments during the 2013-2014 ~~2012-2013~~ state fiscal year.

Section 6. Section 409.9111, Florida Statutes, is created to read:

409.9111 Statewide Medicaid Graduate Medical Education program.—The Statewide Medicaid Graduate Medical Education program is established to improve access to and quality of care for Medicaid beneficiaries, support graduate medical education on an equitable basis, and increase the supply of highly-trained physicians statewide. The agency shall make quarterly Medicaid payments to hospitals, licensed under part I of chapter 395, for their costs associated with providing graduate medical education in each fiscal year that an appropriation is made for this purpose.

(1) On or before July 15 of each year a hospital participating in the Statewide Medicaid Graduate Medical Education program shall provide the agency with the number of medical interns, residents, and fellows reported in the hospital's most recently filed CMS-2522-10 Medicare cost report; the number and type of graduate medical education programs accredited by the Accreditation Council for Graduate Medical

Education or the Council on Postdoctoral Training of the American Osteopathic Association in which the medical interns, residents, and fellows participate; and the direct graduate medical education costs as reported for Medicaid in the hospital's most recently filed CMS-2522-10 Medicare cost report.

(2) The agency shall calculate an allocation fraction to be used for distributing funds to participating hospitals. The allocation fraction for each hospital shall be determined by the following primary factors:

(a) The number of full-time equivalent residents. For purposes of this section, the term "resident" means the number of unweighted full-time equivalent allopathic and osteopathic medical interns, residents, and fellows enrolled in a program accredited by the Accreditation Council for Graduate Medical Education or the Council on Postdoctoral Training of the American Osteopathic Association as reported in the hospital's most recently filed CMS-2522-10 Medicare cost report.

(b) Medicaid payments. For purposes of this section, the term "Medicaid payments" means a hospital's direct medical education costs divided by total facility costs as reported in the most recently filed CMS-2522-10 Medicare cost report multiplied by the sum of the hospital's total Medicaid inpatient reimbursements.

(3) On or before October 1 of each year, the agency shall use the following formula to calculate a participating hospital's allocation fraction:

$$THAF=[(HFTE/TFTE) \times 0.5] + [(HGMP/TGMP) \times 0.5]$$

Where:

THAF = A hospital's total allocation fraction.

HFTE = A hospital's total number of full-time equivalent residents.

TFTE = The sum of all participating hospitals' full-time equivalent residents.

HGMP = A hospital's total Graduate Medical Education payments attributable to Medicaid.

TGMP = The sum of all participating hospitals' total Graduate Medical Education payments attributable to Medicaid.

(4) The agency may adopt rules to administer this section.

Section 7. Paragraphs (b) and (c) of subsection (2) of section 409.9118, Florida Statutes, are amended, and paragraph (d) is added to that subsection, to read:

409.9118 Disproportionate share program for specialty hospitals.—The Agency for Health Care Administration shall design and implement a system of making disproportionate share payments to those hospitals licensed in accordance with part I of chapter 395 as a specialty hospital which meet all requirements listed in subsection (2). Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for patients.

(2) In order to receive payments under this section, a hospital must be licensed in accordance with part I of chapter 395, to participate in the Florida Title XIX program, and meet the following requirements:

(b) Receive ~~all of its~~ inpatient clients through referrals

or admissions from county public health departments, as defined in chapter 154.

(c) Require a diagnosis for the control of active tuberculosis or a history of noncompliance with prescribed drug regimens for treatment of tuberculosis ~~a communicable disease~~ for ~~all~~ admissions for inpatient treatment.

(d) Retain a contract with the Department of Health to accept clients for admission and inpatient treatment pursuant to s. 392.62.

Section 8. This act shall take effect July 1, 2013.

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** PCB HCAS 13-02 Community-Based Care
**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 | | Fontaine WSF | Pridgeon |

### SUMMARY ANALYSIS

The bill conforms statutes to the funding decisions included in the proposed General Appropriations Act (GAA) for Fiscal Year 2013-2014.

This bill amends the equity allocation model provided in section 409.16713, Florida Statutes, to modify the percentage allocation of existing, recurring child welfare core service funds to Community Based Care (CBC) lead agencies. This modification contained in this bill will change the distribution of funds among CBCs beginning with the 2013-14 fiscal year. This bill also specifies that additional core service funds shall be allocated based upon the equity allocation model, unless otherwise directed by the General Appropriations Act.

The effective date of the bill is July 1, 2013.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Florida's child welfare services are provided through 20 regional organizations known as Community-Based Care lead agencies (CBC). The 1998 Florida Legislature mandated the outsourcing of foster care and related child welfare services, and by July 2005, the Department of Children and Families transitioned the provision of child welfare services from a department-based operation to community-based care. The allocation of funding among the CBCs was intended to be equitable, with equality being based upon statewide, per-child budgeted amounts as prescribed through proviso language in multiple GAAs. Proviso in the General Appropriations Act for FY 2010-11 departed from these previous methodologies by providing an equity allocation model using weighted factors to indicate the need for child welfare resources.

The equity allocation model first prescribed by proviso language and later codified by the 2011 Florida Legislature into section 409.16713, Florida Statutes, allocates CBCs' core service funds using the following four weighted factors:

- Number of children in poverty (30 percent);
- Number of reports to the department's abuse hotline (30 percent);
- Number of children in care (30 percent); and,
- CBC lead agency contribution in the reduction of out-of-home care (10 percent).

The statute defines "core services funding" as all funds provided to CBCs with the exceptions of independent living, maintenance adoption subsidies, training for child protective investigators, mental health wrap-around services, nonrecurring appropriations, and those designated for a specific project. For Fiscal Year 2012-13, CBCs received $576.8 million for core service functions.

The current statute allocates 25 percent of CBC core service funds upon the equity allocation model and 75 percent upon the previous year's distribution. This has the effect of transitioning each CBC lead agency's core service allocation towards full utilization of the equity allocation model. This legislation would slow the transition towards the equity allocation model by making 90 percent of CBCs' core service funds be based upon the previous year's distribution and the remaining 10 percent be based upon the equity allocation model. The proposed effects are budget neutral in total, but the allocation of core service funds among the CBCs will be modified. In the event that additional core service funds are provided, the bill specifies the distribution among CBCs be based on the equity allocation model, unless directed otherwise by the General Appropriations Act.

B. SECTION DIRECTORY:

**Section 1**: Amends s. 409.16713, F.S, to modify the equity allocation model that affects the distribution of core service funds among Community-Based Care lead agencies.

**Section 2**: Providing an effective date of July 1, 2013.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

This bill will realign funding distributions to Community-based Care Organizations.

D. FISCAL COMMENTS:

This bill is budget neutral. It modifies the equity allocation model that affects the distribution of recurring core service funds among Community-Based Care lead agencies.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to community-based care; amending s. 409.16713, F.S.; revising allocations of recurring core services funding for community-based care lead agencies; providing an effective date.

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

Section 1. Subsections (3) and (4) of section 409.16713, Florida Statutes, are amended to read:

409.16713 Allocation of funds for community-based care lead agencies.—

(3) Beginning in the 2013-2014 ~~2011-2012~~ state fiscal year, 90 ~~75~~ percent of the recurring core services funding for each community-based care lead agency shall be based on the prior year recurring base of core services funds and 10 ~~25~~ percent shall be based on the equity allocation model.

(4) Except as otherwise specified in the General Appropriations Act ~~For the 2011-2012 state fiscal year~~, any new core services funds shall be allocated based on the equity allocation model. Such allocations shall be proportional to the proportion of funding based on the equity model and allocated only to the community-based care lead agency contracts where the current funding proportion is less than the proportion of funding based on the equity model.

Section 2. This act shall take effect July 1, 2013.

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 411 Children's Initiatives
**SPONSOR(S):** Healthy Families Subcommittee; Fullwood
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 1322

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Healthy Families Subcommittee | 12 Y, 0 N, As CS | Entress | Schoolfield |
| 2) Health Care Appropriations Subcommittee | | Fontaine | Pridgeon |
| 3) Health & Human Services Committee | | | |

## SUMMARY ANALYSIS

Florida children's initiatives, previously called Florida Children's Zones, "assist disadvantaged areas within the state in creating a community-based service network that develops, coordinates, and provides quality education, accessible health care, youth development programs, opportunities for employment, and safe and affordable housing for children and families living within its boundaries." There are currently three Florida children's initiatives, the Miami Children's Initiative, Inc., the New Town Success Zone, and Parramore Kidz Zone. The Miami Children's Initiative, Inc. is the only Florida children's initiative codified in statute.

The bill codifies in statute two existing Florida children's initiatives, one in Jacksonville ("New Town Success Zone") and one in Orlando ("Parramore Kidz Zone"). The bill states that the initiatives are designed to encompass an area large enough to include all necessary components of community life, but small enough to reach every member of each neighborhood who is willing to participate.

The bill clarifies that the evaluation, fiscal management, and oversight by the not-for-profit corporation applies only to the Miami Children's Initiative, Inc.

The bill specifies that the initiatives are subject to Florida public records laws, Florida public meeting laws, and Florida procurement laws.

The bill has no fiscal impact.

The bill provides an effective date of July 1, 2013.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Current Situation:**

History of Children's Initiatives

In 2008, HB 3 was passed by the Legislature and signed into law by the Governor (Chapter 2008-96, Laws of Florida), creating s. 409.147, F.S., which established children's zones, currently referred to as children's initiatives.[1] Florida children's initiatives "assist disadvantaged areas within the state in creating a community-based service network that develops, coordinates, and provides quality education, accessible health care, youth development programs, opportunities for employment, and safe and affordable housing for children and families living within its boundaries."[2] A county or municipality (or a designated area) may apply to the Ounce of Prevention Fund of Florida, Inc. (Ounce) to designate an area as a children's initiative. The area must first adopt a resolution stating that the area has issues related to poverty, that changes are necessary for the area to improve, and that resources are necessary for revitalization of the area.[3] The county or municipality must then establish a children's initiative planning team and develop and adapt a strategic community plan.[4] Once a county or municipality has completed these steps, they must create a not-for-profit corporation to facilitate fundraising and secure broad community ownership of the children's initiative.[5]

HB 3 also created the Magic City Children's Zone, Inc., currently referred to as Miami Children's Initiative, Inc. as a 10-year pilot project zone.[6] Proviso language attached to Line 345A in the 2008-2009 General Appropriations Act provided $3.6 million in non-recurring general revenue funds for the Miami Children's Initiative, Inc.[7] The Ounce was designated in proviso as the agent to oversee the pilot program and directed the funds to be used as a grant over a three-year period to carry out activities in the zones.

The Department of Children and Families (DCF) developed a three-year non-renewable contract with the Ounce (LJ829) and in August of 2008 began paying $300,000 per month.[8] In 2009, HB 381 (Chapter 2009-43, Laws of Florida), s. 409.147(8)(a), F.S. was amended, changing the 10-year pilot zone to a 10-year project and changed the name of the Magic City Children's Zone to the Miami's Children's Initiative.[9]

The Ounce of Florida

The Ounce is a private, nonprofit corporation dedicated to shaping prevention policy and investing in innovative prevention programs that provide measurable benefits to Florida's children, families and communities.[10] As required in statute, DCF must contract with a nonprofit corporation to develop a business plan and for the evaluation, fiscal management, and oversight of the Miami Children's Initiative, Inc.[11] While the statute does not specify that these responsibilities are reserved for the Ounce, proviso language from the 2008 General Appropriations Act specified that the Ounce would be

[1] DCF Analysis of HB 411 dated January 31, 2013. On file with Healthy Families Subcommittee staff.
[2] S. 409.147(1)(b), F.S.
[3] S. 409.147(4)(a), F.S.
[4] S. 409.147(5), 409.147(6), F.S.
[5] S. 409.147(7), F.S.
[6] DCF Analysis of HB 411 dated January 31, 2013. On file with Healthy Families Subcommittee staff.
[7] S. 3, General Appropriations Act of 2008, 2008-152 L.O.F.
[8] DCF Analysis of HB 411 dated January 31, 2013. On file with Healthy Families Subcommittee staff.
[9] *Id.*
[10] The Ounce of Prevention Fund of Florida, accessible at: http://www.ounce.org/.
[11] S. 409.147(9), F.S.

the nonprofit organization responsible for this.[12] This contract expired in 2011 and there is no current contract for these responsibilities.[13] The Ounce is the only organization that designates areas as Florida children's initiatives.[14]

New Town Success Zone

After review of a number of Jacksonville neighborhoods, the New Town community was selected by community leadership of Jacksonville in 2008 as the site for a Florida children's initiative.[15] In 2009, a strategic plan was developed and work began on the New Town Success Zone.[16] The initiative aims to assist parents and caregivers, business leaders, professionals, residents, teachers and other stakeholders create a safe environment and pipeline to success for children residing in the New Town area of Jacksonville.[17] The New Town Success Zone has reported higher FCAT scores, an improvement in school promotion rates, and a reduction in violent crimes, theft and truancy since 2008.[18]

Parramore Kidz Zone

Community leadership in Orlando launched a community project designed to invest in those things that make a difference in children's lives, such as quality early childhood education, after school programs, programs that build family economic success, youth development programs for teenagers, access to health care, and mentoring within the Parramore area of Orlando.[19] The Parramore Kidz Zone began in 2006, and was designated a Florida children's initiative in 2009.[20] The goals of the Parramore Kidz Zone are to "reduce juvenile crime, teen pregnancy, and high school drop-out rates in Orlando's highest poverty, highest crime neighborhood."[21] The Parramore Kidz Zone offers a variety of community services, including tutoring, childcare, and health and wellness programs.[22] Since 2006, the Parramore neighborhood has seen increased test scores and decreased juvenile arrest rates.[23]

Both the New Town and Parramore projects are currently operating and have been designated by the Ounce as a Florida children's initiative.[24]

**Effect of Proposed Changes:**

The bill codifies in statute two Florida children's initiatives, one in Jacksonville and one in Orlando. The Jacksonville initiative is in Council District 9 of Duval County, and is called the "New Town Success Zone." The initiative in Orlando, Orange County, is called the "Parramore Kidz Zone." Both the New Town Success Zone and Parramore Kidz Zone are already in existence in their respective communities.

The bill requires a 10-year project in each city, which must be managed by a not-for-profit corporation, in accordance with chapter 617, F.S. Both initiatives are designed to encompass an area that is large enough to include all of the necessary components of community life, including, but not limited to, schools, places of worship, recreational facilities, commercial areas, and common space, yet small

[12] S. 3, General Appropriations Act of 2008, 2008-152 L.O.F.
[13] Phone conversation with DCF staff. February 25, 2013.
[14] S. 409.147(4), F.S.
[15] "Why New Town Success Zone", The New Town Success Zone website, accessible at: http://www.newtownsuccesszone.com/why.html.
[16] *Id.*
[17] *Id.*
[18] New Town Success Zone Five Year Report to the Community, The New Town Success Zone, accessible at http://www.newtownsuccesszone.com/5year.html.
[19] DCF Analysis of HB 411 dated January 31, 2013. On file with Healthy Families Subcommittee staff.
[20] The Parramore Kidz Zone, The Ounce of Florida, accessible at: http://www.ounce.org/Orlando_CI.html.
[21] The Parramore Kidz Zone, The City of Orlando, accessible at: http://www.cityoforlando.net/fpr/Html/Children/aboutpkz.htm.
[22] *Id.*
[23] *Id.*
[24] DCF Analysis of HB 411 dated January 31, 2013. On file with Healthy Families Subcommittee staff.

enough to allow programs and services to reach every member of the neighborhood who is willing to participate in the project. The bill explains that the legislature determines that public policy dictates that the corporation must operate in the most open and accessible manner consistent with public purpose, and requires the corporation to be subject to chapter 119, relating to public records, chapter 286, relating to public meetings and records, and chapter 287, relating to procurement of commodities or contractual services. These requirements are consistent with existing law for the Florida children's initiative which is already codified, the Miami Children's Initiative.

Upon designation as a Florida children's initiative, the bill requires the Miami Children's Initiative, Inc., the New Town Success Zone, and the Parramore Kidz Zone to assist the state in creating a community-based service network and creating programming that develops, coordinates, and provides quality education, accessible health care, youth development programs, opportunities for employment, and safe and affordable housing for children and families living within their boundaries. The network and programming must be consistent with the legislative intent and purpose of s. 16, chapter 2009-43, Laws of Florida, which is s. 409.147, F.S., the current statute governing Florida children's initiatives.

The bill clarifies that the evaluation, fiscal management, and oversight by the not-for-profit corporation applies only to the Miami Children's Initiative, Inc. The Ounce was the not-for-profit responsible for these responsibilities for the Miami Children's Initiative, Inc., but the contract expired in 2011. There is currently no contract for these responsibilities.

The bill clarifies that the "New Town Success Zone" and the "Parramore Kidz Zone" are not subject to control, supervision, or direction by any department of the state in any manner.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 409.147, F.S., relating to children's initiatives.
**Section 2:** Provides for an effective date.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

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 governments.

2. Other:

None

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 13, 2013, the Healthy Families Subcommittee adopted a strike-all amendment for House Bill 411. The strike-all amendment made the following changes to the bill:

- Eliminates the duplicative language that the "New Town Success Zone" adopt a resolution, establish a planning team, and develop and adopt the strategic community plan before incorporating the non-profit entity. This is required in s. 409.147(7), and the requirement remains unchanged by the amendment.
- Clarified that neither the "New Town Success Zone" and the "Parramore Kidz Zone" are not subject to control, supervision, or direction by any department of the state in any manner.
- Eliminated the requirement that the "New Town Success Zone" be administratively housed in the Department of Children and Families.
- Eliminated the requirement that the not-for-profit corporation responsible for fiscal management and oversight of the Miami Children's Initiative, Inc. also complete these responsibilities for the "Parramore Kidz Zone" and the "New Town Success Zone."
- Removed the provision requiring a legislative appropriation for implementation of the bill

A bill to be entitled

An act relating to children's initiatives; amending s. 409.147, F.S.; establishing the New Town Success Zone in Duval County and the Parramore Kidz Zone in Orange County; providing for the projects to be managed by corporations not for profit that are not subject to control, supervision, or direction by any department of the state; requiring the corporations to be subject to state public records and meeting requirements and procurement of commodities and contractual services requirements; requiring designated children's initiatives to assist in the creation of community-based service networks and programming that provides certain services for children and families residing in disadvantaged areas of the state; providing for evaluation, fiscal management, and oversight of the projects; providing an effective date.

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

Section 1. Subsection (9) of section 409.147, Florida Statutes, is renumbered as subsection (11) and amended, and new subsections (9) and (10) are added to that section, to read:

409.147 Children's initiatives.—

(9) CREATION OF THE NEW TOWN SUCCESS ZONE.—

(a) There is created within the City of Jacksonville Council District 9 in Duval County a 10-year project that shall be managed by an entity organized as a corporation not for

profit that shall be registered, incorporated, organized, and operated in compliance with chapter 617. The New Town Success Zone is not subject to control, supervision, or direction by any department of the state in any manner. The Legislature determines, however, that public policy dictates that the corporation operate in the most open and accessible manner consistent with its public purpose. Therefore, the Legislature declares that the corporation is subject to chapter 119, relating to public records, chapter 286, relating to public meetings and records, and chapter 287, relating to procurement of commodities or contractual services.

(b) This initiative is designed to encompass an area that is large enough to include all of the necessary components of community life, including, but not limited to, schools, places of worship, recreational facilities, commercial areas, and common space, yet small enough to allow programs and services to reach every member of the neighborhood who is willing to participate in the project.

(10) CREATION OF THE PARRAMORE KIDZ ZONE.—

(a) There is created within the City of Orlando in Orange County a 10-year project that is managed by an entity organized as a corporation not for profit that is registered, incorporated, organized, and operated in compliance with chapter 617. The Parramore Kidz Zone program is not subject to control, supervision, or direction by any department of the state. The Legislature determines, however, that public policy dictates that the corporation operate in the most open and accessible manner consistent with its public purpose. Therefore, the

Legislature specifically declares that the corporation is subject to chapter 119, relating to public records, chapter 286, relating to public meetings and records, and chapter 287, relating to procurement of commodities or contractual services.

(b) This initiative is designed to encompass an area that is large enough to include all of the necessary components of community life, including, but not limited to, schools, places of worship, recreational facilities, commercial areas, and common space, yet small enough to allow programs and services to reach every member of the neighborhood who is willing to participate in the project.

(11) ~~(9)~~ IMPLEMENTATION.—

(a) The Miami Children's Initiative, Inc., the New Town Success Zone, and Parramore Kidz Zone have been designated as Florida Children's Initiatives, consistent with the legislative intent and purpose of s. 16, chapter 2009-43, Laws of Florida, and as such, shall each assist the disadvantaged areas of the state in creating a community-based service network and programming that develops, coordinates, and provides quality education, accessible health care, youth development programs, opportunities for employment, and safe and affordable housing for children and families living within their boundaries.

(b) In order to implement this section, for the Miami Children's Initiative, Inc., the Department of Children and Families ~~Family Services~~ shall contract with a not-for-profit corporation to work in collaboration with the governing body to adopt the resolution described in subsection (4), to establish the planning team as provided in subsection (5), and to develop

and adopt the strategic community plan as provided in subsection (6). The not-for-profit corporation is also responsible for the development of a business plan for the evaluation, fiscal management, and oversight of the Miami Children's Initiative, Inc.

Section 2. This act shall take effect July 1, 2013.

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 701 Electronic Benefit Transfer Program
**SPONSOR(S):** Healthy Families Subcommittee; Smith
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 1048

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Healthy Families Subcommittee | 9 Y, 2 N, As CS | Entress | Schoolfield |
| 2) Health Care Appropriations Subcommittee | | Fontaine WS | Pridgeon |
| 3) Health & Human Services Committee | | | |

## SUMMARY ANALYSIS

The bill makes changes to state law in s. 402.82, F.S., for the Electronic Benefits Transfer program. Electronic benefit transfer cards (EBT) cards are used to hold cash assistance and food assistance benefits. The bill conforms state law to federal law by prohibiting the use of EBT cards in:

- An adult entertainment establishment, as defined in s. 847.001, F.S.;
- A pari-mutuel facility, casino, gaming facility, or Internet café, including gaming activities authorized under part II of chapter 285;
- A commercial bingo facility that is not authorized under s. 849.0931, F.S.; and
- An establishment licensed under the Florida Beverage Law to sell distilled spirits containing six percent or more alcohol by volume as a vendor and that is restricted in the types of products that may be sold under ss. 565.04 and 565.045, F.S. or a bottle club as defined in s. 561.01, F.S.

The bill has no fiscal impact on state government.

The bill provides an effective date of July 1, 2013.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background:**

*Use of the Electronic Benefits Card*

Both temporary cash assistance and food assistance monies are placed on an Electronic Benefits Transaction (EBT) card. Under s. 402.82, F.S., the Department of Children and Families (DCF) administers the EBT program. Once an individual applies for cash assistance or food assistance with DCF, they will receive an EBT card in the mail;[1] the card functions much like a credit card or debit card. Food assistance money can be used at any retail store that accepts the EBT SNAP (Supplemental Nutrition Assistance Program) Card. Cash assistance money can be used to purchase a variety of items and may also be used at automatic teller machines (ATM's) and Point of Sale (POS) machines.[2]

EBT vendors cannot block the usage of an EBT card. Instead, any block must be done at the individual or terminal level.[3] The ATM or Point of Service (POS) owners can program the machines to reject any card with the Florida EBT Bank Identification Number, or can prohibit QUEST transactions, as QUEST is the network used specifically for EBT.[4]

*Supplemental Nutrition Assistance Program (SNAP)*

SNAP, previously known as "food stamps", is a federal program that is administered by the individual states. SNAP aims to "provide children and low income people access to food, a healthy diet, and nutrition education."[5]

The Food and Nutrition Act of 2008 defines "eligible food" as "any food or food product intended for human consumption except alcoholic beverages, tobacco, hot foods and hot food products prepared for immediate consumption."[6] Eligible food also includes seeds and plants to grow foods for personal consumption, as well as some additional exceptions to allow for hot food products ready for consumption in certain circumstances.[7]

The Florida Department of Children and Families (DCF) administers the state's food assistance program.[8] The food assistance program is a 100 percent federally-funded program. The United States Department of Agriculture (USDA) determines the amount of food assistance benefits an individual or family receives, based on the families' income and resources.[9] Food assistance benefits are a supplement to a family's food budget. Households may need to spend some of their own cash, along with their food assistance benefits, to buy enough food for a month.[10] State law provides that DCF shall

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[1] Department of Children and Families Access Program. http://www.dcf.state.fl.us/programs/access/foodassistance.shtml. (last visited 1/27/12).
[2] How to use your EBT Card at a Point-of-Sale (POS) or ATM Machine, The Department of Children and Families, *available at*: http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/how-use-your-ebt-card-point-sale-pos-or-atm-machine. (last visited 3/7/13).
[3] Department of Children and Families analysis of HB 701, on file with committee staff.
[4] *Id.*
[5] Nutrition Assistance Programs, USDA Food and Nutrition Service, *available at:* http://www.fns.usda.gov/fns/. (last visited 1/27/12).
[6] 7 C.F.R. s. 271.2.
[7] P.L. 110-246, provides that certain individuals because of age, disability or living arrangement may purchase hot foods with their SNAP EBT card.
[8] s. 414.31, F.S.
[9] *Id.*
[10] DCF Food Assistance Program Fact Sheet, *accessible at*: www.dcf.state.fl.us/programs/access/docs/fafactsheet.pdf .(last visited 1/27/12).

establish procedures in compliance with federal law for notifying the appropriate federal and state agencies of any violation of law regarding the food assistance program and must also notify the Department of Financial Services.[11] As of February 5, 2013, 15,752 Florida retailers accept SNAP benefits.[12]

*Temporary Cash Assistance Program (Cash Assistance)*

DCF administers the cash assistance program with Temporary Assistance for Needy Families (TANF) funds to help families become self-supporting while allowing children to remain in their own homes.[13] Cash assistance is available to two categories of families: work-eligible and child-only.[14] Current law provides that families are eligible for temporary cash assistance for a lifetime cumulative total of 48 months (4 years).[15]

*Temporary Assistance for Needy Families (TANF)*

Under the welfare reform legislation of 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PWRORA), Public Law 104-193, the Temporary Assistance for Needy Families (TANF) program replaced the welfare programs known as Aid to Families with Dependent Children (AFDC), the Job Opportunities and Basic Skills Training (JOBS) program and the Emergency Assistance (EA) program. The law ended federal entitlement to assistance and instead created TANF as a block grant that provides States, territories and tribes federal funds each year. These funds cover benefits, administrative expenses, and services targeted to needy families. TANF became effective July 1, 1997, and was reauthorized in February 2006 under the Deficit Reduction Act of 2005.[16] States receive block grants to operate their individual programs and to accomplish the goals of the TANF program.[17] DCF administers the TANF program in conjunction with the Agency for Workforce Innovation.[18]

*Public Law 112-96 Section 4004, Spending Policies for Assistance Under State TANF Programs*

On February 22, 2012, the Middle Class Tax Relief and Job Creation Act of 2012 (Act) was signed by the President. The act requires states receiving TANF to create policies and practices as necessary to prevent assistance provided under the program from being used in any EBT transaction in the following establishments:

- Any liquor store;
- Any casino, gambling casino, or gaming establishment; or
- Any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.[19]

This public law does not require states to enact legislation in order to comply with the new EBT restrictions. States are required to update their state plans with an explanation of how the restrictions will be implemented. The state plans must also provide an explanation on how recipients will have adequate access to cash assistance with minimal or no fees or charges for withdrawal. States must report to the Secretary of Health and Human Services regarding their implementation of the policies

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[11] s. 414.33, F.S.
[12] SNAP Retailer Locator, United States Department of Agriculture, *accessible at*: http://snap-load-balancer-244858692.us-east-1.elb.amazonaws.com/index.html . (last visited 2/28/12).
[13] DCF Food Assistance Program Fact Sheet, www.dcf.state.fl.us/programs/access/docs/fafactsheet.pdf .(last visited 1/4/12).
[14] S. 414.045(1).
[15] Section 414.105, F.S.
[16] US Dept. of Health and Human Services, Administration on Children and Families, *accessible at*: http://www.acf.hhs.gov/programs/ofa/tanf/about.html (last visited on 12/21/11).
[17] Temporary Assistance for Needy Families, the Department of Children and Families, *accessible at*: http://www.dcf.state.fl.us/programs/access/docs/TANF%20101%20final.pdf.
[18] *Id.*
[19] P.L. 112-96. Section 4004.

and practices by February 22, 2014.[20] If states do not comply with these requirements by that date, the Secretary will reduce the state's family assistance grant by up to five percent. As of March 5, 2013, DCF has not yet issued any policies or practices to implement this requirement. However, DCF plans to adopt the required polices and practices following the 2013 legislative session, in order to implement any additional requirements in this bill.[21] Florida's State Family Assistance Grant, also called the TANF Block Grant is $562,340,120.[22]

**Effect of the Bill:**

The bill prohibits EBT cards from being accepted at the following locations or for the following activities:

- An adult entertainment establishment, as defined in s. 847.001, F.S.;
- A pari-mutuel facility, casino, gaming facility, or Internet café, including gaming activities authorized under part II of chapter 285;
- A commercial bingo facility that is not authorized under s. 849.0931, F.S.; and
- An establishment licensed under the Florida Beverage Law to sell distilled spirits containing six percent or more alcohol by volume as a vendor and that is restricted in the types of products that may be sold under ss. 565.04 and 565.045, F.S. or a bottle club as defined in s. 561.01, F.S.

Many retail establishments sell restricted alcoholic and tobacco products alongside allowable food products. This bill attempts to identify the retailers that are visited primarily to purchase restricted alcoholic products. This distinction will allow cash beneficiaries to continue using EBT cards at ATMs in places where permissible food items are available for purchase (e.g., supermarkets).

The bill conforms state law to the federal requirements for use of TANF benefits and EBT transactions, as specified in the Middle Class Tax Relief and Job Creation Act of 2012 (Act). The Federal Office of Family Assistance, within the Office of Administration for Children and Families, clarified that state legislation is not required as long as the policies and practices required by the Act are in place.[23] If the policies and practices are not implemented, the state of Florida could receive a five percent reduction in TANF block grants for FY 2014, and receive additional five percent reductions for preceding fiscal years until the state provides the necessary policies and practices.

With the current EBT system vendor, any blocks for EBT use must be done at the individual or terminal level. This requires the specified business to be responsible for ensuring that EBT transactions are not allowed at the locations prohibited under the bill.[24] However, DCF has recently completed a procurement process for a new EBT vendor, which is a three year contract and will take effect on October 1, 2014. As part of the contract, the new EBT vendor is required to make any and all required changes to the WIC, EBT, and SNAP systems when policy, rules, or regulatory changes are made by Florida legislation. This must be completed without any additional fees from DCF.[25] There are two steps the vendor must take to restrict the use of EBT at the locations required by law:

- Step 1 Blocking at Point of Sale (POS) Machines. The vendor will block POS transactions from businesses that are identified by the Merchant Category Code (MCC) assigned when retailer agreements are established. The MCCs were developed by the "Card Association". They include Package Stores, Beer, Wine, Liquor, High Risk Adult Entertainment, and Betting

[20] U.S. Department of Health and Human Services, Administration on Children and Families, Office of Family Assistance available at http://www.acf.hhs.gov/programs/ofa/resource/q-a-ebt-transactions. Last visited March 5, 2013.
[21] E-mail correspondence with Gary Scott, Government Operations Consultant with the Department of Children and Families, Marcy 6, 2013.
[22] E-mail correspondence with the Department of Children and Families, February 28, 2013.
[23] Q & A: TANF Requirements Related to EBT Transactions, Office of Family Assistance, *accessible at*: http://www.acf.hhs.gov/programs/ofa/resource/q-a-ebt-transactions.
[24] Department of Children and Families analysis of HB 701, on file with committee staff.
[25] E-mail correspondence with the Jeri Flora, Director of Economic Self Sufficiency, Department of Children and Families, March 13, 2013

including Lottery/Casino/Wagers. The state will identify and share with the vendor which MCC codes the vendor should block. The accuracy of this restriction is dependent on programming of the MCC in the machine to indicate it is located in one of these retailers. MCC codes should be programmed at the time the POS is established.

- Step 2 Blocking at Automated Teller Machine (ATM). The vendor will block ATM transactions by programming a block based on the specific ATM terminal ID. Terminal IDs are not readily accessible, which requires an on-site visit to the ATM machine. Since the ID is not on the exterior of the machine, a special EBT card will be used to generate a transaction to the vendor. The vendor will then enter this terminal ID into their system to block any EBT Cash transactions. The block is associated with the terminal ID; if replaced or moved it will need to be re-blocked or unblocked.[26]

B. SECTION DIRECTORY:

**Section 1:** Amends s. 402.82, F.S., relating to the electronic benefit transfer program.
**Section 2:** Provides an effective date.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

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 governments.

2. Other:

[26] *Id.*

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 13, 2013, the Healthy Families Subcommittee adopted an amendment for House Bill 701, which removed the language prohibiting the use of EBT cards in establishments licensed to sell firearms or ammunition, whose firearm and ammunition sales exceed 35 percent of the establishment's annual sales.

A bill to be entitled

An act relating to the electronic benefit transfer program; amending s. 402.82, F.S., relating to the dissemination of food assistance benefits, temporary cash assistance, and other payments for expenditure by recipients using electronic benefit transfer cards; prohibiting such cards from being accepted in certain locations or for certain activities; providing an effective date.

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

Section 1. Subsection (4) is added to section 402.82, Florida Statutes, to read:

402.82 Electronic benefit transfer program.—

(4) Electric benefit transfer cards may not be accepted at the following locations or for the following activities:

(a) An adult entertainment establishment as defined in s. 847.001.

(b) A pari-mutuel facility, casino, gaming facility, or Internet cafe, including gaming activities authorized under part II of chapter 285.

(c) A commercial bingo facility that is not authorized under s. 849.0931.

(d) An establishment licensed under the Beverage Law to sell distilled spirits containing 6 percent or more alcohol by volume as a vendor and that is restricted in the types of products that may be sold under ss. 565.04 and 565.045 or a

bottle club as defined in s. 561.01.

Section 2. This act shall take effect July 1, 2013.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

| | | |
|---|---|---|
| ADOPTED | ____ | (Y/N) |
| ADOPTED AS AMENDED | ____ | (Y/N) |
| ADOPTED W/O OBJECTION | ____ | (Y/N) |
| FAILED TO ADOPT | ____ | (Y/N) |
| WITHDRAWN | ____ | (Y/N) |
| OTHER | | |

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Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Smith offered the following:

**Amendment**

Remove line 30 and insert:

Section 2. This act shall take effect October 1, 2013.

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 7103 (PCB HFS 13-01) Cross-Over Youth
**SPONSOR(S):** Healthy Families Subcommittee, Harrell
**TIED BILLS:** **IDEN./SIM. BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| Orig. Comm.: Healthy Families Subcommittee | 12 Y, 0 N | Entress | Schoolfield |
| 1) Health Care Appropriations Subcommittee | | Fontaine WF | Pridgeon |
| 2) Health & Human Services Committee | | | |

## SUMMARY ANALYSIS

The term "Cross Over Youth" is used to describe children, under the age of 18, who are under the care of both the Department of Children and Families (DCF) and the Department of Juvenile Justice (DJJ). This population of youth has a high rate of running away and a higher rate of being reported to law enforcement for behavioral problems.

The proposed committee bill authorizes DJJ and DCF to collaborate on a pilot project to demonstrate a more effective service model for cross over youth, in one county, which is mutually agreed upon by DJJ and DCF. The bill requires DCF to seek proposals from interested child welfare service providers to elicit innovative approaches for the pilot and provides preference to counties who have a unified family court system.

The bill requires the pilot project to include the following elements:

- Training provided by the DJJ to pilot home staff.
- Intervention services by the DJJ to post commitment youth residing in pilot homes.
- Enhanced security measures at pilot homes.
- Unified treatment plans for cross over youth served by multiple state and local agencies.
- Interventions to ensure that low risk to reoffend youth are not negatively affected by high risk cross over youth.

The bill requires DCF and DJJ to jointly prepare an interim report due December 31, 2013 and a final report due August 31, 2014, on findings, including specific performance measures identified in the bill and recommendations from the pilot project.

The fiscal impact of this bill is estimated to affect DCF by $280,000, but can be absorbed within existing department resources.

The bill provides an effective date of upon becoming law.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

Department of Juvenile Justice

The Department of Juvenile Justice (DJJ) is established in s. 20.316, F.S. DJJ is authorized in statute for programs including, prevention and victim services, intake and detention, residential and correctional facilities, probation and community corrections, and administration. DJJ's stated mission is to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services that strengthen families and turn around the lives of troubled youth.[1]

DJJ takes children into custody for delinquent acts and violations of law.[2] The intake process assesses the child's needs and risks to determine the most appropriate treatment plan and setting for the child's needs and risks.[3] Intake typically involves the following steps:

1. Detention screening is completed using the Detention Risk Assessment Instrument (DRAI) to determine whether the youth should be placed in secure, non-secure, or home detention care prior to a detention hearing.
2. The state attorney recommendation and pre-disposition report is completed to inform the state attorney of DJJ's suggestion regarding proceeding with the case and to assist the court in determining a disposition for the youth once he or she is adjudicated delinquent.
3. The youth charged with a criminal or delinquent offense is evaluated using the Positive Achievement Change Tool (PACT), which is used as the primary tool for case management, service planning, treatment progress, and readiness for termination of services.
4. The physical health, mental health, substance abuse, academic, educational, or vocational problem for youth anticipated to be placed in residential commitment is evaluated.[4]

Youth in intake are assigned a juvenile probation officer (JPO).[5] The JPOs serve as the primary case manager for the purpose of managing, coordinating, and monitoring the services provided to the child.[6] During the intake process, JPOs are required to screen each child to make a number of determinations, including whether release is appropriate, whether the child should be referred to a diversionary program or community arbitration, for any conditions that may have caused the child to come to the attention of law enforcement, and whether the child is a risk to themselves or others.[7]

All proceedings alleging that a child has committed a delinquent act or violation of law are initiated with the state attorney filing a petition for delinquency.[8] Following the petition, an adjudication hearing is heard as soon as possible after the petition is filed.[9] The court can find that the juvenile has not committed the act and dismiss the case or can find that the child has committed the act.[10] If the court finds the child delinquent, there are a number of options available to the court, including probation and committal to DJJ.[11]

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[1] Mission, Florida Department of Juvenile Justice, *accessible at*: http://www.djj.state.fl.us/about-us/mission.
[2] S. 985.101(1)(b).
[3] S. 985.14(2), F.S.
[4] Rule 63D-9.001, F.A.C.
[5] S. 985.14(1), F.S.
[6] S. 985.145(1), F.S.
[7] S. 985.145(1)(c), F.S.
[8] S. 985.318(1), F.S.
[9] S. 985.35(1), F.S.
[10] S. 985.35, F.S.
[11] S. 985.433, F.S.

*Probation*

When a child is found delinquent by a court,[12] the court can place the child in a probation program under the supervision of DJJ or under the supervision of any other person or agency authorized and appointed by the court.[13] Probation programs consist of penalty components and rehabilitative components. Penalty components include requirements such as restitution, community service, and urine monitoring. Rehabilitative components include requirements such as participation in substance abuse treatment, school, and other educational program attendance.[14] Each youth is assigned a JPO to monitor compliance and help the youth connect with service providers.[15]

Typically, the term of any order placing a child in a probation program lasts until the child's 19th birthday unless he or she is released by the court on the motion of an interested party or on his or her own motion.[16] The court can also allow early termination of probation if the child has substantially complied with the terms and conditions of probation.[17]

If a child violates the conditions of the probation program, DJJ or the state attorney may bring the child before the court on a petition alleging a violation of the program.[18] If the court finds that the youth has not complied with the terms of probation, the youth may be ordered to live in a residential commitment facility for a period of time.[19]

Department of Children and Families

The Department of Children and Families (DCF) is established in s. 20.19, F.S. The mission of DCF is to work in partnership with local communities to protect the vulnerable, promote strong and economically self-sufficient families, and advance personal and family recovery and resiliency.[20] DCF establishes and supervises a variety of programs to provide shelter and care for dependent children who must be placed away from their families, including foster homes, group homes, and emergency shelters.[21]

Prior to 1996, DCF accomplished its mission by directly delivering child protection services to recipients. In 1996, DCF began to privatize child protection services through a Community-Based Care (CBC) pilot program.[22] Through the CBC program, private companies, known as "lead agencies", enter into a contract with DCF to provide foster care services, child abuse services, and mental health services, and other types of assistance. There are currently 20 lead agencies providing these and other services across the state.[23] Lead agencies use subcontractors to deliver services directly to recipients.

*Child Protective Investigations*

Once a call is received to the child abuse hotline and a determination has been made that a child may be a victim of abuse, abandonment, or neglect, a Child Protective Investigator (CPI) is sent out for an immediate onsite investigation, if appropriate, or within 24 hours from the time the report was accepted

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[12] Under s. 985.43(7)(c), a child can also be placed in a probation program following discharge from commitment.
[13] S. 985.35(4)(a).
[14] S. 985.35(4)(a).
[15] Probation and Community Intervention FAQ, Florida Department of Juvenile Justice, *accessible at*: http://www.djj.state.fl.us/faqs/probation-community-intervention.
[16] S. 985.0301(5)(b), F.S.
[17] S. 985.435(6), F.S.
[18] S. 985.439(1)(b), F.S.
[19] S. 985.439(4)(d).
[20] S. 20.19(1)(a), F.S.
[21] S. 409.165(1), F.S.
[22] State of Florida, Department of Children and Families, *Community-Based Care Implementation Plan*, July 1999, pg. 2
[23] Lead Agency Map, State of Florida, Department of Children and Families, at http://www.dcf.f.us/programs/cbc/docs/lead_agency_map.pdf.

by the hotline.[24] DCF is required to report criminal conduct[25] immediately to county law enforcement in which the alleged conduct has occurred. [26] The CPI is required to inform all parties of the report, once the initial assessment is complete, including the parent, legal custodian or other person responsible for the child's welfare.[27] All investigations are required to be completed within 60 days, unless there is a concurrent criminal investigation, the death of a child is involved, or the child is determined to be missing.[28]

Current statute provides two options for response once the CPI determines the report is complete:[29]

1. If the department or the sheriff providing child protective investigative services determines that the interests of the child and the public will be best served by providing the child care or other treatment voluntarily accepted by the child and the parents or legal custodians, the parent or legal custodian and child may be referred for such care, case management, or other community resources.
2. If the department or the sheriff providing child protective investigative services determines that the child is in need of protection and supervision, the department may file a petition for dependency.

DCF currently performs child protection investigation services in 60 counties using department staff. [30] In the remaining 7 counties[31], investigations are conducted by local Sheriff's offices under contract with DCF.[32]

*Petitions*

If during the course of a protective investigation, DCF or law enforcement deems that a child cannot safely remain in a home, because of abuse, abandonment, or neglect, the child can be taken into custody.[33] Once a child is taken into custody, DCF will review the facts supporting the removal of the child and determine if sufficient cause exists to file a shelter petition. If sufficient cause does not exist, the child shall be returned to their parent or legal custodian.[34] If sufficient cause does exist, DCF shall file a petition, schedule a hearing with the courts, and request that a shelter hearing be held within 24 hours from the removal of the child from the home. [35] At the adjudicatory hearing the court may make the following rulings: [36]

- That the child is not a dependent child and dismiss the case;
- That the child is adjudicated dependent and may remain in the home, under supervision of the court, or be placed in out-of-home care;
- That the child may remain in the home, under the supervision of DCF; adjudication of dependency would be withheld assuming the family complies with the conditions of supervision.

DCF will develop a case plan for each child taken from the home with the goal of achieving permanency for the child.

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[24] Rule 65C-29.003, F.A.C.
[25] S. 39.301(2)(b), F.S.
[26] S. 39.301(2)(a), F.S.
[27] Rule 65C-29.003, F.A.C.
[28] S. 39.301(17), F.S.
[29] S. 39.301(9)(c), F.S.
[30] OPPAGA Memorandum, Sheriff's Offices have Advantages for Conducting Child Abuse Investigations, but Quality Cannot be Directly Compared to DCF. (February 26, 2011).
[31] Broward, Citrus, Hillsborough, Manatee, Pasco, Pinellas, and Seminole.
[32] OPPAGA Memorandum, Sheriff's Offices have Advantages for Conducting Child Abuse Investigations, but Quality Cannot be Directly Compared to DCF. (February 26, 2011).
[33] S. 39.401, F.S.
[34] S. 39.401(3)(a), F.S.
[35] S. 39.401(3)(b), F.S.
[36] S. 39.507, F.S.

*Residential Care*

Family foster homes, residential child-caring agencies, and child-placing agencies care for children under the supervision of DCF.[37]

Family Foster Home: A family foster home is a private residence in which children who are unattended by a parent or legal guardian are provided 24-hour care. Such homes include emergency shelter family homes and specialized foster homes for children with special needs.[38] Currently, 5,584 children reside in family foster homes.[39]

Residential Child Caring Agency: A residential child-caring agency is a person, corporation, or agency, other than the child's parent or legal guardian that provides staffed 24-hour care for children in facilities maintained for that purpose. Such residential child-caring agencies include, maternity homes, runaway shelters, group homes that are administered by an agency, emergency shelters that are not in private residences, and wilderness camps.[40] Currently, 2,083 children reside in residential child caring agencies.[41]

Child Placing Agency: A child-placing agency is any person, corporation, or agency that receives a child for placement and places or arranges for the placement of a child in a family foster home, residential child-caring agency, or adoptive home.[42]Child-placing agencies,[43] family foster homes, and residential child-caring agencies must be licensed by DCF before providing care.[44]

Unified Family Courts

A Unified Family Court (UFC) is a fully integrated, comprehensive approach to handling all cases involving children and families, while at the same time resolving family disputes in a fair, timely, efficient, and cost effective manner.[45] UFCs can cover a variety of legal issues under one judge and in one court, which affects a given family. These issues may include domestic relations, domestic violence, dependency, and delinquency.[46] UFCs must have court case management, coordination of multiple cases involving one family, collaboration between the judiciary, stakeholders, and the community to provide service for families, and a less adversarial approach, focusing on minimal harm to the child.[47] There are currently unified family courts available in 18 of 20 judicial circuits in Florida.[48]

Cross Over Youth

The term "Cross Over Youth" is used to describe children, under the age of 18, who are under the care of both DCF and DJJ. It is estimated that monthly, between 600 and 800 youth are in both the DCF and DJJ systems of care at the same time.[49] This population of youth has a high rate of running away and a higher rate of being reported to law enforcement for behavioral problems. A subset of this population during 2012, was analyzed which included 120 children who were released from DJJ residential commitment and placed with DCF in out of home care.[50] Forty Seven percent of these

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[37] S. 409.175(1)(a).
[38] S. 409.175(2)(e), F.S.
[39] Email dated 3/8/13 from Gina Sisk, Department of Children and Families. (on file with Healthy Families Subcommittee)
[40] S. 409.175(2)(j), F.S.
[41] Email dated 3/8/13 from Gina Sisk, Department of Children and Families. (on file with Healthy Families Subcommittee)
[42] S. 409.175(2)(d), F.S.
[43] S. 63.202(1), F.S.
[44] S. 409.175(4)(a), F.S.
[45] Office of Court Improvement, Florida State Courts, *accessible at:* http://www.flcourts.org/gen_public/family/familycourts.shtml.
[46] Video from Unified Family Court Judges, the 17th Judicial Circuit Court of Florida, *accessible at*: http://www.17th.flcourts.org/ufc-1/UFC-1.html.
[47] Florida's Unified Office of Court Improvement Newsletter, Office of the State Courts Administrator, *accessible at*: http://www.flcourts.org/gen_public/family/bin/ufcbrochure.pdf.
[48] Email dated 3/9/13 from Gina Sisk, Department of Children and Families. (on file with Healthy Families Subcommittee).
[49] Email date 1/11/13 from Amanda Prater, Department of Children and Families "DJJ cross over data for House" (on file with Healthy Families Subcommittee)
[50] Committee Packet, Florida House of Representatives Healthy Families Subcommittee, January 16, 2013.

children were placed in a group home and the remainder were in foster home care, with relatives, non-relatives, ran away/abducted, or had an alternative placement.[51] Of these 120 children, 114 had felony charges and 6 had misdemeanor charges in their record.[52]

DCF group home providers have expressed concern about serving these youth who are more costly, have greater mental health needs, require more facility security and higher trained facility staff.[53]

*Georgetown University Model*

The Center for Juvenile Justice, within Georgetown University, has created a cross over youth practice model, which aims to address the unique needs of children involved in both the child welfare system and juvenile justice system.[54] The center developed a practice model that describes the specific practices that need to be in place within a jurisdiction in order to reduce the number of youth who cross over between the child welfare and juvenile justice systems, the number of youth entering and reentering care, and the length of stay in out of home care.[55] Currently, the center has 44 participating jurisdictions, five of which are in Florida.[56] The center uses the following practices for the model:

- the creation of a process for identifying cross over youth at the point of crossing over;
- ensuring that workers are exchanging information in a timely manner, including families in all decision-making aspects of the case;
- ensuring that foster care bias is not occurring at the point of detention or disposition; and
- maximizing the services utilized by each system to prevent cross over from occurring.[57]

**Effect of the Bill:**

The proposed committee bill authorizes DJJ and DCF to collaborate on a pilot project to demonstrate a more effective service model for cross over youth, efficient coordination of services between agencies and the evidence of improved outcomes for youth residing in the pilot project facility.

The pilot project shall be limited to one county mutually agreed upon by DJJ and DCF with a high rate of cross over youth. The bill intends that the cross over youth in the pilot project are in DJJ probation status. DCF shall seek proposals from interested child welfare service providers to elicit innovative approaches for the pilot. Preference will be given to counties who have a unified family court system.

The pilot project shall include but not be limited to the following elements:

- Training provided by the DJJ to pilot home staff.
- Intervention services by the DJJ to post commitment youth residing in pilot homes.
- Enhanced security measures at pilot homes.
- Unified treatment plans for cross over youth served by multiple state and local agencies.
- Interventions to ensure that low risk to reoffend youth are not negatively affected by high risk cross over youth.

The Pilot project may begin upon the bill becoming law and must end no later than June 30, 2014. DCF and DJJ shall jointly prepare an interim report due December 31, 2013 and a final report due August 31, 2014, on findings including specific performance measures identified in the bill and recommendations from the pilot project.

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[51] *Id.*
[52] *Id.*
[53] Testimony given by panelists at Healthy Families Subcommittee, January 16, 2013.
[54] Cross Over Youth Practice Model, The Center for Juvenile Justice, *accessible at:* http://cjjr.georgetown.edu/pm/practicemodel.html.
[55] *Id.*
[56] *Id.*
[57] *Id.*

B. SECTION DIRECTORY:

**Section 1:** Creates an unnumbered section of law, relating to the Cross Over Youth pilot project
**Section 2:** Provides an effective date of upon becoming a law.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

DCF and DJJ have indicated that the cost of the pilot project will be covered with existing program resources. DJJ services will be primarily offered through in-kind services. DCF estimated that $280,000 in expenditures may be required for their portion of the pilot, but can be absorbed within existing department resources.[58]

| Sources of Funds from DCF include: | |
|---|---|
| Contract review for efficiencies: | $59,000 |
| Consulting Services (nonrecurring) | $126,000 |
| One year cost to participating CBC | $25,000 |
| Operational efficiencies (spending analysis) | $70,000 |
| Total | $280,000 |

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

[58] Department of Children & Families Staff Analysis and Economic Impact- Fiscal Note, March 12, 2013.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to cross-over youth; creating a pilot project to serve youth in common to the Department of Children and Families and the Department of Juvenile Justice; providing for selection of a county for the project; requiring proposals from interested providers; specifying elements to be included in the project; requiring reports to the Governor and Legislature; providing an effective date.

WHEREAS, hundreds of youth each month in Florida are served in both the child welfare system and juvenile justice system, and

WHEREAS, a significant number of these children who reside in residential group homes have felony arrest records, and

WHEREAS, these youth tend to have a greater need for specialized services and can have a negative effect on other youth in the same group residential settings, and

WHEREAS, the state needs to assess the impact of these youth on the child welfare and juvenile justice systems and to develop better integrated systems of care and improved services to respond to the needs of these youth, NOW, THEREFORE,

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

Section 1. Cross-Over Youth pilot project.-The Cross-Over Youth pilot project is established as a collaborative initiative of the Department of Children and Families and the Department of

Juvenile Justice. The project will demonstrate a more effective service model for cross-over youth, efficient coordination of services between agencies, and the evidence of improved outcomes for youth residing in the pilot project facility. "Cross-over youth" are youth under the age of 18 who receive services from the Department of Children and Families and the Department of Juvenile Justice.

(1) The pilot project shall be in one county with a high rate of cross-over youth that is mutually agreed upon by the Secretary of Children and Families and the Secretary of Juvenile Justice. Counties that have a unified family court shall be given preference.

(2) The Secretary of Children and Families shall seek proposals from interested child welfare service providers to elicit innovative approaches for the pilot project. The Secretary of Children and Families, in consultation with the Secretary of Juvenile Justice, shall select one or more residential homes from the pilot county to participate in the project.

(3) The pilot project shall include, but not be limited to, the following:

(a) Training provided by the Department of Juvenile Justice to pilot home staff.

(b) Intervention services by the Department of Juvenile Justice to youth on probation who reside in pilot homes.

(c) Enhanced security measures at pilot homes.

(d) Unified treatment plans for cross-over youth served by multiple state and local agencies.

(e) Interventions to ensure that youth at low risk of reoffending are not negatively affected by high-risk cross-over youth.

(f) The pilot project shall begin no later than July 1, 2013, and shall end June 30, 2014.

(g) The Department of Children and Families and the Department of Juvenile Justice shall jointly prepare an interim report and final report on findings and recommendations relating to the pilot project. The reports shall include performance measure data, including, but not limited to, the:

1. Number of youth served by the pilot project, including demographic information, prior offense history, and relative risk to reoffend at time of placement as determined by the Department of Juvenile Justice.

2. Number of youth who receive a charge for a new violation of law while under supervision of the pilot project.

3. Number of youth who receive a violation of probation while under supervision of the pilot project.

4. Reduction in risk factors.

5. Increase in protective factors.

6. Number of youth who transfer out of the pilot home for behavioral reasons.

7. Number of calls to law enforcement as a result of incidents involving youth in the pilot home.

8. Academic performance of youth in the pilot home.

The interim report is due December 31, 2013, and the final report is due August 31, 2014. The Department of Children and

Families and the Department of Juvenile Justice shall submit the reports to the Governor, the Speaker of the House of Representatives, and the President of the Senate.

Section 2. This act shall take effect upon becoming a law.