

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Empowers Families: This bill provides persons with developmental disabilities and their families with increased access to habilitative and behavior analysis services to assist them.

B. EFFECT OF PROPOSED CHANGES:

Background

Developmental Disabilities

In Florida, a developmental disability is defined as “a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.”¹

*Autism Spectrum Disorder*²

Autism spectrum disorder is the name commonly used for pervasive developmental disorders, which include autistic disorder, Asperger’s Syndrome, Rett’s Syndrome,³ and childhood disintegrative disorder.⁴ A child that exhibits symptoms of Asperger syndrome or autistic disorder, but does not meet the criteria for either, will be diagnosed as having a pervasive developmental disorder not otherwise specified (PDD-NOS).

Autism spectrum disorders are generally detected by the age of three and affect from two to six per 1,000 children. The earlier a child is diagnosed with an autism spectrum disorder, the more opportunity a child will have to learn new skills and be fully integrated into the community. Common characteristics shared by children with autism spectrum disorders include varying degrees of deficits in social interaction, verbal and nonverbal communication, and repetitive behaviors or interest. In addition, many children with autism spectrum disorders have some degree of mental impairment.

*Cerebral Palsy*⁵

Cerebral palsy refers to a number of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination. Cerebral palsy is caused by abnormalities in parts of the brain that control muscle movements. While the majority of children with cerebral palsy are born with it, it may not be detected until months or even years later. The early signs of cerebral palsy usually appear before a child reaches 3 years of age, including:

- A lack of muscle coordination when performing voluntary movements.
- Stiff or tight muscles and exaggerated reflexes.
- Walking with one foot or leg dragging.
- Walking on the toes.

¹ s. 393.063(10), F.S.

² All information for this section was obtained from the National Institute of Mental Health brochure on “Autism Spectrum Disorders, Pervasive Developmental Disorders” with addendum January 2007 (citations omitted); located at <http://www.nimh.nih.gov/health/publications/autism/nimhautismspectrum.pdf>.

³ Rett syndrome is linked almost exclusively to females, affecting one out of 10,000 to 15,000 females. It is typically diagnosed between 6 and 18 months when autism-like symptoms begin to develop.

⁴ Childhood degenerative disorder is a very rare autism spectrum disorder with a strong male preponderance. Symptoms typically onset between the ages of three and four years, and may result in the loss of motor, language and social skills, as well as bladder and bowel control.

⁵ All information for this section was obtained from the National Institute of Neurological Disorders and Stroke, http://www.ninds.nih.gov/disorders/cerebral_palsy/cerebral_palsy.htm (last updated February 7, 2008).

- A crouched gait or a “scissored” gait.
- Muscle tone that is either too stiff or too floppy.

*Prader-Willi Syndrome*⁶

Individuals with Prader-Willi Syndrome have a problem in their hypothalamus, a part of the brain that normally controls feelings of fullness or hunger. Consequently, they never feel full and have a constant urge to eat that they cannot control. Most cases of Prader-Willi syndrome result from a spontaneous genetic error in genes on chromosome 15 that occurs at conception. In very rare cases, the mutation is inherited.

There are generally two stages of symptoms for people with Prader-Willi syndrome:

- Stage 1. As newborns, babies with Prader-Willi can have low muscle tone, which can affect their ability to suck properly. As a result, babies may need special feeding techniques to help them eat, and infants may have problems gaining weight. As these babies grow older, their strength and muscle tone usually get better. They meet motor milestones, but are usually slower in doing so.
- Stage 2. Between the ages of 1 and 6 years old, the disorder changes to one of constant hunger and food seeking. Most people with Prader-Willi syndrome have an insatiable appetite, meaning they never feel full. In fact, their brains are telling them they are starving. They may have trouble regulating their own eating and may need external restrictions on food, including locked kitchen and food storage areas.

*Spina Bifida*⁷

Spina bifida (SB) is a neural tube defect⁸ caused by the failure of the fetus's spine to close properly during the first month of pregnancy. Infants born with SB sometimes have an open lesion on their spine where significant damage to the nerves and spinal cord has occurred. Although the spinal opening can be surgically repaired shortly after birth, the nerve damage is permanent, resulting in varying degrees of paralysis of the lower limbs. In addition to physical and mobility difficulties, most individuals have some form of learning disability.

The three most common types of SB are:

- Myelomeningocele, the severest form, in which the spinal cord and its protective covering protrude from an opening in the spine.
- Meningocele, in which the spinal cord develops normally but the meninges protrude from a spinal opening.
- Occulta, the mildest form, in which one or more vertebrae are malformed and covered by a layer of skin.

SB may also cause bowel and bladder complications, and many children with SB have hydrocephalus.⁹

Diagnosis and Treatment of Developmental Disabilities

There is no cure for autism spectrum disorder, cerebral palsy, Prader-Willi syndrome, or spina bifida. However, there are a number of treatment options available to minimize the symptoms of these disorders.

⁶ All information for this section was obtained from the National Institute of Child Health and Human Development, National Institutes of Health, http://www.nichd.nih.gov/health/topics/Prader_Willi_Syndrome.cfm (last updated September 10, 2006).

⁷ All information for this section was obtained from the National Institute of Neurological Disorders and Stroke, http://www.ninds.nih.gov/disorders/spina_bifida/spina_bifida.htm (last updated December 11, 2007).

⁸ A birth defect of the brain and spinal cord.

⁹ Excessive accumulation of fluid in the brain.

*Autism Spectrum Disorder*¹⁰

A number of developmental screening tests have been developed for pediatricians to screen children during “well child” check-ups to analyze a child’s social and communicative development. Available screenings include the Checklist for Autism in Toddlers, the modified Checklist for Autism in Toddlers, the Screening tool for Autism in Toddlers and the Social Communication Questionnaire that is used on children 4 years of age and older. For milder forms of autism spectrum disorders, such as Asperger’s Syndrome, an Autism Spectrum Screening Questionnaire, the Australian Scale for Asperger’s Syndrome, or a Childhood Asperger Syndrome Test may be given.

If indicators are present after any of these screenings are administered, a referral for possible diagnosis can be obtained, which includes comprehensive diagnostic testing by multidisciplinary teams that include a psychologist, neurologist, psychiatrist, speech therapist, or other necessary professionals that may make diagnoses. Diagnostic testing typically includes neurologic and genetic assessment, in-depth cognitive and language testing, as well as other tests that evaluate a child’s communication and social skills, movements and ability to adapt to change, and hearing.

There are a number of treatment options to minimize symptoms and bolster learning. Treatment options vary from child to child, but typically include language, imitation, attention, motivation, compliance and initiative of interaction, including behavioral methods, communication, occupational and physical therapy, and social play interventions.

*Cerebral Palsy*¹¹

Cerebral palsy is generally diagnosed by a physician who examines the child for physical and behavioral signs. Treatment options for cerebral palsy will often improve a child’s capabilities, and many children go on to enjoy near-normal adult lives if their disabilities are properly managed. Generally, the earlier treatment begins, the better chance a child has of overcoming developmental disabilities or learning new ways to accomplish the tasks that challenge them. Treatment may include physical and occupational therapy, speech therapy, drugs to control seizures, relax muscle spasms, and alleviate pain; surgery to correct anatomical abnormalities or release tight muscles; braces and other orthotic devices; wheelchairs and rolling walkers; and communication aids such as computers with attached voice synthesizers.

*Prader-Willi Syndrome*¹²

Prader-Willi Syndrome is generally diagnosed by a health care provider through a blood test. Early intervention for Prader-Willi Syndrome can help individuals build skills for adapting to the disorder. Early diagnosis can also help parents learn about the condition and prepare for future challenges. Treatment options include exercise and physical activity to help control weight and help with motor skills, as well as speech therapy to help with oral skills.

*Spina Bifida*¹³

Treatment options for spina bifida (SB) may include surgery, medication, and physiotherapy. Many individuals with SB will need assistive devices such as braces, crutches, or wheelchairs. Ongoing therapy, medical care, and/or surgical treatments may be necessary to prevent and manage complications throughout the individual’s life. Surgery to close the newborn’s spinal opening is generally

¹⁰ All information for this section was obtained from the National Institute of Mental Health brochure on “Autism Spectrum Disorders, Pervasive Developmental Disorders” with addendum January 2007 (citations omitted); located at <http://www.nimh.nih.gov/health/publications/autism/nimhautismspectrum.pdf>.

¹¹ All information for this section was obtained from the National Institute of Neurological Disorders and Stroke, http://www.ninds.nih.gov/disorders/cerebral_palsy/cerebral_palsy.htm (last updated February 7, 2008).

¹² All information for this section was obtained from the National Institute of Child Health and Human Development, National Institutes of Health, http://www.nichd.nih.gov/health/topics/Prader_Willi_Syndrome.cfm (last updated September 10, 2006).

¹³ All information for this section was obtained from the National Institute of Neurological Disorders and Stroke, http://www.ninds.nih.gov/disorders/spina_bifida/spina_bifida.htm (last updated December 11, 2008).

performed within 24 hours after birth to minimize the risk of infection and to preserve existing function in the spinal cord.

Insurance Coverage

Coverage for Developmental Disabilities

Coverage for developmental disabilities is not currently mandated in Florida.¹⁴ Thus, if health insurers or HMOs provide coverage for a developmental disability, they do so on a voluntary basis.

*State Employees Group Health Insurance Coverage*¹⁵

According to the Department of Management Services, the State Employees' PPO and HMO plans include coverage for the diagnosis and limited medical treatment, including prescription drugs, of autism, Asperger's syndrome, and other pervasive developmental disorders. Some types of therapy under the PPO Plan and HMO plans that would be used for the treatment of autism spectrum disorder are either limited or excluded.

Under the HMO plans all covered types of therapy must be accompanied by a written treatment plan and the covered person's condition is expected to improve significantly within 60 days. The PPO Plan and the HMO plans exclude coverage for experimental or investigational treatment, custodial care, non-prescription drugs, and training and educational services (except for diabetes self-management training and educational services pursuant to section 627.6408, Florida Statutes). The State Employees' PPO plan has a limited pre-existing condition provision that excludes coverage for pre-existing conditions for the first twelve months of coverage even though those conditions would otherwise be considered a covered service.

Moreover, both the PPO and HMO plans have certain limitations applicable to treatments for mental and nervous disorders, which are set forth below. For the State Employees' PPO Plan, treatments for mental and nervous disorders are covered benefits, subject to limitations. Additionally, under the State Employees' PPO Plan, physical therapy coverage is limited to 4 treatments per treatment day and 21 treatment days during any six-month period. For the State-contracted HMOs, rehabilitative services, including physical and speech therapies, are covered with limitations. The primary care physician or Health Plan must specifically approve a written plan of treatment and agree that the condition should improve significantly within 60 days from the date therapy begins. Coverage includes services for the purpose of aiding in the restoration of normal physical function. Rehabilitative services provided while the covered person is confined to a hospital are covered for the duration of the hospital confinement. Outpatient rehabilitative services are limited to 60 visits per injury (emphasis added, exact policy language).

For state-contracted HMOs, rehabilitative services do not include:

- Services or supplies provided to a covered person as an inpatient in a hospital or other facility, where the admission is primarily to provide rehabilitative services;
- Services or supplies that maintain rather than improves a level of physical function, or where it has been determined that the services shall not result in significant improvement in the covered person's condition within a 60 day period; or
- Other therapies including recreational, educational, marital or sleep therapy.

Health Insurance Mandates

A health insurance mandate is a legal requirement that an insurance company or health plan cover services by particular health care providers, specific benefits, or specific patient groups. Florida currently has at least¹⁶ 48 mandates, ranking 13th highest in the nation for the number of mandates.¹⁷

¹⁴ Eleven states currently mandate coverage for autism. See "Health Insurance Mandates in the States 2008," Council for Affordable Health Insurance; located on March 2, 2008 at

http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf.

¹⁵ All information provided in this section was pulled directly from the Department of Management Services' 2008 Bill Analysis.

Florida enacted section 624.215, F.S., to take into account the impact of insurance mandates and mandated offerings on premiums when making policy decisions. That section requires that any proposal for legislation that mandates health benefit coverage must be submitted with a report to the Agency for Health Care Administration (agency) and the legislative committee having jurisdiction. The report must assess the social and financial impact of the proposed coverage, including, to the extent information is available, the following:

- To what extent is the treatment or service generally used by a significant portion of the population.
- To what extent is the insurance coverage generally available.
- If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment.
- If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship.
- The level of public demand for the treatment or service.
- The level of public demand for insurance coverage of the treatment or service.
- The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.
- To what extent will the coverage increase or decrease the cost of the treatment or service.
- To what extent will the coverage increase the appropriate uses of the treatment or service.
- To what extent will the mandated treatment or service be a substitute for a more expensive treatment or service.
- To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.
- The impact of this coverage on the total cost of health care.

Insurance Compacts

At least three states have convened workgroups to develop a voluntary agreement among insurers to provide coverage for the patient care costs for individuals enrolled in cancer clinical trials. These states include:

- Georgia. The Georgia Cancer Coalition developed the Georgia Clinical Trials Agreement to “provide for insurance coverage for certain services related to cancer for those Georgians covered by the health insurance policies by the undersigned insurers.”¹⁸
- Michigan. The Michigan Working Group to Improve Cancer Outcomes was formed to develop a voluntary agreement to provide such coverage. The working group notes that the goal of the agreement is to “increase participation in select cancer-related clinical trials by making payment for services provided within the context of clinical trials predictable.”¹⁹ The agreement “codif[ies] the process so that providers, patients, and plans know where they stand as they make decisions regarding treatment.”²⁰

¹⁶ Depending on how liberally the term is defined, an alternate count indicates that there are 51 health insurance mandates in Florida. “Expanding Opportunities for Health Insurance Coverage in Florida” 11, Michael Bond, Ph.D., James Madison Institute; located on March 2, 2008 at <http://www.jamesmadison.org/pdf/materials/548.pdf>.

¹⁷ “Health Insurance Mandates in the States 2008,” Council for Affordable Health Insurance; located on March 2, 2008 at http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf.

¹⁸ Georgia Cancer Coalition, Georgia Clinical Trials Agreement, <http://www.gacancercoalition.com/treat-trials.php> (last viewed April 21, 2008).

¹⁹ Michigan Working Group to Improve Cancer Outcomes, Consensus Guidelines for Healthcare Coverage of Routine Patient Care Costs Associated with Oncology Clinical Trials, <http://www.michigancancer.org/PDFs/MichWkgGroupImpCaOutcomes-ConsensusGuidelines-060601.pdf> (last viewed April 21, 2008).

²⁰ Michigan Working Group to Improve Cancer Outcomes, <http://www.michigancancer.org/WhatWeDo/MichiganWorkingGroupImproveCancerOutcomes.cfm> (last updated August 5, 2007).

- New Jersey. The New Jersey Working Group to Improve Outcomes in Cancer Patients was created to develop a voluntary agreement to cover the routine costs of treatment and prevention trials.²¹

State Services for Children with Developmental Disabilities

Children with developmental disabilities may be enrolled in the Early Steps program, which is administered by the CMS Network and Related Programs in Children's Medical Services at the Department of Health. The Early Steps Program is a statewide network of early intervention services for children from birth to 3 years old who have physical, sensory, cognitive, social or emotional, and adaptive developmental delays or disabilities. At age three, a child with developmental disabilities may become eligible for services through the Agency for Persons with Disabilities.

Section 1004.55 F.S., created the Centers for Autism and Related Disabilities (CARD). CARD is comprised of 7 regional autism centers located at various universities in Florida. These centers provide nonresidential resource and training services for persons of all ages and of all levels of intellectual functioning who have autism, who have a pervasive developmental disorder that is not otherwise specified; who have an autistic-like disability; who have a dual sensory impairment; or who have a sensory impairment with other handicapping conditions. Each center is operationally and fiscally independent and provides services within its geographical region of the state. Service delivery is consistent for all centers and each center coordinates services within and between state and local agencies and school districts but may not duplicate services provided by those agencies or school districts.

Autism Spectrum Disorder Task Force

In March 2008, Governor Charlie Crist created the Task Force on Autism Spectrum Disorders.²² The Task Force, which is administratively housed at the Department of Health, is comprised of 21 members who are charged with exploring options for health coverage of autism treatments and assessing the economic impact of autism on families and the State of Florida. In addition, the Task Force will work to coordinate and review the efforts of state agencies and organizations, encourage public-private partnerships, develop a comprehensive Florida autism website, and develop a strategy for early diagnosis and intervention. The Task Force will present a report to the Governor on March 20, 2009.

Kidcare

The Legislature established the Florida KidCare Program in 1998 to reduce the number of uninsured children in Florida through a combination of Medicaid expansions and public/private partnerships.

The Florida KidCare program provides health care coverage to over 1.4 million children in Florida. There are four administrative components of the KidCare program:

- The Agency for Health Care Administration (AHCA) administers the Medicaid and MediKids programs. AHCA serves as the state contact with the federal Centers for Medicare and Medicaid. It distributes federal funds, monitors program enrollment ceilings, and manages the Florida Healthy Kids Corporation contract. AHCA develops and maintains the Title XXI, Florida KidCare State Plan agreement with the federal government.
- The Department of Children and Families performs Medicaid (Title XIX) eligibility determination, and administers the Behavioral Health Network, which is part of the Children's Medical Services Network for children with special needs.

²¹ New Jersey Cancer Trial Connect, New Jersey Insurance Agreement Policies and Guidelines, http://www.njctc.org/default.aspx?section=insure&subpage=main_01_sub_03 (last viewed April 21, 2008).

²² See Executive Order 08-36.

- The Department of Health administers the Children’s Medical Services (CMS) Network for children with special needs, and staffs the Florida KidCare Coordinating Council.
- The Florida Healthy Kids Corporation, under contract with AHCA, performs administrative functions for the overall KidCare program, and administers the State Children’s Health Insurance Program (SCHIP), Healthy Kids program. The corporation handles eligibility determination, premium billing and collection, refunds, and customer service for KidCare, except for the large Medicaid component that is administered by AHCA and the Department of Children and Families.

The Florida Healthy Kids Corporation contracts with managed care plans throughout the state for the provision of health care coverage. The Corporation also contracts with a fiscal agent to perform initial eligibility screening for the program and final eligibility determination for children who are not eligible for Medicaid.

Eligibility for the different program components is based on age, family income, and whether the child has a serious health condition. Florida KidCare primarily targets uninsured children under age 19 whose family income is at or below 200 percent of the federal poverty level. Section 409.814(5), F.S., allows a child whose family income is above 200 percent of the Federal Poverty Level (FPL), or a child who is not eligible for premium assistance, to participate in Healthy Kids if the family pays the full premium. The Healthy Kids full-pay premium is \$110 per child per month. Current law limits the participation of full-pay families to no more than 10 percent of total enrollees, based on the possibility of adverse selection through enrollment of families with expensive health care needs. Section 409.814(5), F.S., excludes the Medicaid component of KidCare from the full-pay provision.

Florida’s Healthy Kids Program existed prior to the implementation of the federal Title XXI, SCHIP. Florida was one of three states with an existing child health insurance program grandfathered in as part of the Balanced Budget Act of 1997, which created SCHIP. The Florida KidCare Program is established in sections 409.810 through 409.821, F.S. The non-profit Florida Healthy Kids Corporation that manages the Healthy Kids component of KidCare is established in s. 624.91, F.S.

Medicaid State Plan—Home and Community Based Services

The federal Deficit Reduction Act of 2005, authorized states, in section 6086 (Section 1915(i) of the Social Security Act), to provide a new optional Medicaid state plan benefit. This option allows the state to cover home and community based services under a Medicaid state plan to individuals who have incomes at 150 percent of poverty or less. Prior to this Act, states were generally required to provide home and community based services under Medicaid waiver programs. Specifically, a state may limit the number of individuals who may receive the optional benefit. In addition, a state may limit the provision of the optional benefit based on an assessment of an individual's support needs and capabilities.

Education-Related Issues Concerning Disabilities

Learning Gateway

In 2000, the Legislature created a 16-member commission to conduct a study on children with developmental delays and submit a report to the Legislature with recommendations. The purpose of the study was to focus on developing early intervention strategies and programs that would enable children and their families to avoid the unnecessary suffering that occurs when learning problems and developmental delays are not identified or are mislabeled.²³

In January 2001, the commission submitted its report, including proposed legislation, to the presiding officers of the Legislature. The commission examined the research and best practices in the pertinent professional disciplines and recommended three pilot programs (Orange, Manatee, and St. Lucie

²³ Chapter 2000-330, L.O.F. (2000).

Counties) to determine the organizational arrangement of the delivery system that would assure coordination and integration with existing systems. The commission also recommended a steering committee to oversee the pilot programs and provide them with technical assistance. In 2001, the Legislature enacted CS/SB 1018 to create the pilot programs and enacted the recommendations of the study commission. However, the Governor vetoed the bill. The Legislature also appropriated \$6 million for implementation of the pilot programs, which was also vetoed.²⁴

In 2002, the Legislature again authorized pilot programs in Orange, Manatee, and St. Lucie counties to identify and address learning problems in children from birth to age 9, earlier and more efficiently. Each pilot program was established to develop a Learning Gateway that provides a single point of access for parents who suspect that their children have potential learning problems. The Learning Gateway was to inform parents, pediatricians, and teachers of the early warning signs of learning problems according to the best current research. The Learning Gateway pilot programs were to provide information and referral, but were not to provide direct services, to children or parents. The 2002 legislation also created a steering committee of parents, practitioners, and individuals with scientific, medical, and business expertise to support and oversee the pilot programs. Although the Governor approved the 2002 legislation,²⁵ the Governor vetoed the \$2.6 million appropriation provided to fund the pilot programs.²⁶ The Legislature has not subsequently provided funding for the Learning Gateway pilot programs and, consequently, the programs have not been implemented.

Voluntary Prekindergarten Education Program

In 2002, the voters of Florida approved an amendment to the State Constitution which required the Legislature to establish a prekindergarten program for every 4-year-old child in the state.²⁷ The amendment specified that the prekindergarten program must be voluntary, high quality, free, and delivered according to professionally accepted standards. In December 2004, to implement the constitutional amendment, the Legislature created the Voluntary Prekindergarten Education (VPK) Program.²⁸ The VPK program allows a parent to enroll his or her child in a voluntary, free prekindergarten program offered during the year before the child is eligible for admission to kindergarten. The program gives parents of eligible children a choice among three program options:²⁹

- A 540-instructional-hour school-year VPK program delivered by a private provider;³⁰
- A 300-instructional-hour summer VPK program delivered by a public school or private provider;³¹ or
- If offered in a school district that meets class-size reduction requirements, a 540-instructional-hour school-year VPK program delivered by a public school.³²

A child residing in the state who will have attained 4 years of age on or before September 1 of the school year is eligible for the VPK program during that school year. A child remains eligible until the beginning of the school year for which the child is eligible for admission to kindergarten in a public school (i.e., the child attains the age of 5 years on or before September 1 of the school year³³) or is admitted to kindergarten, whichever occurs first.

Current law allows a private provider or public school offering the VPK program to select or design its own curriculum.³⁴ However, a curriculum must be developmentally appropriate and must:

²⁴ Specific Appropriation 131B, § 2, ch. 2001-253, L.O.F. (2001).

²⁵ Section 5-8, ch. 2002-265, L.O.F. (2002).

²⁶ Specific Appropriation 119A, § 2, ch. 2002-384, L.O.F. (2002).

²⁷ Section 1(b) & (c), Art. IX of the State Constitution.

²⁸ Chapter 2004-484, L.O.F. (2004); part V of ch. 1002, F.S.

²⁹ Section 1002.53, F.S.

³⁰ Section 1002.55, F.S.

³¹ Section 1002.61, F.S.

³² Section 1002.63, F.S.

³³ See § 1003.21(1)(a)2., F.S.

³⁴ Section 1002.67(2)(a), F.S.

- Be designed to prepare a student for early literacy;
- Enhance the age-appropriate progress of students in achieving performance standards³⁵ adopted by the Department of Education (DOE); and
- Prepare students to be ready for kindergarten.³⁶

Thirty-one early learning coalitions are regionally established in communities to administer early learning programs at the local level.³⁷ The Agency for Workforce Innovation (AWI) administers the operational aspects of the VPK program at the state level,³⁸ while DOE administers the accountability aspects of the VPK program.³⁹

John M. McKay Scholarships for Students with Disabilities

The John M. McKay Scholarships for Students with Disabilities Program was originally created by the Legislature in 1999 as a pilot program in Sarasota County. The program was later expanded to serve students with disabilities statewide for the 2000-2001 school year. According to the DOE's most recent quarterly report, there were 19,439 McKay scholarship recipients attending 836 participating private schools in February 2008.⁴⁰

Currently, a parent of a public school student with a disability, who is dissatisfied with the student's progress, may receive a McKay scholarship to attend a public school of choice or a private school if the student: (a) has an individual education plan written in accordance with State Board of Education rules; and (b) spent the *prior school year in attendance*⁴¹ at a public school or the Florida School for the Deaf and Blind.⁴²

"Prior school year in attendance" means that the student was enrolled and reported for Florida Education Finance Program (FEFP) funding purposes during the previous October and February surveys:

- By a school district or the Florida School for the Deaf and the Blind in kindergarten through grade 12; or
- By a school district, was at least 4 years old when enrolled and reported, and was eligible for services under section 1003.21(1)(e), F.S. Under paragraph (e), a child with a disability who is at least 3 years old is eligible for admission to public special education programs and for related services under rules adopted by the State Board of Education and the district school board.

Effective July 1, 2006, statute was amended to require: (a) private schools to maintain a physical location in this state where a McKay scholarship recipient attends classes; and (b) a scholarship recipient to have "regular and direct contact" with his or her private school teachers at the school's physical location.⁴³ Subsequently, the State Board of Education adopted a rule to define "regular and direct contact" as meaning a program that provides at least 170 actual school instruction days for a

³⁵ See § 1002.67, F.S.; Florida Department of Education, *Florida Voluntary Prekindergarten Education Standards* (2005), available at <http://www.unf.edu/dept/fie/PDF%20Folder/vpk.pdf> (last visited Apr. 21, 2008).

³⁶ Section 1002.67(2)(b), F.S.

³⁷ Each early learning coalition is composed of 18 to 35 members. Section 411.01(5)(a)4., F.S. The chair and two additional members of a coalition are appointed by the Governor, and the remaining members are appointed locally. Section 411.01(5)(a)5. and 6., F.S.

³⁸ Section 1002.75(1), F.S.

³⁹ Section 1002.73(1), F.S.

⁴⁰ See http://www.floridaschoolchoice.org/Information/McKay/quarterly_reports.asp (last visited on April 21, 2008).

⁴¹ The "prior school year in attendance" requirement is waived, however, for dependent children of military families who are transferred to a school in this state from another state or country pursuant to a parent's permanent change of station orders. Section 1002.39(2)(a), F.S.

⁴² Section 1002.39(1) and (2), F.S.

⁴³ See chapter 2006-75, § 1, L.O.F. (amending § 1002.39(3)(h) and (8)(d), F.S.).

specified number of instructional hours⁴⁴ under the direct instruction of the private school teacher at the school's physical location with occasional offsite activities under the supervision of the private school teacher.⁴⁵

It is estimated by the Coalition for McKay Scholarship Schools that 50 to 90 students with disabilities, who received scholarships in the 2005-2006 school year, became ineligible for a 2006-2007 scholarship due to the "regular and direct contact" requirement.

Disabilities Terminology

The *Florida K-20 Education Code*⁴⁶ uses numerous terms describing various types of disabilities. Several of these terms have been superseded in common usage within the field of special education. For example, the term "mental retardation" has been replaced in common usage by the term "intellectual disability."⁴⁷

Effect of Proposed Changes

Developmental Disabilities

The bill expands the types of developmental disabilities served by the Agency for Persons with Disabilities by amending the definition of "developmental disability" to include Down syndrome.

KidCare

The bill phases out the Medikids program component of KidCare by requiring, as of January 1, 2009, enrollment of all new Kidcare applicants between the ages of 1 and 5 years in the Healthy Kids program component. Further, eligibility for full-pay families to participate in the Healthy Kids program component is expanded by removing the 10 percent enrollment limitation.

In addition, the Healthy Kids benefit coverage is expanded by:

- Expanding therapy services to include habilitative services for improvements in and maintenance of human behavior, skill acquisition, and communication. Habilitative services are limited to enrollees who are diagnosed with autism spectrum disorder, mental retardation, cerebral palsy, spina bifida, or Prader-Willi syndrome.
- Including behavior analysis services, which means the design, implementation, and evaluation of instructional and environmental modifications to produce socially significant skill acquisition and reduction of problematic behavior.

The Healthy Kids lifetime maximum benefit is amended to impose a maximum of \$36,000 annually and \$108,000 lifetime for the combination of behavior analysis services, speech therapy, physical therapy, and occupational therapy for enrollees diagnosed with autism spectrum disorder, mental retardation, cerebral palsy, spina bifida, or Prader-Willi syndrome.

Last, the Florida Healthy Kids Corporation is required to provide information on a quarterly basis to the Legislature and Governor assessing the cost and utilization of services for the Florida Healthy Kids

⁴⁴ Under Rule 6A-1.09512, F.A.C., the number of required instructional hours is determined according to grade level as follows: (a) Kindergarten: 540 net instructional hours; (b) grades 1-3: 720 net instructional hours; and (c) grades 4-12: 900 net instructional hours.

⁴⁵ Rule 6A-6.03315(1)(c), F.A.C.

⁴⁶ Chapters 1000-1013, F.S.

⁴⁷ See, e.g., Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, *Intellectual Disability*, at <http://www.cdc.gov/ncbddd/dd/ddmr.htm> (last visited Mar. 25, 2008); American Association on Intellectual and Developmental Disabilities, *Press Release: World's Oldest Organization on Intellectual Disability Has a Progressive New Name* (Nov. 2, 2006), available at http://www.aaidd.org/About_AAIDD/name_change_PRdreen.htm (last visited Apr. 21, 2008).

benefit plans provided through the corporation. The information must be specific to each eligibility component of the plan and include:

- Monthly enrollment and expenditures for enrollees.
- Cost and utilization of specific services.
- An analysis of premiums impacts following implementation of the bill.
- Analysis of trends regarding transfer of enrollees from the Florida Healthy Kids plans to the Children's Medical Services Network Plan.
- Recommendations resulting from the quarterly assessment.

Medicaid

The bill creates an optional Medicaid benefit for home and community based services autism spectrum disorder and other developmental disabilities. The agency is required to seek and implement a state plan amendment for home and community based services for occupational therapy, speech therapy, physical therapy, behavior analysis, and behavior assistant services in accordance with Section 1915(i) of the Social Security Act.

The new benefit is limited to individuals under the age of 5 with an income up to 150 percent of the Federal Poverty Level who have a diagnosis of autism spectrum disorder, mental retardation, cerebral palsy, spina bifida, or Prader-Willi syndrome. The benefit is limited to \$36,000 annually and \$108,000 lifetime.

In accordance with Section 1915(i) of the Social Security Act, the agency is authorized to limit the benefit to a select number of individuals in select geographic areas.

The agency is required to coordinate with the Agency for Persons with Disabilities and the Department of Health in selecting and defining the services that will be submitted in the state plan amendment.

Last, the agency is required to annually submit, beginning on January 1, 2009, a report to the Legislature regarding the implementation of the state plan amendment.

Healthcare Practitioners

The bill requires the boards of certain licensees to require each licensee to complete a 2-hour continuing education course on developmental disabilities, including autism spectrum disorder, every third biennial relicensure period. The course must include information on the diagnosis and treatment of developmental disabilities and information on counseling and education of a parent whose child is diagnosed with a developmental disability. The licensees include each person licensed under chapter 458 and chapter 459 (physicians and physician assistants), part I of chapter 464 (nurses), chapter 490 (psychologists), or chapter 491 (clinical social workers, marriage and family therapists, and mental health counselors).

Failure to complete the continuing education requirement constitutes grounds for disciplinary action under each respective practice act and s. 456.072(1)(k).⁴⁸

Last, the Department of Health is required to develop and implement a plan to promote awareness of developmental disabilities, with a focus on autism spectrum disorder, to physicians and parents. The plan must be developed in coordination with the Boards of Medicine and Osteopathic Medicine, nationally recognized organizations promoting awareness of developmental disabilities, and organizations representing physicians. The plan must include distribution of educational materials to parents, including a developmental assessment tool.

Insurance Coverage

⁴⁸ This paragraph reads, in part, "Failing to perform any statutory or legal obligation placed upon a licensee."

Health Insurance Mandates

The bill requires health maintenance organizations and health insurance plans, effective July 1, 2010, to provide coverage to an eligible individual for:

- Well-baby and well-child screening for diagnosing the presence of a developmental disability.
- Intervention and treatment of a developmental disability through speech therapy, occupational therapy, physical therapy, and behavioral interventions.

An eligible individual is an individual under the age of 18 years of age or an individual 18 years of age or older who is in high school who has been diagnosed as having a developmental disability at 8 years of age or younger.

Coverage is limited to treatment prescribed by a treating physician in accordance with a treatment plan, and must not exceed \$36,000 annually and \$108,000 lifetime. Coverage may be subject to other exclusions and limitations, including coordination of benefits, participating provider requirements, and utilization review of health care services.

The coverage required by the bill may not be less favorable than coverage for other covered physical illnesses, with regard to dollar limits, deductibles, or coinsurance. An insurer or health maintenance organization is prohibited from denying or refusing to issue coverage for medically necessary services as well as refusing to contract with or refusing to renew, reissue, or otherwise terminating or restricting coverage for an individual because he or she is diagnosed with a developmental disability.

The required treatment plan must include a diagnosis, the proposed treatment by type, the frequency and duration of treatment, the anticipated outcomes as goals, the frequency by which the treatment plan will be updated, and the treating physician's signature.

The coverage limits must be adjusted annually, beginning July 1, 2011, to reflect any change from the previous year in the medical component of the Consumer Price Index for all urban consumers.

The mandate applies only to those insurers and HMOs who fail to enter into the Developmental Disabilities compact described below.

Developmental Disabilities Compact

The bill requires the Office of Insurance Regulation to convene a workgroup to negotiate a compact that includes a binding agreement among the participants regarding insurance and access to services for persons with developmental disabilities.

The workgroup must include the following members:

- Representatives of all health insurers licensed under chapter 624.
- Representatives of all health maintenance organizations licensed under part I of chapter 641.
- Representatives of employers with self-insured health benefit plans.
- A designee of the Governor.
- A designee of the President of the Senate.
- A designee of the Speaker of the House of Representatives.

The compact must include:

- Procedures for clear and specific notice to policy holders identifying the amount, scope, and conditions under which coverage is provided for speech therapy, physical therapy, occupational therapy, and behavioral interventions when necessary due to the presence of a developmental disability.
- Penalties for documented cases of denial, due to the presence of a developmental disability, of claims for medically necessary services.

- Proposals for new product lines that may be offered in conjunction with traditional health insurance and provide a more appropriate means of spreading risk, financing costs, and accessing favorable prices.

The Office of Insurance Regulation must report to the Legislature and Governor upon completion of compact negotiations and must continue to monitor participation, compliance, and effectiveness of the compact, reporting findings at least annually.

Education-Related Issues Concerning Disabilities

Learning Gateway

The bill directs the Centers for Autism and Related Disabilities (CARD), in collaboration with the Department of Education (DOE) and the Florida Diagnostic and Learning Resources System (FDLRS), to establish regional learning gateways within the seven CARD regions.⁴⁹ Each learning gateway must:

- Establish a single point of access for parents to obtain information and receive referrals for developmental screenings, diagnostic evaluations, early intervention services, and early learning programs for their children (birth through 5 years of age);
- Have a central telephone number and Internet website to provide information on diagnostic services, early intervention services, and early learning programs for children with disabilities;
- Provide follow up contact for children determined ineligible for Part B or Part C services under the federal Individuals with Disabilities Act (IDEA);
- Provide interagency⁵⁰ coordination to implement strategies for reducing a child's waiting time for services, reducing interagency duplication, and reducing interagency differences in eligibility criteria for services and programs which cause cross-agency diagnostic evaluations;
- Facilitate the integration of services, linkages among providers, and the array of services required to address the needs of children and families;
- Improve community awareness and education about developmental milestones, and the warning signs or precursors of disabilities in young children; and
- Provide training and technical assistance for parents, practitioners, and providers.

The bill creates the State Learning Gateway Council to provide statewide coordination of the regional learning gateways and advise the Governor and Legislature. The 13-member commission is composed of the following agency heads, and officers of the following organizations, or their permanent designees:

- Secretary of Children and Family Services;
- Director of the Agency for Persons with Disabilities;

⁴⁹ The CARD centers are organized into seven regions:

- Department of Communication Disorders at Florida State University (Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington counties);
- College of Medicine at the University of Florida (Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Levy, Marion, Putnam, Suwannee, and union Counties);
- University of Florida Health Science Center at Jacksonville (Baker, Clay, Duval, Flagler, Nassau, and St. Johns counties);
- Louis de la Parte Florida Mental Health Institute at the University of South Florida (Charlotte, Collier, DeSoto, Glades, Hardee, Hendry, Highlands, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, and Sarasota counties);
- Mailman Center for Child Development and the Department of Psychology at the University of Miami (Broward, Dade, and Monroe counties);
- College of Health and Public Affairs at the University of Central Florida (Brevard, Lake, Orange, Osceola, Seminole, Sumter, and Volusia Counties); and
- Department of Exceptional Student Education at Florida Atlantic University (Palm Beach, Martin, St. Lucie, Okeechobee, and Indian River counties). Section 1004.55(1), F.S.

⁵⁰ The bill specifies that the regional learning gateways shall provide interagency coordination among the regional offices of state agencies, including Children's Medical Services; FDLRS regional centers; FDLRS centers at state universities; school districts; early learning coalitions; county and municipal agencies; community agencies and organizations; and public and private providers.

- Director of Workforce Innovation;
- State Surgeon General;
- Secretary of Health Care Administration;
- Commissioner of Education;
- Director of a regional diagnostic and learning resources center (appointed by the Commissioner of Education);
- Director of a diagnostic and learning resources center at a state university (selected from among the directors of the university centers);
- Chair of the Florida Early Learning Advisory Council;
- President of the Autism Society of Florida;
- President of the Florida Association for Behavioral Analysis;
- President of the Florida Pediatric Society; and
- President of the Florida Psychological Association.

The council membership selects the council chair from among its members. The bill authorizes the council members to receive per diem and travel expenses for required attendance at council meetings. The council is directed to conduct its initial meeting within 45 days after the bill takes effect.

The council is assigned to DOE for administrative purposes. The bill directs the agencies represented by the council's membership to enter into an interagency agreement to provide staffing and administrative support for the council. The executive directors of the seven CARD centers select one of their executive directors to serve as the council's executive director.

The bill expands the mission of the CARD centers to include additional children with disabilities, revises the CARD centers' duties to include coordination of the regional learning gateways and approval of early intervention service providers under the VPK program for children with disabilities.

The bill also repeals the obsolete provisions in part II of chapter 411, F.S.,⁵¹ which established the Learning Gateway in 2002, but which ultimately did not receive funding for implementation.

Voluntary Prekindergarten Education Program

The bill creates a VPK program option (beginning with the 2011-2012 school year) for children with disabilities⁵² who are otherwise eligible for the VPK program (i.e., 4 years of age on or before September 1 and reside in Florida) and who have a current individual educational plan (IEP) developed for the child in accordance with State Board of Education rules.⁵³

Eligible children are authorized to receive appropriate early intervention services (e.g., applied behavior analysis, speech-language pathology, occupational therapy, and physical therapy) from approved service providers selected by each child's parent. The bill directs the early learning coalition to reimburse approved service providers for early intervention services provided to eligible children. However, reimbursements for an eligible child are limited to the VPK base student allocation⁵⁴ in the General Appropriations Act.

⁵¹ Sections 411.226, 411.227, and 411.228, F.S.

⁵² The bill specifies that a child with a disability for purposes of the VPK program option for children with disabilities means "students who have an intellectual disability, autism spectrum disorder, a speech impairment, a language impairment, an orthopedic impairment or other health impairment, traumatic brain injury, a visual impairment, an emotional or behavioral disability, or a specific learning disability, including, but not limited to, dyslexia, dyscalculia, or developmental aphasia; students who are deaf or hard of hearing or dual sensory impaired; students who are hospitalized or homebound; and children, birth through 5 years of age with developmental delays, and children birth through 2 years of age with established conditions, which are identified in State Board of Education rules."

⁵³ Rule 6A-6.0331, F.A.C.

⁵⁴ For the 2007-2008 fiscal year, the base student allocation for the VPK program was \$2,677. Specific Appropriation 85, § 2, chapter 2007-72, L.O.F. (2007).

The bill directs each CARD center to approve early intervention service providers in its respective region, maintain approved provider lists, and notify each school district and early learning coalition in the region of the approved list. Upon request of a parent, a CARD center may approve a service provider that is not on the approved list.

Early intervention services must be provided according to professionally accepted standards and must address the age-appropriate progress of children in the development of the capabilities, capacities, and skills required under the State Constitution (i.e., “development of language and cognitive capabilities and emotional, social, regulatory and moral capacities”),⁵⁵ in accordance with DOE’s performance standards for the VPK program.⁵⁶

The bill also allows a parent to reenroll his or her child in another VPK school-year and summer option, as long as child has not received more than 10 percent of the authorized funds for early intervention services.

John M. McKay Scholarships for Students with Disabilities

The bill expands the McKay scholarship eligibility criteria, which presently requires having been reported for FEFP funding purposes during the preceding school year, to also provide eligibility to a student who: (a) received early intervention services under the VPK program pursuant to section 1002.66, F.S.; and (b) has a current IEP. As discussed above, however, eligibility for such services under section 1002.66, F.S., does not begin until the 2011-2012 school year. Accordingly, the new McKay scholarship eligibility criteria will not impact awards until the 2012-2013 school year.

The bill also creates an exception to the requirement that a McKay scholarship recipient have “regular and direct contact” with his or her teachers at the private school’s physical location. Under the exception, a scholarship recipient may receive regular and direct instruction and services at a site other than the school’s physical location if:

- The medical doctor or psychologist treating the student’s disability provides a notarized statement certifying that the student’s welfare or the welfare of other students in the classroom will be jeopardized if he or she regularly attends class at the school’s physical location. The statement must be annually provided by the parent to the DOE at least 60 days before the first scholarship payment and must be based on an annual review of the student’s disability by the doctor or psychologist.
- The private school:
 - Retains a case manager who coordinates and monitors the student’s instruction and services and provides the student’s parent and private school with monthly student progress reports.
 - Requires its personnel to submit to the case manager documentation of the instruction and services provided and the student’s progress.
 - Notifies the DOE of each student subject to the exception.

Finally, the bill provides retroactive scholarship eligibility for the 2008-2009 school year to a student who received a scholarship in the 2005-2006 school year, but who was unable to receive a scholarship in the 2006-2007 school year due to the “regular and direct contact” requirement that took effect on July 1, 2006. Such student must demonstrate that he or she would have met the bill’s exception to the “regular and direct contact” requirement at the time of his or her 2006-2007 scholarship.

Disabilities Terminology

The bill replaces several terms used throughout the *Florida K-20 Education Code* which describe various types of disabilities for purposes of:

⁵⁵ Section 1(b), Art. IX of the State Constitution.

⁵⁶ See *supra* note 35.

- Student eligibility requirements for the John M. McKay Scholarships for Students with Disabilities Program;⁵⁷ and
- The definition of “exceptional student” for purposes of public K-12 education.⁵⁸

C. SECTION DIRECTORY:

Section 1. Providing a short title.

Section 2. Amends s. 393.063, F.S., relating to definitions.

Section 3. Amends s. 409.8132, F.S., relating to the Medikids program component.

Section 4. Amends s. 409.814, F.S., relating to eligibility.

Section 5. Amends s. 409.815, F.S., relating health benefits coverage and limitations.

Section 6. Amends s. 409.906, F.S., relating to optional Medicaid services.

Section 7. Creates s. 456.0291, F.S., relating to requirement for instruction on developmental disabilities.

Section 8. Amends s. 624.91, F.S., relating to the Florida Healthy Kids Corporation Act.

Section 9. Creates s. 624.916, F.S., relating to the Developmental Disabilities Compact.

Section 10. Creates s. 627.6686, F.S., relating to coverage for developmental disabilities.

Section 11. Creates s. 641.31098, F.S., relating to coverage for developmental disabilities.

Section 12. Amends s. 1002.39, F.S., relating to the John M. McKay Scholarships for Students with Disabilities Program.

Section 13. Amends s. 1002.51, F.S., relating to definitions.

Section 14. Amends s. 1002.53, F.S., relating to the Voluntary Prekindergarten Education Program.

Section 15. Creates s. 1002.66, F.S., relating to the prekindergarten program for children with disabilities.

Section 16. Amends s. 1002.71, F.S., relating to funding and financial and attendance reporting.

Section 17. Amends s. 1002.75, F.S., relating to the power and duties of the Agency for Workforce Innovation.

Section 18. Amends s. 1003.01, F.S., relating to definitions.

Section 19. Amends s. 1004.55, F.S., relating to the Centers for Autism and Related Disabilities.

Section 20. Amends s. 1006.03, F.S., relating to the Florida Diagnostic and Learning Resources System.

Section 21. Designates ss. 1006.80 and 1006.82, F.S., as part III of chapter 1006.

⁵⁷ See § 1002.39(1), F.S.

⁵⁸ See § 1003.01(3)(a), F.S.

Section 22. Creates s. 1006.80, F.S., relating to regional learning gateways.

Section 23. Creates s. 1006.82, F.S., relating to the State Learning Gateway Council.

Section 24. Repeals ss. 411.226, 411.227, and 411.228, F.S.

Section 25. Provides an effective date of July 1, 2008.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill expands eligibility in the Florida Healthy Kids component to include 1 to 4 year olds and removes the 10 percent limit on enrollment for full-pay enrollees. The bill also provides habilitative and behavioral analysis benefits for all Florida Healthy Kids enrollees to address developmental disabilities with certain caps and lifetime benefits.

The bill includes several provisions that are likely to produce a significant, but indeterminate fiscal impact. Those provisions with a positive fiscal impact include the expansion of covered lives in the Florida Healthy Kids component through the phasing out of the Medikids component. This may expand the number of healthy lives covered through the program and mitigate some of the expected premium increase. Counterbalancing these impacts are provisions to remove the limit on full-pay enrollees and the increase in types of services provided. However, the bill imposes lifetime caps on the amounts of services.

The proposed General Appropriation Act for Fiscal Year 2008-09 includes \$36.4 million to increase enrollment by approximately 38,000 under the current Kidcare structure. Based on the program changes, there will be an indeterminate reduction in the number of new slots available. The bill requires quarterly information to the Legislature and the Governor that assesses the costs and utilization of services for the Florida Healthy Kids benefits plans to monitor program expenditures and to assist the Social Services Estimating Conference in making enrollment decisions for the program.

The bill directs the Agency for Health Care Administration to seek a Section 1915(i) waiver to cover home and community based services under the Medicaid state plan. In accordance with Section 1915(i) of the Social Security Act, the agency is authorized to limit the benefit to a select number of individuals in select geographic areas. Services will be limited to occupational, speech, and physical therapies, as well as behavior analysis and behavior assistant services. Services will be limited to individuals who are under age 5 with incomes up to 150 percent of the Federal Poverty Level, and have a diagnosis of autism spectrum disorder, mental retardation, cerebral palsy, spina bifida or Prader-Willi syndrome. Services will be limited to \$36,000 annually and will have a lifetime cap of \$108,000.

Under the 1915(i) authority, the state may limit the state fund investment in these services. State general revenue funding of \$10 million would draw \$12,451,728 in federal matching funds for a total of \$22,451,728. Assuming individuals would use the maximum of \$36,000 in services annually, a total of 623 individuals could be served under this waiver. If the state general revenue investment were increased to \$20 million, a total of \$44,903,458 in funding would be available. Assuming

individuals would use the maximum of \$36,000 in services annually, a total of 1,247 individuals could be served under this waiver.

The Division of State Group Insurance states that it is difficult to assess the impact of expanding coverage for developmental disabilities. However, they note that a 2005 analysis for autism disorders estimated the fiscal impact of similar legislation to be \$294,000 to \$1,164,000. The DSGI also notes that since that time, the incidence of autism has been adjusted from 1 in 250 births to 1 in 150 births, a 66 percent increase in the number of incidents. When applied to the fiscal estimates results from above, the range of fiscal impact increases to be \$490,000 to \$1,940,000. Since this bill imposes a lifetime cap on benefits of \$108,000 with a \$36,000 annual maximum and covers all developmental disabilities, not just autism disorders, the assumptions for the fiscal impact would be markedly different.

The DSGI also believes that this legislation is likely to increase administrative appeals due to disputes regarding whether a prescribed treatment is covered under the PPO plan. The PPO plan and most HMOs exclude or have limitations on the various therapies that are often prescribed to treat autism. For example, therapies that are behavioral based usually have limited coverage as to treatment periods, as do massage therapy and speech therapy. Prescribed treatment for autism also often involves educational programs and nutritional alternative programs, both of which are excluded under the PPO plan.

Beginning with the 2011-2012 school year, the bill establishes a VPK program of early intervention services for children with disabilities. The Department of Education estimates that an option of early intervention services for children with disabilities would likely increase participation in the VPK program by 10 to 15 percent. The Agency for Workforce Innovation estimates that the estimated cost of this program option to the state would be approximately \$25.7 million for fiscal year 2011-2012.

Beginning with the 2012-2013 school year, the bill allows students with disabilities who received early intervention services through the VPK program to be eligible for a McKay scholarship. This expansion of eligibility creates a fiscal impact on the state to the extent that such VPK students did not attend a public special education program under section 1003.21(1)(e), F.S., or would not have chosen a public school kindergarten. The fiscal impact is indeterminate, however, as the number of such VPK students is not known at this time.

It is estimated by the Coalition for McKay Scholarship Schools that 50 to 90 students with disabilities, who received McKay scholarships in the 2005-2006 school year, became ineligible for a 2006-2007 scholarship due to the "regular and direct contact" requirement enacted in 2006. The bill provides retroactive scholarship eligibility for the 2008-2009 school year to these students. In 2006-2007, McKay scholarship awards ranged from \$5,039 to \$21,907, with an average award amount of \$7,206.⁵⁹ Accordingly, the fiscal impact of the retroactive eligibility provision is expected to range from \$251,950 (50 students x \$5,039) to \$1,971,630 (90 students x \$21,907).

The bill creates the 13-member State Learning Gateway Council and requires the seven Centers for Autism and Related Disabilities (CARD) to establish regional learning gateways. The estimated costs for implementing these learning gateway requirements are indeterminate at this time. However, in 2002, the Legislature appropriated \$2.4 million for substantially similar learning gateways and a statewide steering committee.⁶⁰

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

⁵⁹ See http://www.floridaschoolchoice.org/Information/McKay/files/Fast_Facts_McKay.pdf (last visited on April 21, 2008).

⁶⁰ See *supra* note 26 and accompanying text.

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Individuals may experience an increase in their health insurance premiums due to the health coverage requirements included in the bill. Private schools may experience a positive impact due to increased enrollments through the McKay Scholarships.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill assigns additional duties to the Agency for Workforce Innovation (AWI) for administering a VPK program for children with disabilities. AWI's rulemaking authority for the VPK program is found in section 1002.79(2), F.S.

The bill's creation of an exception to the McKay scholarship's "regular and direct contact" requirement will necessitate amendments to the State Board of Education's rule governing private school scholarship compliance.⁶¹

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR

N/A

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

⁶¹ See Rule 6A-6.03315, F.A.C.