Health Care Appropriations Subcommittee

Tuesday, March 28, 2017
8:00 AM – 11:00 AM
Sumner Hall (404 HOB)

Meeting Packet

Richard Corcoran
Speaker

Jason Brodeur
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Care Appropriations Subcommittee

Start Date and Time:	Tuesday, March 28, 2017 08:00 am
End Date and Time:	Tuesday, March 28, 2017 11:00 am
Location:	Sumner Hall (404 HOB)
Duration:	3.00 hrs

Consideration of the following bill(s):

HB 883 Memory Disorder Clinics by Miller, M., Plakon
HB 1041 Laboratory Screening by Raschein
CS/HB 1121 Child Welfare by Children, Families & Seniors Subcommittee, Stevenson
HB 1195 Health Care Facility Regulation by Miller, A., White
HB 7075 Child Welfare by Children, Families & Seniors Subcommittee, Harrell

Consideration of the following proposed committee bill(s):

PCB HCA 17-01 -- Medicaid Services
PCB HCA 17-02 -- Prescription Drug Monitoring Program
PCB HCA 17-03 -- Department of Veterans' Affairs

Chair's Budget Proposal for FY 2017-18

NOTICE FINALIZED on 03/24/2017 4:16PM by SPB

The Florida House of Representatives

Appropriations Committee
Health Care Appropriations Subcommittee

Richard Corcoran
Speaker

Jason Brodeur
Chair

March 28, 2017

AGENDA
8:00 a.m. – 11:00 a.m.
Sumner Hall (404)

I. Call to Order/Roll Call

II. Opening Remarks

III. Consideration of the following bills(s)

- HB 883 Memory Disorder Clinics by Miller, M., Plakon
- HB 1041 Laboratory Screening by Raschein
- CS/HB 1121 Child Welfare by Children, Families & Seniors Subcommittee, Stevenson
- HB 1195 Health Care Facility Regulation by Miller, A., White

- HB 7075 Child Welfare by Children, Families & Seniors Subcommittee, Harrell

IV. Consideration of the following proposed committee bill(s)

- PCB HCA 17-01 -- Medicaid Services
- PCB HCA 17-02 -- Prescription Drug Monitoring Program
- PCB HCA 17-03 -- Department of Veterans' Affairs

V. Chair's Budget Proposal for FY 2017-18

VI. Closing Remarks/Adjournment

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 883 Memory Disorder Clinics
SPONSOR(S): Miller, M. and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1050

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	9 Y, 0 N	Royal	McElroy
2) Health Care Appropriations Subcommittee		Clark	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Section 430.502 establishes 15 Memory Disorder Clinics (MDCs) in the State of Florida that provide comprehensive assessments, diagnostic services, and treatment to individuals who exhibit symptoms of Alzheimer's disease and related memory disorders. MDCs also develop training programs and materials, and conduct training for caregivers, respite service providers, and health care professionals in the care of persons with Alzheimer's disease and related memory disorders. In addition, MDCs conduct service-related research projects. MDCs receive performance based funding from the General Revenue.

HB 883 establishes a 16th MDC at Florida Hospital in Orange County. Florida Hospital in Orange County established a self-funded memory disorder program in 2012. The bill does not provide any appropriation of funds to the MDC at the Florida Hospital.

The bill does not have a fiscal impact on state or local governments.

The bill provides an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Alzheimer's Disease

Alzheimer's disease is a form of dementia, a general term for memory loss. It is a progressive brain disorder that damages and eventually destroys brain cells, leading to memory loss and changes in the functions of the brain.[1] Alzheimer's disease accounts for 60 to 80 percent of dementia cases.[2] Alzheimer's disease is a progressive disease in which dementia symptoms worsen gradually over time. In the early stages of Alzheimer's disease, memory loss is mild, but in late-stage Alzheimer's, individuals lose the ability to carry on a conversation and respond to their environment.[3] Currently, there is no cure for Alzheimer's disease, but treatments that can temporarily slow the worsening of symptoms do exist.[4]

There are an estimated 5.5 million people in the United States with Alzheimer's disease, including 5.3 million people aged 65 and older and 200,000 individuals under age 65 who have younger-onset Alzheimer's disease.[5] By 2030, the segment of the United States population aged 65 years and older is expected to double, and the estimated 71 million older Americans will make up approximately 20 percent of the total population.[6] By 2050, the number of people aged 65 and older with Alzheimer's disease is expected to nearly triple to a projected 13.8 million people.[7]

Since 2000, deaths attributed to Alzheimer's disease have increased 89 percent nationally, while deaths attributed to heart disease, the number one cause of death, decreased by 14 percent. [8] Alzheimer's disease is the sixth leading cause of death in the United States and the fifth leading cause of death age 65 and older.[9]

An estimated 520,000 Floridians have Alzheimer's disease.[10] The projected number of Floridians with Alzheimer's disease in 2025 is 720,000.[11] Alzheimer's disease is the 6th leading cause of death in Florida. The Medicaid cost of caring for people with Alzheimer's disease in Florida is 2.279 billion dollars.[12]

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[1] Alzheimer's Association. *What We Know Today About Alzheimer's Disease and Dementia.* Available at: http://www.alz.org/research/science/alzheimers_research.asp (last visited March 17, 2017).
[2] Id.
[3] Alzheimer's Association. *What is Alzheimer's?.* Available at: http://www.alz.org/alzheimers_disease_what_is_alzheimers.asp (last visited March 17, 2017).
[4] Id.
[5] Alzheimer's Association. *2017 Alzheimer's Disease Fact and Figures.* Available at http://www.alz.org/alzheimers_disease_facts_and_figures.asp (last visited March 17, 2017).
[6] Id.
[7] Id.
[8] Id
[9] Id.
[10] Alzheimer's Association. *Florida Factsheet.* Available at: http://www.alz.org/documents_custom/facts_2017/statesheet_florida.pdf?type=interior_map&facts=undefined&facts=facts (last visited March 17,2017).
[11] Id.
[12] Id.

Alzheimer's Disease Research[13]

There are several not-for-profit institutions and associations in Florida who have invested capital to support "Alzheimer's disease and related forms of dementia" (ADRD) research.[14] Research investments at the state and federal levels in institutions such as Scripps, Torrey Pines, and Burnham have added to our general research capabilities, but very few scientists at these institutions focus on ADRD.[15] The 15 state funded MDCs provide valuable ADRD research, and the majority of academic institutions in Florida have active ADRD research programs.[16]

The National Institute on Aging, within the National Institute of Health (NIH), funds 29 Alzheimer's Disease Research Centers (ADRCs) at major medical institutions across the United States.[17] NIH ADRCs serve a similar role to nationally designated cancer centers. They create infrastructure that supports clinical care for patients with ADRD.[18]

In order to be eligible for funding and recognition as an ADRC, institutions are required to have an established ongoing base of high-quality Alzheimer's disease research or research in other neurodegenerative diseases, or in aging of the nervous system.[19]

Currently, the Mayo Clinic Alzheimer's Disease Research Center and the University of Florida Alzheimer's Disease Center are the only NIH ADRCs in Florida.[20] NIH ADRCs receive $1.5 million in federal funding, annually, for five years.[21] The Mayo Clinic ADRC focuses their research on patient-oriented research and basic science research. [22] Scientists at the Mayo Clinic ADRC were among the first in the United States to identify novel genetic mutations in some families with frontotemporal dementia[23] and the three most common dominantly inherited gene mutations that cause frontotemporal dementia were discovered at the Mayo Clinic ADRC.[24]

Alzheimer's Disease Initiative

The Alzheimer's Disease Initiative (ADI)[25] was created within the Department of Elder Affairs (DOEA) to provide a continuum of services to meet the changing needs of individuals with Alzheimer's disease

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[13] Department of Elder Affairs, Purple Ribbon Task Force, *2013 Final Report and Recommendation,* available at http://elderaffairs.state.fl.us/doea/purple_ribbon.php (last visited March 17, 2017).
[14] Id.
[15] Id.
[16] Id.
[17] National Institute on Aging, Alzheimer's Disease Research Centers, *see http://www.nia.nih.gov/alzheimers/alzheimers-disease-research-centers* (last visited February 28, 2014).
[18] *Supra*, note 13.
[19] National Institute of Health Funding Opportunities, *NIH Guide for Grants and Contract, Alzheimer's Disease Research Centers, Eligibility Information*, available at http://grants.nih.gov/grants/guide/rfa-files/RFA-AG-13-019.html (last visited March 17, 2017).
[20] *Supra,* note 17.
[21] *Supra*, note 13.
[22] The Mayo Clinic Alzheimer's Disease Research Center. Focus Areas. Available at: http://www.mayo.edu/research/centers-programs/alzheimers-disease-research-center/research-activities/focus-areas (last visited March 117,2017).
[23] The Mayo Clinic defines Frontotemporal dementia as: (frontotemporal lobar degeneration) is an umbrella term for a diverse group of uncommon disorders that primarily affect the frontal and temporal lobes of the brain — the areas generally associated with personality, behavior and language. In frontotemporal dementia, portions of these lobes atrophy or shrink. Signs and symptoms vary, depending upon the portion of the brain affected. Some people with frontotemporal dementia undergo dramatic changes in their personality and become socially inappropriate, impulsive or emotionally indifferent, while others lose the ability to use language. Frontotemporal dementia is often misdiagnosed as a psychiatric problem or as Alzheimer's disease. But frontotemporal dementia tends to occur at a younger age than does Alzheimer's disease, generally between the ages of 40 and 75. Available at: http://www.mayoclinic.org/diseases-conditions/frontotemporal-dementia/basics/definition/con-20023876 (last visited March 17, 2017).
[24] *Supra*, note 22.
[25] Section 430.503, F.S.

and their families.[26] In conjunction with a ten-member advisory committee appointed by the Governor[27], the initiative includes the following four programs administered by DOEA.[28]

Respite Services

ADI Respite care programs exist in all 67 Florida counties and provide in-home, facility-based, emergency and extended care (up to 30 days) respite for caregivers who serve individuals with memory disorders.[29] Additional services include caregiver training and support, education, counseling, specialized medical equipment, services and supplies, and case management.[30]
Funds for respite care programs are contracted according to an allocation formula based on the number and proportion of the county population of individuals who are 75 years of age and older.[31]

Model Day Care

Model Day Care programs[32] have been established in conjunction with Memory Disorder Clinics to test therapeutic models of care and provide day care services.[33] Model Day Care programs provide a safe environment where Alzheimer's patients gather for the day and socialize with each other, as well as receive therapeutic treatments designed to maintain or improve their cognitive functioning.[34] Model Day Care programs also provide training for health care and social service personnel that care for persons having Alzheimer's disease and related memory disorders.[35] Currently, model day care programs have been established in Gainesville, Tampa, and Miami.[36]

Brain Bank[37]

The Florida Alzheimer's disease Brain Bank is a service and research oriented network of statewide regional sites. The intent of the Brain Bank program is to collect and study the brains of deceased patients who had been clinically diagnosed with dementia. Mt. Sinai Medical Center contracts annually with the state of Florida to operate the primary Brain Bank. Coordinators at regional brain bank sites in Orlando, Tampa and Pensacola help recruit participants and act as liaisons between the Brain Bank and participants' families.

Memory Disorder Clinics

The State of Florida has designated by statute 15 MDCs[38] that provide comprehensive assessments, diagnostic services, and treatment to individuals who exhibit symptoms of Alzheimer's disease and related memory disorders.[39] MDCs also develop training programs and materials, and conduct training for caregivers, respite service providers, and health care professionals in the care of persons with Alzheimer's disease and related memory disorders.[40] In addition, MDCs conduct service-related research projects through model day care programs and respite care programs.[41] MDCs are

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[26] Chapter 95-418, L.O.F., *see also* ss. 430.501-430.504, F.S.
[27] Section 430.501,F.S., Alzheimer's Disease Advisory Committee.
[28] Florida Department of Elder Affairs. *Alzheimer's Disease Initiative*. Available at: http://elderaffairs.state.fl.us/english/alz.php (last visited March 17, 2017).
[29] Id.
[30] *Supra,* note 13.
[31] Section 430.502(5), F.S.
[32] Section 430.502(7), F.S.
[33] *Supra,* note 28.
[34] Id
[35] Id
[36] Id
[37] The Florida Brain Bank. Available at: http://elderaffairs.state.fl.us/doea/BrainBank/index.php (last visited March 18, 2017).
[38] Section 430.502(1), F.S.
[39] *Supra*, note 28
[40] Id.
[41] Supra, note 13.

established at medical schools, teaching hospitals, and public and private not-for-profit hospitals throughout the state in accordance with section s. 430.502, F.S.

MDCs receive performance based funding from the General Revenue.[42] In order to receive base level funding, MDCs must meet minimum performance measures established by DOEA. Incentive funding, subject to legislative approval, is available for MDCs that meet additional performance measures established by DOEA.[43] Performance measures are established by DOEA in its annual contracts with the MDCs.[44]

Each MDC receives $222,801 in base level funding.[45] Pursuant to the 2016-2017 contract, MDCs may receive up to $50,000 in incentive funding if the MDC meets any of the incentive performance measures.[46] The $50,000 incentive funding is allocated based on how many incentive performance measures the MDCs meet and is divided amongst all 15 MDCs.[47] For example, if all 15 MDCs achieved 10 of the incentive performance measures, the $50,000 would be divided by 10 and then by 15, resulting in each MDC receiving approximately $333.00 in incentive funding.

Section 430.502(1), F.S. expressly prohibits decreasing funding for MDCs funded as of June 30, 1995,[48] solely to accommodate subsequent MDC additions.[49]

The minimum performance measures for base level funding for Fiscal Year 2016-2017 are as follows.[50]

Quarterly Base Level Funding Measures	Quarterly Minimum
Unduplicated patients with symptoms of memory loss or other cognitive impairment that received diagnostic evaluation.	81
New persons with symptoms of memory loss or other cognitive impairment that received a diagnostic evaluation	25
Evaluations, reevaluations, and follow-ups	30
Referrals made	230
Percentage of patients with driving issues addressed	100%
Percentage of Silver Alerts received by MDC for which protocol forms were submitted to DOEA	100%
Percentage of patients informed of Brain Bank	100%
Percentage of patients that received information about community resources, including Silver Alert	100%
Training/education presentations, programs, events or support groups	6
Yearly Base Level Funding Measures	**Yearly Minimum**
Staff liaisons to Area Agencies on Aging/Aging and Disability Resource Centers	1
Specialized training programs provided for caregivers, caregiver groups/organizations and service providers	1
Hours of in-service training to ADI model day care and respite care providers	4
Service-related research projects	1
Percentage of subcontractors monitored	100%

[42] Section 430.502(3) and (4), F.S.; Department of Elder Affairs. *2017 Legislative Bill Analysis HB 883, March 9, 2017.* On file with Health Quality Subcommittee.
[43] Id.
[44] Section 430.502(3) and (4), F.S; Department of Elder Affairs. *Standard Contract-Alzheimer's Disease Initiative-Memory Disorder Clinic*, June 2016-July 2017. On file with the Health Quality Subcommittee.
[45] Department of Elder Affairs. *2017 Legislative Bill Analysis HB 883, March 9, 2017.* On file with Health Quality Subcommittee.
[46] *Supra*, note 44.
[47] *Supra*, note 45.
[48] Prior to 1995, MDCs were established at each of the three medical schools in the state, major private nonprofit research-oriented teaching hospital and in a public hospital that is operated by an independent special hospital taxing district that governs multiple hospitals and is located in a county with a population greater than 800,000 persons. *See s. 37, ch. 95-418 L.O.F.*
[49] Section 430.502 (1), F.S.
[50] Department of Elder Affairs. *Standard Contract-Alzheimer's Disease Initiative-Memory Disorder Clinic, June 2016-July 2017.* On file with the Health Quality Subcommittee.

To receive base level funding, MDCs must also operate Monday-Friday from 8 a.m.-5 p.m.

Fiscal Year 2016-2017 performance measures for incentive funding are as follows.[51]

Yearly Incentive Funding Measures	Yearly Minimum
Unduplicated patients with symptoms of memory loss or other cognitive impairment that received diagnostic evaluation.	486
New persons with symptoms of memory loss or other cognitive impairment that received a diagnostic evaluation	150
Evaluations, reevaluations, and follow-ups	180
Referrals made	1378
Medicaid patients that received diagnostic evaluation	12
Patients with commercial insurance policy that received diagnostic evaluation	125
In-person outreach to medical professionals to increase access to services	20
Education events conducted with community entities to increase awareness	4
Training/education presentations, programs, events or support groups	50
Outreach events in low-income or minority areas	4
Caregiver training events, programs or sessions with pre- and post-assessment	4
Caregiver trainings that included discussion of disaster preparedness	100%
Specialized training for law enforcement and/or first responders	1
Articles published in DOEA newsletter	1
Percentage of clients that would recommend MDC to others	85%
Service-related research projects	2
Research partners	4
Grants or contracts that provided additional funding	1
Total amount of institutional financial commitments received	$46,201
Newsletters, brochures, handouts by MDC; or MDC Coordinator Quarterly Meetings or ADI Advisory Committee meeting hosted by MDC; or Trainings provided in another language; or Leadership roles relating to dementia taken by MDC Coordinator/Administrator/Director	1

In the Fiscal Year 2015-2016, the MDCs:[52]

- Saw 4,745 new patients.
- Completed 9,810 medical memory evaluations.
- Conducted 1,529 free memory screenings.
- Made 26,739 referrals to medical or community services for patients and families.
- Provided 3,828 hours of training to 33,240 family caregivers, medical professionals, health students, social service workers, and the general public.
- Provided 7,131 family caregivers with educational training on how to care for a loved one at home who has dementia.
- Made 17,769 phone contacts to provide information and referrals to community resources that assist individuals affected by dementia.
- Followed up with family members upon the cancellation of 239 Silver Alerts to provide education, resources, and referrals to assist the recovered person and to help prevent future elopement.

[51] Id.
[52] Department of Elder Affairs, *Memory Disorder Clinic Statewide Report*, 2015-2016. Available at: http://elderaffairs.state.fl.us/doea/alz/MDC_Year_End_Summary_2015-2016.pdf (last visited March 18, 2017)

Florida Hospital Maturing Minds Clinic[53]

In 2012, Florida Hospital in Orange County established a self-funded memory disorder program, the Florida Hospital Maturing Minds Clinic (FHMMP). FHMMP serves patients with Alzheimer's disease and related disorders in Orange, Seminole and Osceola County. FHMMP provides early screening and diagnosis, management of symptoms, caregiver education and training, and conducts research. FHMMP conducts over 360 new patient memory loss evaluations per year.

Effect of Proposed Changes

HB 883 amends s. 430.502 by establishing a MDC at the Florida Hospital in Orange County, making it the16th MDC in Florida and the second located in Orlando. The bill does not provide any appropriation of funds to the MDC at the Florida Hospital.

The bill provides an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 430.502 relating to Alzheimer's disease; memory disorder clinics and day care and respite care.
Section 2: Provides an effective date of July 1, 2017.

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:

The MDC at Orlando Health has a six-county service area which contains 62,684 probable persons living with Alzheimer's Disease. The Orlando Health MDC may see reduced numbers of clients served if patients begin visiting the new Florida Hospital MDC instead.[54]

D. FISCAL COMMENTS:

None.

[53] Jean Van Smith, Florida Hospital Government Relations, *Support HB 883/SB 1050, Memory Disorder Clinics*. On file with the Health Quality Subcommittee.
[54] *Supra*, note 45.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

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 memory disorder clinics; amending s. 430.502, F.S.; establishing a memory disorder clinic at Florida Hospital in Orange County; providing an effective date.

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

Section 1. Paragraphs (l) and (m) of subsection (1) of section 430.502, Florida Statutes, are amended, and paragraph (n) is added to that subsection, to read:

430.502 Alzheimer's disease; memory disorder clinics and day care and respite care programs.—

(1) There is established:

(l) A memory disorder clinic at Morton Plant Hospital, Clearwater, in Pinellas County; ~~and~~

(m) A memory disorder clinic at Florida Atlantic University, Boca Raton, in Palm Beach County; and~~,~~

(n) A memory disorder clinic at Florida Hospital in Orange County,

for the purpose of conducting research and training in a diagnostic and therapeutic setting for persons suffering from Alzheimer's disease and related memory disorders. However, memory disorder clinics funded as of June 30, 1995, shall not

receive decreased funding due solely to subsequent additions of memory disorder clinics in this subsection.

Section 2. This act shall take effect July 1, 2017.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1041 Laboratory Screening
SPONSOR(S): Raschein
TIED BILLS: **IDEN./SIM. BILLS:** SB 1144

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	13 Y, 0 N	Tuszynski	McElroy
2) Health Care Appropriations Subcommittee		Mielke	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Department of Health (DOH) provides numerous public health education and screening programs including:

- The Newborn Screening Program which screens all newborns to identify, diagnose, and manage newborns at risk for selected disorders that, without detection and treatment, can lead to permanent developmental and physical damage or death.
- The Lead Poisoning Prevention Screening and Education program that screens children under 6 years of age who are determined to be at-risk of having elevated blood-lead levels.
- A statewide network of county health departments and other sites that provide confidential and anonymous HIV testing, counseling, prevention outreach, and education to the public.

HB 1041 amends the Lead Poisoning Prevention Screening and Education Act to:

- Update the definition of "elevated blood-lead level" allowing DOH to update the blood-lead cutoff level to align with national guidance as the science determining acceptable blood-lead level changes;
- Require DOH to adopt rules to follow established national guidelines related to reporting elevated blood-levels;
- Remove certain requirements and provide flexibility for DOH to develop and distribute educational information on lead poisoning; and
- Reduce DOH's reporting and record maintenance requirements.

The bill amends the Newborn Screening Program to:

- Allow the State Laboratory to release metabolic tests to the parent or legal guardian, personal representative, or a person designated by the newborn's parent or legal guardian;
- Recognize that disorders with no known treatment may be added to the Newborn Screening Panel (NSP) and that detection of these disorders, even without treatment, helps families plan for the care of their children and avoid unnecessary costs in diagnosis; and
- Update the composition of the Genetics and Newborn Screening Advisory Council (GNSAC).

The bill removes the requirement for providers in healthcare settings to inform a person seeking an HIV test that a positive test result will be reported to the County Health Departments and of the availability and location of anonymous testing sites.

The bill also authorizes DOH to perform laboratory testing related to public health for other states on a fee-for-service basis.

The bill does not have a fiscal impact on state or local governments.

The bill has an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Human Immunodeficiency Virus

Current Situation

Human Immunodeficiency Virus (HIV) is an immune system debilitating virus that can lead to fatal acquired immunodeficiency syndrome (AIDS). HIV affects specific cells of the immune system and over time the virus can destroy enough of these cells that the body can no longer fight off infection and disease.[1] There is no cure for HIV but it can be controlled with proper medical care, including antiretroviral therapy (ART). If taken properly, ART can dramatically prolong the lives of people infected with HIV, keep them healthy, and greatly lower the chance of infecting others.[2] A person diagnosed with HIV and treated before the disease is able to advance can live nearly as long as someone who does not have HIV. However, untreated HIV is almost always fatal.[3]

HIV Testing

In the United States, approximately 1.2 million people are living with HIV, 12.5 % of which are unaware of their infection.[4] HIV testing is essential for improving the health of people living with HIV and reducing new HIV infections. The Centers for Disease Control and Prevention (CDC) recommend that testing occur as part of a routine healthcare visit.[5] This is especially important for people who may not consider themselves at risk for HIV.[6]

The most common type of HIV test is an HIV antibody test, where blood or saliva are checked for specific HIV fighting proteins known as HIV antibodies.[7] It can take 3 to 12 weeks for the body to produce enough HIV antibodies for the test to detect.[8] Nucleic acid tests (NATS) are another, less common, form of testing that can diagnose an HIV infection in a blood sample 1 to 4 weeks after a person is first infected.[9] Legal and programmatic advances have streamlined testing services to provide confidentiality, and, in some cases, anonymity to test subjects, to encourage widespread testing. To increase HIV screening, the CDC does not recommend prevention counseling with HIV diagnostic testing or as part of HIV screening programs in healthcare settings.[10] The CDC strongly encourages prevention counseling in settings in which routine assessment of risk behaviors occurs, but indicates it should not be required for HIV testing.[11]

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[1] Centers for Disease Control and Prevention, *About HIV/AIDS*, accessible at: http://www.cdc.gov/hiv/basics/whatishiv.html#panel0 (last accessed March 12, 2017).
[2] Id.
[3] Id.
[4] Centers for Disease Control and Prevention, *HIV in the United States: At a Glance,* accessible at: http://www.cdc.gov/hiv/statistics/basics/ataglance.html#ref1 (last accessed March 11, 2017).
[5] Centers for Disease Control and Prevention, *State HIV Testing Laws: Consent and Counseling Requirements*, July 11, 2013, accessible at http://www.cdc.gov/hiv/policies/law/states/testing.html (last accessed March 11, 2017).
[6] In Florida, only 42.2% of adults reported having ever been tested for HIV; Florida Department of Health, *Florida Charts*, accessible at: http://www.flhealthcharts.com/charts/Brfss/StateDataViewer.aspx?bid=119 (last accessed March 11, 2017).
[7] U.S. Department of Health and Human Services, *Types of HIV Tests*, accessible at: http://aids.gov/hiv-aids-basics/prevention/hiv-testing/hiv-test-types/index.html (last accessed March 11, 2017).
[8] Id.
[9] Id.
[10] Centers for Disease Control, MMWR, *Revised Recommendations for HIV testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*, 2006, available at: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm (last accessed March 12, 2017).
[11] Id.

HIV Testing in Florida

HIV testing in Florida is governed by s. 381.004, F.S., which creates a statewide network of confidential and anonymous HIV testing and counseling sites, procedures for HIV testing, informed consent requirements, and reporting requirements. The Department of Health (DOH) county health departments (CHDs) are the primary sources for state-sponsored HIV programs and provide testing, counseling, prevention outreach, and education to the public.[12] The statute was enacted to create an environment in Florida in which people will agree to or seek out HIV testing because they are sufficiently informed about HIV infection and assured about the privacy of a decision to be tested.[13]

To promote an environment of informed patient decision-making, providers are prohibited from performing an HIV test without a person's knowledge and informed consent, except under certain defined circumstances.[14] The statute gives the patient special rights to control who learns of the HIV test results and requires providers in both "health care"[15] and "nonhealth care"[16] settings to inform the person seeking an HIV test that a positive result will be reported to the CHD with sufficient information to identify the test subject and of the availability and location of sites that provide anonymous testing.[17]

Effect of Proposed Changes

HB 1041 amends s. 381.004(2)(a), F.S., to remove the requirement for providers in healthcare settings to inform a person seeking an HIV test that a positive test result will be reported to the CHD and of the availability and location of anonymous testing sites. Providers in nonhealth care settings will still be required to inform persons seeking HIV testing of those facts.

Pursuant to ss. 381.0031 and 384.25, F.S., providers in health care settings will still be required to report positive HIV test results to DOH.[18] The bill does not remove the reporting requirement, only the requirement to provide the person seeking an HIV test with the information that a positive result will be reported.

[12] County health departments are the local sector of the Florida Department of Health, providing public health services in all 67 Florida counties. Their core functions are infectious disease prevention and control, basic family health services, and environmental health services. Florida Department of Health, *County Health Departments*, accessible at: http://www.floridahealth.gov/public-health-in-your-life/county-health-departments/index.html (last accessed March 11, 2017).

[13] Hartog, Jack, *Florida's Omnibus AIDS Act: A Brief Legal Guide for Health Care Professionals,* Florida Dep't of Health, accessible at: http://www.floridahealth.gov/diseases-and-conditions/aids/administration/_documents/Omnibus-booklet-update-2013.pdf (last accessed March 12, 2017).

[14] Section 381.004(2)(h), F.S., lists the exceptions to the requirement to obtain informed consent, including: when a person is tested for sexually transmitted diseases; when blood, plasma, or other human fluids or tissues are donated; when a determination for appropriate emergency medical care or treatment is required; during an autopsy; when testing pregnant women; when a defendant is charged with sexual battery and is consented to by the defendant, pursuant to court order; or for certain research purposes.

[15] S. 381.004(1)(a), F.S.; "Health care setting" means a setting devoted to the diagnosis and care of persons or the provision of medical services to persons, such as county health department clinics, hospitals, urgent care clinics, substance abuse treatment clinics, primary care settings, community clinics, blood banks, mobile medical clinics, and correctional health care facilities.

[16] S. 381.004(1)(d), F.S.; "Nonhealth care setting" means a site that conducts HIV testing for the sole purpose of identifying HIV infection. Such setting does not provide medical treatment but may include community-based organizations, outreach settings, county health department HIV testing programs, and mobile vans.

[17] S. 381.004(2)(a), F.S.

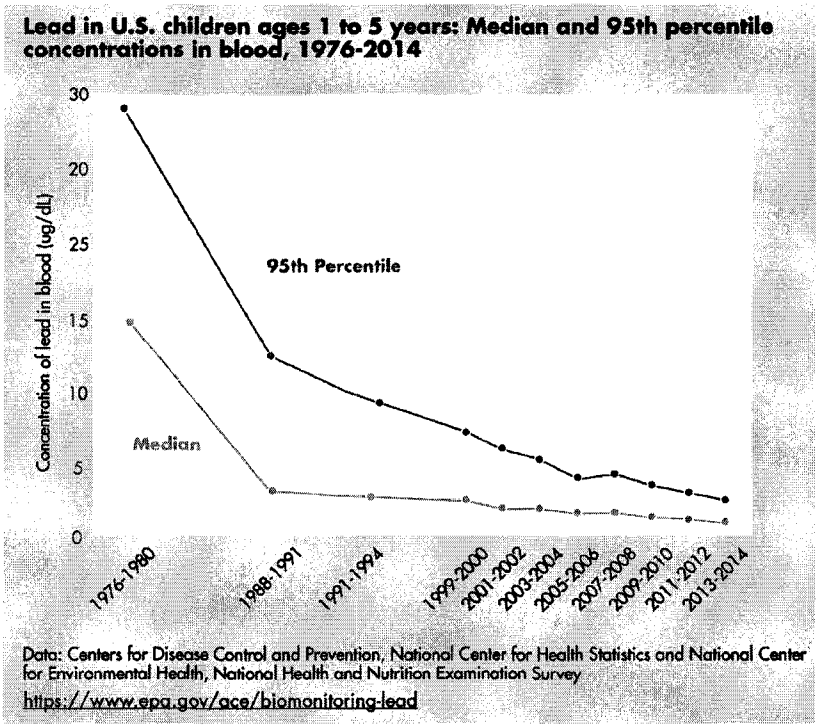
[18] Rule 64D-3.029, F.A.C.

Lead Screening and Education

Current Situation

Childhood Lead Poisoning

The CDC has termed excessive absorption of lead as "one of the most common pediatric health problems in the United States today, and it is entirely preventable."[19] Enough is known about the prevention of lead exposure to eradicate permanently this disease, making the persistence of lead poisoning in the U.S. a singular and direct challenge to public health authorities, clinicians, regulatory agencies, and society.[20] While the U.S. has not eradicated lead poisoning, tremendous progress in reducing lead exposure has been made.[21] Median blood lead levels of children in the U.S. have declined from 15 µg/dL from 1976-1980 to 0.7 µg/dL in 2013-214, a decrease of 95%.[22] The largest decline occurred from the 1970s to the 1990s following the elimination of lead in motor-vehicle gasoline, the ban on lead paint for residential use, removal of lead from solder in food cans, bans on the use of lead pipes and plumbing fixtures and other limitations on the uses of lead.[23]



The CDC reports that currently at least 4 million households have children living in them that are being exposed to high levels of lead.[24] While no safe blood level in children exists, there are approximately half a million children in the U.S. between the ages of 1 to 5 years old with blood levels above 5 micrograms per deciliter (µg/dL), the level at which the CDC recommends the initiation of public health action.[25]

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[19] Centers for Disease Control and Prevention, Preventing Lead Poisoning in Young Children, A Statement by the Centers for Disease Control, October 1991, available at: https://www.cdc.gov/nceh/lead/publications/books/plpyc/Chapter1.htm (last accessed March 12, 2017).
[20] Id.
[21] President's Task Force on Environmental Health Risks and Safety Risks to Children, *Key Federal Program to Reduce Childhood Lead Exposures and Eliminate Associated Health Impacts*, November 2016, available at: https://ptfceh.niehs.nih.gov/features/assets/files/key_federal_programs_to_reduce_childhood_lead_exposures_and_eliminate_associated_health_impactspresidents_508.pdf (last accessed March 12, 2017).
[22] Id.
[23] Id.
[24] Centers for Disease Control and Prevention, Lead, available at: https://www.cdc.gov/nceh/lead/ (last accessed March 13, 2017).
[25] Id.

Lead Poisoning Prevention Screening and Education Act

In 2006, the Legislature created the Lead Poisoning Prevention Screening and Education Act (Act). The Act requires DOH to establish a program for the early identification of persons at risk of having elevated blood-lead levels. Section 381.985(1), F.S., requires the program to systematically screen children under 6 years of age in certain target populations for the presence of elevated blood-lead levels. DOH is required to consult with professional medical groups and other sources and adopt rules that establish procedural guidelines for the screening of children under 6 years of age, appropriate intervals for screening, and follow-up for children found to have elevated blood-lead levels.[26] The Act defines "elevated blood-lead level" as a quantity of lead in whole venous blood that exceeds 10 µg/dL or such other level as provided in the Act.[27]

The Act requires DOH to establish a statewide, multifaceted, ongoing educational program designed to meet the needs of tenants, property owners, health care providers, early childhood educators, care providers, and realtors concerning lead poisoning prevention.[28] This educational program requires DOH to:

- Sponsor public service announcements on radio, television, print media, and the internet about the nature of lead-based paint hazards, the importance of standards for lead poisoning prevention, and the purposes and responsibilities of the Act; and
- Develop culturally and linguistically appropriate information pamphlets regarding lead poisoning, testing, prevention, treatment, and the purposes of the Act.[29]

DOH previously had federal funding to conduct a lead poisoning prevention program, including funding for a large media campaign.[30] However, the federal funding for this program ended in 2012.

The Act also requires DOH to maintain records of all screenings conducted pursuant to the Act indexed geographically and by owner to determine the location of areas of relatively high incidence of lead poisoning and other elevated blood-lead levels. All confirmed and probable cases of lead poisoning found in the course of screening must be reported to the affected individual, his or her parent or legal guardian if he or she is a minor, and the State Surgeon General.[31]

Effect of Proposed Changes

HB 1041 amends s. 381.985(1), F.S., to require DOH to adopt rules to follow established national guidelines or recommendations such as those issued by the Council of State and Territorial Epidemiologists and the CDC related to reporting elevated blood-levels. The bill amends the definition of "elevated blood-lead level" by removing the 10 µg/dL cutoff and requires the cutoff level to be specified by DOH rule. The rule must be based on national recommendations developed by the council of State and Territorial Epidemiologists and the CDC. This change allows DOH to change reporting and screening requirements as the science relating to blood-lead levels changes.

The bill amends s. 381.984, F.S., to remove the requirement for DOH to sponsor public service announcements and develop educational pamphlets. The change permits flexibility and cost savings in the distribution of information and educational materials regarding childhood lead poisoning.

The bill amends s. 381.985(3), F.S., to reduce the reporting and record maintenance requirements on DOH. The new language requires DOH to maintain comprehensive records of all screenings indicating an elevated blood-lead level and removes the requirement for DOH to report screening results to individuals. This change removes the requirement to maintain geographically indexed records and

[26] S. 381.985(1), F.S.
[27] S. 381.983(3), F.S.
[28] S. 381.984(1), F.S.
[29] Ss. 381.984(2) and (3), F.S.
[30] Department of Health, Agency Analysis of 2017 House Bill 1041, (March 1, 2017).
[31] S. 381.985(3), F.S.

creates s. 381.985(4), F.S., to require the health care provider who ordered or conducted the blood-lead level screen to report the results to the screened individual who, or the screened individual's parent or legal guardian if he or she is a minor.

Newborn Screening Program

Current Situation

Federal Recommendations for Newborn Screening

The United States Department of Health and Human Services (HHS) Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC)[32] was established to reduce morbidity and mortality in newborns and children who have, or are at risk for, heritable disorders.[33] The ACHDNC advises the Secretary of HHS on the most appropriate application of universal newborn and child screening tests and technical information for the development of policies and priorities that will enhance the ability of state and local health agencies to provide for screening, counseling, and health care services for newborns and children having, or at risk for, heritable disorders.[34] As part of this process, ACHDNC establishes the list of heritable disorders on the federal Recommended Uniform Screening Panel (RUSP). The RUSP currently recommends screening for 32 core conditions and 26 secondary conditions.[35]

Florida Newborn Screening Program

Section 383.14(5), F.S., establishes the Florida Genetics and Newborn Screening Advisory Council (GNSAC) to advise the Department of Health (DOH) about which disorders should be added to the Newborn Screening Program (NSP) panel of screened disorders and the procedures for collecting and transmitting specimens.[36] Florida's NSP currently screens for 50 of the 58 disorders recommended by the RUSP, including 31 core conditions and 28 secondary conditions.[37] Currently, every disorder on the NSP panel has known treatment options. However, the GNSAC recommended the addition of X-linked ALD (ALD)[38] on February 19, 2016. One of ALD's presentations has no known treatment at this time.[39]

The GNASC is made up of 15 members, including consumer members, various state agency representatives and healthcare providers, and one representative from each of the four medical schools in the state.[40] When the GNSAC was created, the state only had 4 medical schools. Currently there are 10 medical schools in Florida.

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[32] 42 U.S.C. s. 300b-10; 42 U.S.C. s. 217a: Advisory councils or committees (2016).
[33] U.S. Department of Health and Human Services, *Advisory Committee on Heritable Disorders in Newborns and Children*, http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/index.html (last accessed March 11, 2017).
[34] Secretary of Health and Human Services, *Charter Discretionary Advisory Committee on Heritable Disorders in Newborns and Children*, April 24, 2013, available at: http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/about/charterdachdnc.pdf (last accessed March 11, 2017).
[35] Advisory Committee on Heritable Disorders in Newborns and Children, *Recommended Uniform Screening Panel (as of November 2016), available at*: http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf (last visited March 11, 2017).
[36] S. 383.14(5), F.S.
[37] Florida Department of Health, *Disorder List*, available at: http://www.floridahealth.gov/programs-and-services/childrens-health/newborn-screening/_documents/newborn-screening-disorders.pdf (last accessed March 11, 2017); this list is also maintained by DOH in Rule Rule 64C-7.002, F.A.C.
[38] X-Linked ALD is a genetic disorder that occurs primarily in males with an incidence rate of approximately 1 in 20,000-50,000. It mainly affects the nervous system and the adrenal glands, which are small glands located on top of each kidney. In this disorder, the fatty covering (myelin) that insulates nerves in the brain and spinal cord is prone to deterioration (demyelination), which reduces the ability of the nerves to relay information to the brain. In addition, damage to the outer layer of the adrenal glands (adrenal cortex) causes a shortage of certain hormones (adrenocortical insufficiency). Adrenocortical insufficiency may cause weakness, weight loss, skin changes, vomiting, and coma. There are three distinct types of X-linked adrenoleukodystrophy: a childhood cerebral form, an adrenomyeloneuropathy type, and a form called Addison disease only.
[39] Infra, FN 46 at pg. 3.
[40] Supra, FN 36

The NSP screens all newborns for hearing impairment and to identify, diagnose, and manage newborns at risk for selected disorders that, without detection and treatment, can lead to permanent developmental and physical damage or death.[41] The NSP involves coordination among several entities, including the Bureau of Public Health Laboratories Newborn Screening Laboratory in Jacksonville (State Laboratory), Children's Medical Services (CMS) Newborn Screening Follow-up Program, and referral centers, birthing centers, and physicians throughout the state.[42]

Currently, the State Laboratory is only authorized to release the results of a newborn's metabolic tests or screenings to the newborn's health care practitioner.[43] Federal regulations require public health laboratories to release screening results, upon request, to the patient, the patent's parent or legal guardian, the patient's personal representative, or person designated by the patient or legal guardian.[44]

Effect of Proposed Changes

HB 1041 amends s. 383.14(5), F.S., to update the composition of the GNSAC to include a representative from 4 of the 10 medical schools in the state. The number of medical school representatives remains the same, but this change allows representatives from all medical schools in the state the potential to be appointed to the GNSAC, not just those medical schools in existence when the GNSAC was created.

The bill amends s. 383.14(1)(c), F.S, to allow the State Laboratory to release metabolic tests or screenings to a newborn's parent or legal guardian, the newborn's personal representative, or a person designated by the newborn's parent or legal guardian. This change aligns state law with federal regulations relating to public health laboratories.

The bill also amends s. 383.14(3)(f), F.S., to recognize that disorders with no known treatment may be added to the NSP panel and that detection of these disorders, even without treatment, helps families plan for the care of their children and avoid unnecessary costs in diagnosis. The bill also adds language to this paragraph to recognize that DOH's duty to promote genetic studies includes the promotion of the services associated with those studies. These changes update the duties of DOH to reflect the advances of newborn screening and disorder detection as well as promote the availability of evidence-based services associated with genetic studies.

Public Health Laboratory Testing for Other States

Current Situation

Section 381.0202, F.S., directs DOH to establish and maintain laboratories in the state for microbiological and chemical analysis and any other purpose it determines necessary for the protection of public health. DOH operates the Bureau of Public Health Laboratories that provide diagnostic screening, monitoring, reference, research and emergency public health laboratory services to county health departments and other official agencies, physicians, hospitals and private laboratories.[45]

Due to costs and resource limitations, it is not feasible for all 50 states to maintain public health testing infrastructure.[46] Furthermore, reagents to test for rare or emerging pathogens are often only available in

[41] Florida Department of Health, Florida Newborn Screening Guidelines, 2012, available at: https://www.peds.ufl.edu/divisions/genetics/programs/newborn_screening/2012%20newborn%20screening%20guidelines%20FL.pdf (last accessed March 11, 217).
[42] Florida Department of Health, Newborn Screening, http://www.floridahealth.gov/programs-and-services/childrens-health/newborn-screening/ (last accessed March 11, 2017).
[43] S. 383.14(1)(c), F.S.
[44] 42 C.F.R. § 493.1291(l)
[45] Florida Department of Health, Bureau of Public Health Laboratories, available at: http://www.floridahealth.gov/programs-and-services/public-health-laboratories/index.html (last accessed March 13, 2017).
[46] Department of Health, Agency Analysis of 2017 House Bill 1041, (March 1, 2017).

limited quantities from the CDC.[47] In response, the CDC advocates for the establishment of regional testing centers to perform specialized testing for multiple states.[48]

Current statutory language does not give DOH authority to perform public health laboratory testing for samples from other states.

Effect of Proposed Changes

HB 1041 amends s. 381.0202, F.S., to authorize DOH to perform laboratory testing related to public health for other states on a fee-for-service basis.

The bill provides for an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 381.004, F.S., relating to HIV testing.
Section 2: Amends s. 381.0202, F.S., relating to laboratory services.
Section 3: Amends s. 381.983, F.S., relating to definitions.
Section 4: Amends s. 381.984, F.S., relating to educational programs.
Section 5: Amends s. 381.985, F.S., relating to screening program.
Section 6: Amends s. 383.14, F.S., relating to screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.
Section 7: Provides for an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Any revenue for lab testing services performed by DOH for other states would be cost neutral. The per test cost varies between $40-$60 and DOH would charge other states the actual cost per test, to include the cost of reagents, controls, labor, and overhead required to produce the result. DOH anticipates performing fewer than 10 tests per month.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

[47] Id.
[48] Id.

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:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to laboratory screening; amending s. 381.004, F.S.; clarifying that certain requirements related to the reporting of positive HIV test results to county health departments apply only to testing performed in a nonhealth care setting; amending s. 381.0202, F.S.; authorizing the Department of Health to perform laboratory testing for other states; amending s. 381.983, F.S.; redefining the term "elevated blood-lead levels"; amending s. 381.984, F.S.; authorizing, rather than requiring, that the Governor, in conjunction with the State Surgeon General, sponsor a public information initiative on lead-based paint hazards; amending s. 381.985, F.S.; revising requirements for the State Surgeon General's program for early identification of persons at risk of having elevated blood-lead levels; requiring the department to maintain records showing elevated blood-lead levels; requiring that health care providers report to the individual who was screened the results that indicate elevated blood-lead levels; amending s. 383.14, F.S.; authorizing the State Public Health Laboratory to release the results of a newborn's hearing and metabolic tests to certain individuals; requiring the department to promote the availability

of services to promote detection of genetic conditions; clarifying that the membership of the Genetics and Newborn Screening Advisory Council must include one member representing each of four medical schools in this state; providing an effective date.

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

Section 1. Paragraph (a) of subsection (2) of section 381.004, Florida Statutes, is amended to read:

381.004 HIV testing.—

(2) HUMAN IMMUNODEFICIENCY VIRUS TESTING; INFORMED CONSENT; RESULTS; COUNSELING; CONFIDENTIALITY.—

(a) Before performing an HIV test:

1. In a health care setting, the person to be tested shall be notified orally or in writing that the test is planned and that he or she has the right to decline the test. If the person to be tested declines the test, such decision shall be documented in the medical record. A person who has signed a general consent form for medical care is not required to sign or otherwise provide a separate consent for an HIV test during the period in which the general consent form is in effect.

2. In a nonhealth care setting, a provider shall obtain the informed consent of the person upon whom the test is to be performed. Informed consent shall be preceded by an explanation

of the right to confidential treatment of information identifying the subject of the test and the results of the test as provided by law. The provider shall also inform the test subject that a positive HIV test result will be reported to the county health department with sufficient information to identify the test subject and provide him or her with information on the availability and location of sites where anonymous testing is performed. As required in paragraph (3)(c), each county health department shall maintain a list of sites where anonymous testing is performed which includes site locations, telephone numbers, and hours of operation.

~~The test subject shall also be informed that a positive HIV test result will be reported to the county health department with sufficient information to identify the test subject and of the availability and location of sites at which anonymous testing is performed. As required in paragraph (3)(c), each county health department shall maintain a list of sites at which anonymous testing is performed, including the locations, telephone numbers, and hours of operation of the sites.~~

Section 2. Section 381.0202, Florida Statutes, is amended to read:

381.0202 Laboratory services.—

(1) The department shall establish and maintain, in suitable and convenient places in the state, laboratories for

microbiological and chemical analyses and any other purposes it determines necessary for the protection of the public health.

(2) The department may contract or agree with any person or public or private agency to provide laboratory services relating to or having potential impact on the public health or relating to the health of clients directly under the care of the state.

(3) The department is authorized to establish and collect reasonable fees and charges for laboratory services provided. Such fees and charges shall be deposited in a trust fund administered by the department and shall be used solely for this purpose.

(4) The department may perform laboratory testing related to public health for other states on a fee-for-service basis.

Section 3. Subsection (3) of section 381.983, Florida Statutes, is amended to read:

381.983 Definitions.—As used in this act, the term:

(3) "Elevated blood-lead level" means a quantity of lead in the ~~whole venous~~ blood, measured from a venous or capillary draw ~~expressed in micrograms per deciliter (ug/dL)~~, which exceeds the cutpoint specified in department rule. The determination of elevated blood-lead level must be based on national recommendations developed by the Council of State and Territorial Epidemiologists and the Centers for Disease Control and Prevention. ~~10 ug/dL or such other level as specifically~~

~~provided in this act.~~

Section 4. Subsections (2) and (3) of section 381.984, Florida Statutes, are amended to read:

381.984 Educational programs.—

(2) PUBLIC INFORMATION INITIATIVE.—The Governor, in conjunction with the State Surgeon General and his or her designee, may ~~shall~~ sponsor a series of public service announcements on radio, television, and the Internet~~,~~ and in print media about the nature of lead-based-paint hazards, the importance of standards for lead poisoning prevention in properties, and the purposes and responsibilities set forth in this act. In developing and coordinating this public information initiative, the sponsors may ~~shall~~ seek the participation and involvement of private industry organizations, including those involved in real estate, insurance, mortgage banking, and pediatrics.

(3) DISTRIBUTION OF INFORMATION ~~LITERATURE~~ ABOUT CHILDHOOD LEAD POISONING.~~—By January 1, 2007,~~ The State Surgeon General or his or her designee shall develop culturally and linguistically appropriate information and distribution methods ~~pamphlets~~ regarding childhood lead poisoning, the importance of testing for elevated blood-lead levels, prevention of childhood lead poisoning, treatment of childhood lead poisoning, and, as ~~where~~ appropriate, the requirements of this act. This ~~These~~ information ~~pamphlets~~ shall be distributed to parents or ~~the~~

~~other~~ legal guardians of children 6 years of age or younger on the following occasions:

(a) By a health care provider at the time of a child's birth and at the time of any childhood immunization or vaccination unless it is established that such information ~~pamphlet~~ has been provided ~~previously~~ to the parent or legal guardian by the health care provider within the prior 12 months.

(b) By the owner or operator of any child care facility or preschool or kindergarten class on or before each October 15 ~~of the calendar year~~.

Section 5. Section 381.985, Florida Statutes, is amended to read:

381.985 Screening program.—

(1) The State Surgeon General shall establish guidelines ~~a program~~ for early identification of persons at risk of having elevated blood-lead levels and for the systematic screening of ~~. Such program shall systematically screen~~ children under 6 years of age in the target populations identified in subsection (2) for the presence of elevated blood-lead levels. Children within the specified target populations shall be screened with a blood-lead test at age 12 months and age 24 months, or between the ages of 36 months and 72 months if they have not previously been screened. The State Surgeon General shall, after consultation with recognized professional medical groups and such other sources as the State Surgeon General deems appropriate, adopt

rules to follow established national guidelines or recommendations such as those issued by the Council of State and Territorial Epidemiologists and the Centers for Disease Control and Prevention related to reporting elevated blood-lead levels and screening results to the department pursuant to this section. ~~promulgate rules establishing:~~

~~(a) The means by which and the intervals at which such children under 6 years of age shall be screened for lead poisoning and elevated blood-lead levels.~~

~~(b) Guidelines for the medical followup on children found to have elevated blood-lead levels.~~

(2) In developing screening programs to identify persons at risk with elevated blood-lead levels, priority shall be given to persons within the following categories:

(a) All children enrolled in the Medicaid program at ages 12 months and 24 months, or between the ages of 36 months and 72 months if they have not previously been screened.

(b) Children under the age of 6 years exhibiting delayed cognitive development or other symptoms of childhood lead poisoning.

(c) Persons at risk residing in the same household, or recently residing in the same household, as another person at risk with an elevated ~~a~~ blood-lead level ~~of 10 ug/dL or greater~~.

(d) Persons at risk residing, or who have recently resided, in buildings or geographical areas in which significant

numbers of cases of lead poisoning or elevated blood-lead levels have recently been reported.

(e) Persons at risk residing, or who have recently resided, in an affected property contained in a building that during the preceding 3 years has been subject to enforcement for violations of lead-poisoning-prevention statutes, ordinances, rules, or regulations ~~as specified by the State Surgeon General~~.

(f) Persons at risk residing, or who have recently resided, in a room or group of rooms contained in a building whose owner also owns a building containing affected properties which, during the preceding 3 years, has been subject to an enforcement action for a violation of lead-poisoning-prevention statutes, ordinances, rules, or regulations.

(g) Persons at risk residing in other buildings or geographical areas in which the State Surgeon General reasonably determines there is ~~to be~~ a significant risk of affected individuals having an elevated blood-lead level. ~~a blood-lead level of 10 ug/dL or greater.~~

(3) The department ~~State Surgeon General~~ shall maintain comprehensive records of all screenings indicating an elevated blood-lead level. ~~conducted pursuant to this section. Such records shall be indexed geographically and by owner in order to determine the location of areas of relatively high incidence of lead poisoning and other elevated blood-lead levels.~~

~~All cases or probable cases of lead poisoning found in the course of screenings conducted pursuant to this section shall be reported to the affected individual, to his or her parent or legal guardian if he or she is a minor, and to the State Surgeon General.~~

(4) The results of screenings conducted pursuant to this section shall be reported by the health care provider who conducted or ordered the screening to the individual who was screened, or to the individual's parent or legal guardian if he or she is a minor.

Section 6. Paragraph (c) of subsection (1), paragraph (f) of subsection (3), and subsection (5) of section 383.14, Florida Statutes, are amended to read:

383.14 Screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.—

(1) SCREENING REQUIREMENTS.—To help ensure access to the maternal and child health care system, the Department of Health shall promote the screening of all newborns born in Florida for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect, as screening programs accepted by current medical practice become available and practical in the judgment of the department. The department shall also promote the identification and screening of all newborns in this state and their families for environmental risk factors such as low income, poor education, maternal and family

stress, emotional instability, substance abuse, and other high-risk conditions associated with increased risk of infant mortality and morbidity to provide early intervention, remediation, and prevention services, including, but not limited to, parent support and training programs, home visitation, and case management. Identification, perinatal screening, and intervention efforts shall begin prior to and immediately following the birth of the child by the attending health care provider. Such efforts shall be conducted in hospitals, perinatal centers, county health departments, school health programs that provide prenatal care, and birthing centers, and reported to the Office of Vital Statistics.

(c) *Release of screening results.*—Notwithstanding any law to the contrary, the State Public Health Laboratory may release, directly or through the Children's Medical Services program, the results of a newborn's hearing and metabolic tests or screenings to the newborn's health care practitioner, the newborn's parent or legal guardian, the newborn's personal representative, or a person designated by the newborn's parent or legal guardian. As used in this paragraph, the term "health care practitioner" means a physician or physician assistant licensed under chapter 458; an osteopathic physician or physician assistant licensed under chapter 459; an advanced registered nurse practitioner, registered nurse, or licensed practical nurse licensed under part I of chapter 464; a midwife licensed under chapter 467; a

speech-language pathologist or audiologist licensed under part I of chapter 468; or a dietician or nutritionist licensed under part X of chapter 468.

(3) DEPARTMENT OF HEALTH; POWERS AND DUTIES.—The department shall administer and provide certain services to implement the provisions of this section and shall:

(f) Promote the availability of genetic studies, services, and counseling in order that the parents, siblings, and affected newborns may benefit from detection and available knowledge of the condition.

All provisions of this subsection must be coordinated with the provisions and plans established under this chapter, chapter 411, and Pub. L. No. 99-457.

(5) ADVISORY COUNCIL.—There is established a Genetics and Newborn Screening Advisory Council made up of 15 members appointed by the State Surgeon General. The council shall be composed of two consumer members, three practicing pediatricians, at least one of whom must be a pediatric hematologist, a ~~one~~ representative from each of ~~the~~ four medical schools in this ~~the~~ state, the State Surgeon General or his or her designee, one representative from the Department of Health representing Children's Medical Services, one representative from the Florida Hospital Association, one individual with experience in newborn screening programs, one individual

representing audiologists, and one representative from the Agency for Persons with Disabilities. All appointments shall be for a term of 4 years. The chairperson of the council shall be elected from the membership of the council and shall serve for a period of 2 years. The council shall meet at least semiannually or upon the call of the chairperson. The council may establish ad hoc or temporary technical advisory groups to assist the council with specific topics which come before the council. Council members shall serve without pay. Pursuant to the provisions of s. 112.061, the council members are entitled to be reimbursed for per diem and travel expenses. It is the purpose of the council to advise the department about:

(a) Conditions for which testing should be included under the screening program and the genetics program.

(b) Procedures for collection and transmission of specimens and recording of results.

(c) Methods whereby screening programs and genetics services for children now provided or proposed to be offered in the state may be more effectively evaluated, coordinated, and consolidated.

Section 7. This act shall take effect July 1, 2017.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1121 Child Welfare
SPONSOR(S): Children, Families & Seniors Subcommittee, Stevenson
TIED BILLS: **IDEN./SIM. BILLS:** SB 1044

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	10 Y, 0 N, As CS	Tuszynski	Brazzell
2) Health Care Appropriations Subcommittee		Fontaine	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Chapter 39, F.S., creates Florida's child welfare system that aims to protect children and prevent abuse, abandonment, and neglect. The Department of Children and Families (DCF) Office of Child Welfare works in partnership with local communities and the courts to ensure the safety, timely permanency and well-being of children.

DCF's child welfare practice model (model) standardizes the approach to risk assessment and decision making used to determine a child's safety. The model seeks to achieve the goals of safety, permanency, and child and family well-being. The model emphasizes parent engagement and empowerment as well as the training and support of child welfare professionals to assess child safety and emphasizes a family-centered practice with the goal of keeping children in their homes whenever possible.

HB 1121 makes multiple changes to the child welfare statutes to protect vulnerable children. The bill:

- Improves the assessment of risk for children by changing the process that DCF and the dependency court use to assess and order services for substance exposed newborns and children who enter households already under investigation or under the dependency court's jurisdiction;
- Expedites permanency for children by making changes to the procedures the dependency court and DCF use to identify and locate prospective parents requiring an inquiry and search much earlier in the dependency case; and
- Fosters more meaningful engagement of families by making changes that facilitate more participation by a child in his or her case planning, streamline processes for child protective investigators, and align statute with current practice to include conditions for return and Family Functioning Assessments.

The bill also:

- Allows DCF to use confidential abuse registry information and investigation records for residential group home employment screening, to align with foster home screening requirements;
- Defines "Child Welfare Trainer" and grants DCF rulemaking authority to create requirements for child welfare trainers;
- Permits hospitals and physician's offices to release patient records to DCF or its contracted entities for the purpose of investigations of or services for cases of abuse, neglect, or exploitation of children or vulnerable adults;
- Repeals obsolete sections of law related to residential group care, including provisions dealing with equitable reimbursement for group care services and reimbursement methodology; and
- Makes conforming cross reference changes based on the provisions of the bill.

The bill does not appear to have a fiscal impact on state or local government, or the court system.

The bill provides for an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Florida's Child Welfare System

Chapter 39, F.S., creates Florida's child welfare system that aims to protect children and prevent abuse, abandonment, and neglect.[1] The Department of Children and Families (DCF) Office of Child Welfare works in partnership with local communities and the courts to ensure the safety, timely permanency and well-being of children.

DCF's practice model is based on preserving and strengthening the child's family ties whenever possible, removing the child from his or her home only when his or her welfare and safety cannot be adequately safeguarded otherwise.[2] DCF contracts with community-based care lead agencies to coordinate case management and services for families within the dependency system.

Practice Model

DCF's child welfare practice model (model) standardizes the approach to risk assessment and decision making used to determine a child's safety.[3] The model seeks to achieve the goals of safety, permanency, and child and family well-being.[4] The model emphasizes parent engagement and empowerment as well as the training and support of child welfare professionals to assess child safety,[5] and emphasizes a family-centered practice with the goal of keeping children in their homes whenever possible.[6]

Community-Based Care Organizations and Services

DCF contracts for case management, out-of-home care, and related services with lead agencies, also known as community-based care organizations (CBCs). The model of using CBCs to provide child welfare services is designed to increase local community ownership of service delivery and design.[7]

DCF, through the CBCs, is required to administer a system of care[8] for children that is directed toward:

- Prevention of separation of children from their families;
- Intervention to allow children to remain safely in their own homes;
- Reunification of families who have had children removed from their care;
- Safety for children who are separated from their families;
- Focus on the well-being of children through emphasis on educational stability and timely health care;
- Permanency; and
- Transition to independence and self-sufficiency.

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[1] S. 39.001(8), F.S.
[2] S. 39.001(4), F.S.
[3] The Department of Children and Families, *2013 Year in Review*, available at: http://www.dcf.state.fl.us/admin/publications/year-in-review/2013/page19.shtml (last accessed March 6, 2017).
[4] The Department of Children and Families, *Florida's Child Welfare Practice Model*, available at: http://www.myflfamilies.com/service-programs/child-welfare/child-welfare-practice-model (last accessed March 7, 2017).
[5] Supra, FN 3.
[6] The Department of Children and Families, *2012 Year in Review*, available at: http://www.dcf.state.fl.us/admin/publications/year-in-review/2012/page9.shtml (last accessed March 7, 2017).
[7] Community-Based Care, The Department of Children and Families, accessible at http://www.myflfamilies.com/service-programs/community-based-care (last viewed February 12, 2016).
[8] S. 409.145(1), F.S.

CBCs are responsible for providing foster care and related services. These services include, but are not limited to, counseling, domestic violence services, substance abuse services, family preservation, emergency shelter, and adoption.[9] The CBC must give priority to services that are evidence-based and trauma informed.[10] CBCs contract with a number of subcontractors for case management and direct care services to children and their families.[11] There are 17 CBCs statewide, which together serve the state's 20 judicial circuits.[12]

Dependency Case Process

When child welfare necessitates that DCF remove a child from his or her home, a series of dependency court proceedings must occur to adjudicate the child dependent and place him or her in out-of-home care, as indicated by the chart below.

Proceeding	Description	Statute
Removal	The child's home is determined to be unsafe, and the child is removed	s. 39.401, F.S.
Shelter Hearing	A shelter hearing occurs within 24 hours after removal. The judge determines whether to keep the child out-of-home.	s. 39.401, F.S.
Petition for Dependency	A petition for dependency occurs within 21 days of the shelter hearing. This petition seeks to find the child dependent.	s. 39.501, F.S.
Arraignment Hearing and Shelter Review	An arraignment and shelter review occurs within 28 days of the shelter hearing. This allows the parent to admit, deny, or consent to the allegations within the petition for dependency and allows the court to review any shelter placement.	s. 39.506, F.S.
Dependency Adjudicatory Trial	An adjudicatory trial is held within 30 days of arraignment, to determine whether a child is dependent.	s. 39.507, F.S.
Disposition Hearing	Disposition occurs within 15 days of arraignment or 30 days of adjudication. The judge reviews and orders the case plan for the family and the appropriate placement of the child.	ss. 39. 506 and 39.521, F.S.
Judicial Review Hearings	The court must review the case plan and placement every 6 months, or upon motion of a party.	s. 39.701, F.S.
Petition for Termination of Parental Rights (TPR)	After 12 months, if DCF determines that reunification is no longer a viable goal, termination of parental rights is in the best interest of the child, and other requirements are met, a petition for TPR is filed.	ss. 39.802, 39.8055, 39.806, and 39.810, F.S.
Advisory Hearing	This hearing is set as soon as possible after all parties have been served with the petition for TPR. The hearing allows the parent to admit, deny, or consent to the allegations within the petition for TPR.	s. 39.808, F.S.
TPR Adjudicatory Trial	An adjudicatory trial shall be set within 45 days after the advisory hearing. The judge determines whether to terminate parental rights to the child at this trial.	s. 39.809, F.S.

Throughout the dependency process, multiple child welfare stakeholders, including case managers, Guardians ad Litem, service providers, and the court monitor a child's well-being and safety.

[9] Id.
[10] S. 409.988(3), F.S.
[11] Supra, FN 7.
[12] Community Based Care Lead Agency Map, The Department of Children and Families, available at: http://www.myflfamilies.com/service-programs/community-based-care/cbc-map (last accessed March 6, 2017).

HB 1121 makes multiple changes to the child welfare statutes to protect vulnerable children. The bill improves the assessment of risk for children by making changes to the process that DCF and the dependency court use to assess substance exposed newborns and children who enter households already under investigation or under the dependency court's jurisdiction. The bill expedites permanency for children by making changes to the procedures the dependency court and DCF use to identify and locate prospective parents requiring inquiry and searches much earlier in the dependency case. The bill also fosters more meaningful engagement of families by making multiple changes that facilitate more participation by a child in his or her case planning, streamline processes for child protective investigators, and align statute with current practice.

Determination of Paternity and Diligent Searches

Current Situation

Statute defines "parent" to mean a woman who gives birth to a child and a man whose consent to the adoption[13] of the child would be required.[14] If a child has been legally adopted, the term "parent" means the adoptive mother or father of the child.[15] The term does not include an individual whose parental relationship to the child has been legally terminated or a prospective parent.[16]

If the identity or location of a parent is unknown, the court is required to conduct an inquiry to identify or locate that parent. This inquiry requirement is found in the sections of statute relating to dependency adjudication[17] and termination of parental rights (TPR),[18] but there is no requirement for this paternity inquiry during a shelter hearing.[19] In both sections where required, the court must inquire:[20]

- Whether the mother of the child was married at the probable time of conception of the child or at the time of birth of the child.
- Whether the mother was cohabiting with a male at the probable time of conception of the child.
- Whether the mother has received payments or promises of support with respect to the child or because of her pregnancy from a man who claims to be the father.
- Whether the mother has named any man as the father on the birth certificate of the child or in connection with applying for or receiving public assistance.
- Whether any man has acknowledged or claimed paternity of the child in a jurisdiction in which the mother resided at the time of or since conception of the child, or in which the child has resided or resides.

A diligent search is required when the identity or location of a prospective parent is unknown. Currently, diligent search requirements under ss. 39.503(6) and 39.803(6) are not the same. A diligent search under s. 39.503(6), F.S., must include:

- A search of an electronic database designed for locating persons;
- Inquiries of all offices of program areas of DCF likely to have information about the parent or prospective parent;
- Inquiries of other state and federal agencies likely to have information about the parent or prospective parent;
- Inquiries of appropriate utility and postal providers;
- A thorough search of at least one electronic database specifically designed for locating persons; and
- Inquiries of appropriate law enforcement agencies.

[13] S. 63.062(1) F.S
[14] S. 39.01(49), F.S.
[15] Id.
[16] Id.
[17] S. 39.503, F.S.
[18] S. 39.803, F.S.
[19] S. 39.402(8), F.S.
[20] S. 39.503(1), F.S.

However, a diligent search under s. 39.803(6), F.S., does not require the search of an electronic database, and a search of the Florida Putative Father Registry is not currently required under either section.

If the court's inquiry and a subsequent diligent search identify a prospective parent, that person must be given the opportunity to become a party to the proceedings by completing a sworn affidavit of parenthood and filing it with the court or DCF.[21] A prospective parent who files a sworn affidavit of parenthood shall be considered a parent for all purposes under the statute unless the other parent contests the determination of parenthood.[22] When a prospective parent contests recognition as a parent, current statute requires the dependency court to delay determination of maternity or paternity until proceedings under a separate chapter relating to determination of parentage are final.[23]

Effect of Proposed Language

The bill creates a definition of "legal father" to mean a man married to the mother at the time of conception or birth of the child, unless paternity has been otherwise determined by a court of competent jurisdiction. If no man was married to the mother at the time of birth or conception of the child, then "legal father" means a man named on the birth certificate of the child or determined by a court order or administrative proceeding to be the father of the child. The bill also revises the definition of "parent" to reflect this new language.

The bill requires the court, when conducting a paternity inquiry at adjudication of dependency and TPR, to do so under oath and to inquire whether a man is named on the birth certificate of the child or whether a man has been determined by a court order or administrative proceeding to be the father of the child. The bill also requires a trial court to conduct the same paternity inquiry under oath at the shelter hearing to determine the identity and location of the legal father. These changes will expedite permanency by requiring a paternity inquiry during the earliest step in the dependency process involving the court, the shelter hearing, and by including expanded instances of paternity determination to identify legal fathers sooner in the process.

The bill allows a court to order scientific testing within the dependency proceeding to determine the maternity or paternity of a child if an identified prospective parent does not file a sworn affidavit of parenthood or if the other parent contests the determination of parenthood. If the court finds the prospective parent to be a parent as a result of the scientific testing, the bill requires the court to enter a judgment of maternity or paternity, assess the cost of the scientific testing to the parent, and enter an amount of child support to be paid.

The bill requires a search of the Florida Putative Father Registry when conducting a diligent search. The bill also aligns the various diligent search requirements in different sections of ch. 39, F.S. This requires a search of at least one electronic database, as well as the Florida Putative Father Registry, when conducting a diligent search for a prospective parent whose location or identity are unknown and clarifies that DCF is the state agency administering Title IV-B and IV-E funds such that it shall be provided access to the federal and state locator services pursuant to federal law.[24] The bill also permits a trial court to proceed with a dependency case without further notice to prospective parents if a diligent search fails to identify and locate him or her.

If the court has ordered that no further notice is required to a prospective parent that a diligent search has failed to identify or locate, the bill provides that personal service and notice relating to the petition to terminate parental rights does not need to be provided to that prospective parent. The bill requires that, if there is not an identified legal father, notice of the petition for termination of parental rights must be provided to any prospective father that has been identified and located unless the prospective father

[21] S. 39.503(8), F.S.
[22] Id.
[23] Ch. 742, F.S.
[24] 42 U.S.C. s. 653(c)(4)

executes, and the court accepts, an affidavit of non-paternity or a consent to termination of his parental rights.

These changes relating to paternity and diligent search will expedite permanency for children whose adoption or other permanency plans are delayed by the inability to identify or locate prospective parents by moving the initial inquiry of paternity to the start of the case and allowing more efficient procedures when DCF is unable to locate prospective parents.

Adjudication of Dependency

Current Situation

Statute requires that a dependency case have only one order of adjudication.[25] The order of adjudication establishes the legal status of the child as dependent and may be based on the conduct of one parent, both parents, or a legal custodian.[26] If the court holds a subsequent evidentiary hearing on allegations against the other parent, the court can supplement the adjudicatory order, the disposition order, and the case plan.[27] This supplemental order grants the court jurisdiction over the other parent and allows the court to order services for that parent.

In certain areas of the state, based on a holding from the Fifth District Court of Appeal (DCA), [28] a child can be adjudicated dependent as to the first parent based upon evidence of *risk of harm* but cannot be adjudicated dependent as to the second parent unless *actual harm* is proven. The court held that a supplemental evidentiary hearing on dependency adjudication must address whether the parent had actually abused or neglected the child, not whether the child was at substantial risk of imminent abuse or neglect. [29]

In contrast, the Third DCA[30] rejected the Fifth DCA's reasoning and held that a court can supplement the adjudicatory order where a child is at substantial risk of abuse, abandonment, or neglect.[31]

Effect of Proposed Language

The bill requires a court to determine whether each parent has engaged in conduct that places the child at substantial risk of imminent abuse, abandonment, or neglect. If an initial evidentiary hearing is conducted with only one parent present or having been served, the evidentiary hearing shall address the abuse, abandonment, or neglect alleged in the petition regardless of whether any of the allegations are made against the second parent. The bill further clarifies that the petitioner is not required to show actual harm by the second parent in order for the court to make supplemental findings regarding the conduct of the second parent. This change will protect children in the circuits of the Fifth DCA by allowing risk of harm, the same standard required by the initial adjudication, by a second parent to be sufficient to supplement an order of adjudication and order services for the second parent.

[25] S. 39.507(7)(a), F.S.
[26] Id.
[27] S. 39.507(7)(b), F.S.
[28] Including Circuits 5 (Hernando, Lake, Marion, Citrus, and Sumter), 7 (Flagler, Putnam, St. Johns, and Volusia), 9 (Orange and Osceola), and 18 (Brevard and Seminole).
[29] P.S. v. Department of Children and Families, 4 So. 3d 719 (Fla. 5th DCA 2009).
[30] Including Miami-Dade and Monroe Counties.
[31] (D.A. v. Department of Children & Family Services, 84 So. 3d 1136 (Fla. 3d DCA 2012).

Safety Assessments for Children Born or Moving Into a Household

Current Situation

DCF's current policy regarding new children in households with an active investigation or ongoing services requires the CPI or Case Manager to add any new child(ren) in a household to the child welfare case and assess the new child as part of the Family Functioning Assessment.[32] DCF requires an ongoing assessment as to how the parent will manage the care of the new child, the family conditions that led to the safety plan, how the birth of the child or addition of the child will affect those family conditions, and the new child's need for protection.[33] In the case of a child born into or entering a home with ongoing case management or judicial oversight, DCF must assess the family and plan services prior to the birth of the child. This must include an assessment for whether this new infant will be vulnerable to the identified danger in the home and what influences an infant will have on the management of the safety plan and whether the current level of intrusiveness is still appropriate.

Effect of Proposed Language

The bill requires DCF to add a child to a current investigation and assess that child's safety when he or she is born or moves into a household with an active investigation. The bill also requires DCF to assess a child's safety and provide notice to the court if a child is born or moves into a family that is under the court's jurisdiction. DCF must complete an assessment of the family to determine how the addition of a child will impact family functioning at least 30 days before a child is expected to be born or move into a household. If the birth or addition will occur in fewer than 30 days, DCF must complete an assessment within 72 hours after learning of the pregnancy or potential addition. The assessment must be filed with the court. DCF is required to complete a progress update and file the progress update with the court once a child is born or moves into the household. The bill grants the court the discretion to hold a hearing on the progress update filed by DCF. The bill also provides that DCF must adopt rules to implement this subsection.

Additionally, the bill requires DCF to provide post-placement supervision for no less than 6 months in any home in which the child is reunified to align with the requirement that the dependency court maintain jurisdiction for 6 months after reunification.

Conditions for Return

Current Situation

DCF began the transition in 2013 to a new practice model that focused on child safety within the child's home and timely reunification for children removed from their homes when conditions allowed reunification with services.[34] In 2014, as part of a major effort to reform the child welfare system with SB 1666 (2014),[35] the Legislature required child protective investigators (CPI) to implement an in-home safety plan whenever present or impending danger is identified within a home and a removal is not necessary,[36] and for cases with judicial oversight, required DCF to file all safety plans with the court.[37] In-home safety plans are required to be specific, sufficient, feasible and sustainable to ensure child safety while the child remains in the home.[38]

[32] Department of Children and Families, Proposed Bill Agency Analysis of 2017 "Pathway to Permanency", p. 3 (unpublished) (on file with Children, Families, & Seniors Subcommittee staff).
[33] Id.
[34] Supra, FN 3.
[35] Ch. 14-244, Laws of Fla.
[36] Ch. 14-244, Laws of Fla.; s. 39.301(9)(a)6., F.S.
[37] Ch. 14-244, Laws of Fla.; s. 39.501(3)(a), F.S.
[38] S. 39.301(9)(a)6.a., F.S.

In addition to safety plans, DCF is required to file a predisposition study (PDS) with the court prior to the disposition hearing that details services that may have prevented removal or services that may be needed at the time of reunification.[39] The PDS does not specifically assess conditions for return or the potential use of an in-home safety plan to provide protections that would allow a child to be placed back in his or her home. DCF uses the Family Functioning Assessment (FFA) as the PDS.

When determining whether to place a child back into his or her home or whether to move forward with another permanency option, the court uses the PDS and the case plan to determine whether a parent has achieved substantial compliance with the tasks ordered in the case plan to the extent that the safety, well-being, and the physical, mental and emotional health of the child is not endangered by the return of the child to the home.[40] Acceptable conditions for return with an in-home safety plan may occur much sooner than substantial compliance with a case plan, as substantial compliance with services may not occur until many months into the dependency case.

Effect of Proposed Language

This bill updates language to align with current practice and support the use and review of the FFA and concurrent safety plan(s) by judges during the disposition hearing and judicial reviews so that a child may be reunited with his or her parent more quickly with the use of an in-home safety plan.

The bill removes reference to the term "predisposition study" and replaces it with "family functioning assessment." The bill requires that a written case plan and a family functioning assessment prepared by an authorized agent of DCF must be approved by the court. The bill requires DCF to file the case plan and the family functioning assessment with the court, serve a copy of the case plan on the parents of the child, and provide a copy of the case plan to the guardian ad litem program and to all other parties:

- Not less than 72 hours before the disposition hearing if the disposition hearing occurs on or after the 60th day after the child was placed in out-of-home care; or
- If the disposition hearing occurs before the 60th day after the child was placed in out-of-home care and a case plan has not been submitted, the case plan must be filed and served not less than 72 hours before the case plan acceptance hearing, which must occur within 30 days after the disposition hearing.

The bill updates what the family functioning assessment must contain, to include evidence and circumstances of maltreatment, active danger threats in the home, an assessment of adult functioning, an assessment of parenting practices, an assessment of child functioning, a safety analysis describing the capacity for an in-home safety plan, and conditions for return.

The bill allows the court to grant an exception to the requirement for a family functioning assessment to be filed upon finding that all of the family and child information required in the assessment is available in other documents filed with the court.

When determining whether a child should be reunified with a parent, the bill requires the court to determine whether the circumstances that caused the out-of-home placement have been remedied to the extent that the safety, well-being and physical, and mental and emotional health of the child are not endangered by the return of the child with an in-home safety plan. This moves away from the lengthier standard of substantial compliance and allows faster reunification by allowing a child to be returned as soon as the cause of the out-of-home placement is addressed and the parent is able to be safely reunified with an in-home safety plan.

[39] S. 39.521(1), F.S.
[40] S. 39.522, F.S.

This bill also provides expanded judicial enforcement by allowing the court to issue an order to show cause to DCF as to why it should not return the child to the custody of the parents upon the presentation of evidence that the conditions for return of the child have been met.

Safety Planning for Domestic Violence and Injunctions

Current Situation

In the case of domestic violence, child protective investigators are required to implement a separate safety plan for the perpetrator of the domestic violence and must seek issuance of a protective injunction if the perpetrator is not the parent, guardian, or legal custodian of the child.[41] This injunction protects the child victims of domestic violence by allowing the court to order the perpetrator to:[42]

- Refrain from further abuse and domestic violence;
- Participate in treatment;
- Limit contact and communication with the child victim or other children in the home;
- Refrain from contact with the child;
- Require supervision of contact with the child;
- Vacate the home; and/or
- Comply with a safety plan.

There are instances where a perpetrator of domestic violence is unable to be located to receive or participate in a safety plan or receive service for an injunction. There are also instances where dependency proceedings and injunction proceedings regarding the same children are heard by different judges. This may require DCF to take the same witness testimony on two separate occasions in front of two separate judges increasing the chance for differing court findings and results.

Effect of Proposed Language

The bill amends the title of s. 39.504, F.S., from "injunction pending disposition of petition; penalty" to "injunction; penalty."

The bill would require CPIs to implement a safety plan for the perpetrator only if the CPI is able to locate the perpetrator. The bill would relieve CPIs of the requirement to see seek an issuance of an injunction if DCF intends to file a shelter or dependency petition. This shelter or dependency petition would protect a child victim of domestic violence, as a dependency court is able to order all of the same protections provided by an injunction once a shelter or dependency petition is filed. After filing an affidavit of diligent search by DCF, the bill would allow the court to issue an injunction based on the sworn petition and affidavits when DCF is unable to locate the alleged perpetrator.

For cases with dependency court involvement, the bill would require the same judge to hear both the dependency and the injunction proceeding and also allow the court to consider a sworn petition, testimony, or an affidavit. HB 1121 would also allow the court to hear all relevant and material evidence at the injunction hearing, including oral and written reports, to the extent of its probative value even though it would not be competent evidence at an adjudicatory hearing. These changes would align current procedure with the concept of the Unified Family Court.[43]

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[41] S.39.301(9)(a), F.S.
[42] S. 39.504(4), F.S.
[43] *See* In re: Report of the Family Court Steering Committee, 794 So. 2d 518 (Fla. 2001)("Family Courts IV").

Case Planning

Current Situation

DCF must develop a case plan with input from all parties to the dependency case that details the problems being addressed as well as the goals, tasks, services, and responsibilities required to ameliorate the concerns of the state.[44] The case plan follows the child from the provision of voluntary services through dependency, or termination of parental rights.[45] Once a child is found dependent, a judge reviews the case plan, and if the judge accepts the case plan as drafted, orders the case plan to be followed.[46]

Section 39.6011, F.S., details the development of the case plan and who must be involved, such as the parent, guardian ad litem, and if appropriate, the child. This section also details what must be in the case plan, such as descriptions of the identified problems, the permanency goal, timelines, and notice requirements.

Recent changes in federal law require children age 14 years and older the opportunity to participate in the development of case plans.[47] However, the new federal language does not provide for the protection of confidential information that might be shared at a case planning conference. There are currently no statutory safeguards in Florida law related to the confidentiality of information shared at a case planning conference.

Effect of Proposed Language

The bill allows DCF to discuss confidential information during the case planning conference in the presence of individuals who participate in the staffing and requires all individuals who participate in the staffing to maintain the confidentiality of all information shared.

Permanent Guardianship

Current Situation

When reunification with a parent or adoption is not in the best interest of the child as a permanency option, the dependency court may place the child in a permanent guardianship, if certain conditions are met.[48] Permanent guardians are intended to be permanent placements while the legal parent-child relationship is maintained, including the child's inheritance rights, the parents' right to consent to a child's adoption, and the parents' responsibility to provide financial, medical, and other support to the child.[49] Once a case closes in permanent guardianship, the court terminates supervision of the case while maintaining jurisdiction.[50] Statute is silent regarding a permanent guardian moving from his or her current geographical location.

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[44] Ss, 39.6011 and 39.6012, F.S.
[45] S. 39.01(11), F.S.
[46] S. 39.521, F.S.
[47] 42 U.S.C. s. 675(1)(B).
[48] S. 39.6221, F.S.; Permanent guardianship of a dependent child.—
(1) If a court determines that reunification or adoption is not in the best interest of the child, the court may place the child in a permanent guardianship with a relative or other adult approved by the court if all of the following conditions are met:
(a) The child has been in the placement for not less than the preceding 6 months.
(b) The permanent guardian is suitable and able to provide a safe and permanent home for the child.
(c) The court determines that the child and the relative or other adult are not likely to need supervision or services of the department to ensure the stability of the permanent guardianship.
(d) The permanent guardian has made a commitment to provide for the child until the child reaches the age of majority and to prepare the child for adulthood and independence.
(e) The permanent guardian agrees to give notice of any change in his or her residential address or the residence of the child by filing a written document in the dependency file of the child with the clerk of the court.
[49] S. 39.6221(6), F.S.
[50] S. 39.6221(5), F.S.

In 2015, the Fourth DCA held that the provisions of s. 61.13001, F.S., which relates to parental relocation in dissolution of marriage or time-sharing cases, apply to permanent guardianship placements.[51] As a result, if a permanent guardian in that circuit wishes to relocate more than 50 miles from his or her current residence, the guardian must either obtain the parents' agreement to the relocation or file with the circuit court a petition to relocate and potentially present his or her case at a hearing. Under limited circumstances, a parent may petition the court to reopen a case closed in permanent guardianship and request reunification. However, under Ch. 39, F.S., permanent guardians are not considered parties to the dependency case and are unable to file any pleadings.[52]

Effect of Proposed Language

The bill states that for any child placed in permanent guardianship under Ch. 39, F.S., the requirements of s. 61.13001, F.S., do not apply. This allows the permanent guardian of a child to move freely.

Termination of Parental Rights

Current Situation

When a parent fails to remedy the issues within their family that brought a child into the dependency system, DCF may file a Petition for Termination of Parental Rights (TPR).[53] This step must be taken for a child to be adopted, as the legal ties to his or her parents must be severed before an adoption can take place. DCF has grounds to terminate a parent's rights if his or her conduct caused the child to be placed in out-of-home care in Florida on three or more occasions.[54] A child's prior placements in out-of-home care in a state other than Florida cannot serve as a basis for the termination of parental rights.

While TPRs are usually filed against both parents, a single-parent TPR is permitted when certain grounds for termination are proven, such as incarceration, egregious conduct, and chronic substance abuse.[55] A single-parent TPR severs the legal relationship between one parent and his or her child, while maintaining that legal relationship with the other parent. Current TPR grounds such as a parent's conduct that demonstrates that continued involvement with the child threatens the child's life, safety, well-being, or physical, mental, or emotional health[56] and a conviction that requires the parent to register as a sexual predator[57] are not included.

Effect of Proposed Language

The bill expands section 39.806(1)(l) F.S., to establish a ground for termination of parental rights where on three or more occasions the child or another child of the parent has been placed in out-of-home care pursuant to the law of any state, territory, or jurisdiction of the United States that is substantially similar to Ch. 39, F.S. The bill also expands the grounds for a single-parent termination to include both conduct that demonstrates continued involvement threatens the child and a conviction that requires registration as a sexual predator. These changes will further protect and expedite permanency for children by expanding the grounds for two-parent and single-parent TPR.

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[51] T.B. v. Department of Children & Families, 189 So. 3d 150 (Fla. 4th DCA 2015).
[52] S. 39.01(51), F.S.; "Party" means the parent or parents of the child, the petitioner, the department, the guardian ad litem or the representative of the guardian ad litem program when the program has been appointed, and the child.
[53] S. 39.8055, F.S.
[54] S. 39.806(1)(l), F.S.
[55] S. 39.811(6), F.S.
[56] S. 39.806(1)(c), F.S.
[57] S. 39.806(1)(n), F.S.

Substance Exposed Newborns

Current Situation

Drug abuse during pregnancy creates adverse health effects in newborns termed Neonatal Abstinence Syndrome (NAS).[58] Newborns with NAS suffer from withdrawal symptoms such as tremors, abdominal pain, weight loss, sweating, incessant crying, rapid breathing, sleep disturbance and seizures.[59] The incidence of NAS has increased substantially in the past decade.[60]

In 2012 the legislature created the Statewide Task Force on Prescription Drug Abuse and Newborns to begin addressing the growing problem of NAS.[61] The 15-member Task Force was composed of medical professionals, law enforcement, prevention experts and state legislators. This Task Force was charged by the Legislature with examining the scope of NAS in Florida, its long-term effects and the costs associated with caring for drug exposed babies, and which drug prevention and intervention strategies work best with pregnant mothers.[62] The task force made multiple policy recommendations including education initiatives, drug screening initiatives for pregnant women, immunity provisions for pregnant women, and collaboration with communities and social welfare agencies.[63]

The dependency court has wide discretion as to what case plan tasks and services a parent may be ordered to participate in based on the particular case and facts.[64] This means a dependency court may not order a substance abuse disorder assessment or compliance with treatment in cases in which there is evidence of a substance abuse disorder.

Effect of Proposed Language

The bill requires the court to order any parent whose actions relating to substance abuse have caused harm to a child, such as being born substance-exposed, to submit to a substance abuse disorder evaluation or assessment and participate and comply with treatment services identified by the assessment or evaluation. The bill also states that adjudication of a child as dependent based upon evidence of harm as defined in s. 39.01(30) (g), F.S.,[65] demonstrates good cause for such order. This removes discretion from a dependency court to order this particular task in circumstances when an adjudication of dependency is based on harm caused by substance abuse.

The bill also requires DCF to include an evaluation or assessment and participation and compliance with treatment services identified by the assessment or evaluation as a required case plan task to align with the requirement of an order for evaluation and treatment.

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[58] McQueen, K. and Murphy-Oikonen, J, *Neonatal Abstinence Syndrome*, The New England Journal of Medicine, Review Article, December 22, 2016, available at: http://www.nejm.org/doi/pdf/10.1056/NEJMra1600879 (last accessed March 10, 2017).
[59] Id.
[60] Id.
[61] Id.
[62] Id.
[63] Florida Office of the Attorney General, Statewide Task Force on Prescription Drug Abuse & Newborns, 2014 Progress Report, available at: http://myfloridalegal.com/webfiles.nsf/WF/RMAS-9GUKBJ/$file/Progress-Report-Online-2014.pdf (last accessed March 10, 2017).
[64] *See* s. 39.521, F.S.
[65] Exposes a child to a controlled substance or alcohol. Exposure to a controlled substance or alcohol is established by:
1. A test, administered at birth, which indicated that the child's blood, urine, or meconium contained any amount of alcohol or a controlled substance or metabolites of such substances, the presence of which was not the result of medical treatment administered to the mother or the newborn infant; or
2. Evidence of extensive, abusive, and chronic use of a controlled substance or alcohol by a parent when the child is demonstrably adversely affected by such usage.

Relative Caregiver Program

Current Situation

The Relative Caregiver Program (RCP) provides temporary cash assistance to individuals who meet eligibility rules and have custody of a relative child under age 18 who has been placed in his or her home through the dependency system.[66] The intent of the RCP is to provide relative caregivers who could not otherwise afford to take the child into their homes, a means to avoid exposing the child to the trauma of shelter or foster care.

The RCP provides one type of child-only cash assistance. Payments are based on the child's age and any countable income.[67] DCF ceases to provide child-only RCP benefits when the parent or step-parent resides in the home with the relative caregiver and the child. DCF terminates the benefits in this situation based on the requirement in s. 414.095(2)(a)5., F.S., that parents who live with their minor children to be included in the eligibility determination and households containing a parent are considered work-eligible households. Through rule 65C-28.008(2)(d), F.A.C., DCF terminates payments through the RCP if the parent is in the home for 30 consecutive days.[68] However, at least one court has ruled that caregivers may continue to receive the Relative Caregiver Program benefits while the parent resides in the home, because the prohibition against the parent residing in the home is not in statute and DCF rules cannot be used to establish an eligibility guideline not included in the statute. Court orders in such cases result in DCF being required to make disallowed Temporary Assistance for Needy Families payments violating federal rules.

Effect of Proposed Language

The bill places the prohibition against a parent or stepparent of the dependent child in statute, maintaining the possibility for payment if the relative or nonrelative caregiver is caring for a minor parent and the minor parent's child. If ineligible for the RCP, the caregiver may still be eligible for other assistance programs.

This bill also clarifies that the program will be established, implemented and operated by rule as deemed necessary by DCF, and that DCF determines eligibility for the Relative Caregiver Program.

Other Changes

The bill also:

- Allows DCF to use confidential abuse registry information and investigation records for residential group home employment screening, to align with foster home screening requirements. Currently, statute does not clearly authorize access to this information and records for group home employee employment screening.
- Defines a "Child Welfare Trainer" to mean a person providing training for the purposes of child welfare professionals earning certification and grants DCF rulemaking authority to implement the section, including creating requirements for child welfare trainers. The Joint Administrative Procedures Committee had previously indicated that DCF did not have sufficient rule authority to create such requirements.
- Permits hospitals, licensed under Ch. 395, F.S., and physician's offices to release patient records to DCF or its contracted entities for the purpose of investigations of or services for cases of abuse, neglect, or exploitation of children or vulnerable adults, as some providers have been hesitant to release these records without additional statutory authority.

[66] S. 39.5085(2), F.S.
[67] Rule 65C-28.008(2)(g), F.A.C.
[68] However, a relative may receive the RCP payment for a minor parent who is in his or her care, as well as for that minor parent's child, if both children have been adjudicated dependent and meet all other eligibility requirements.

- Repeals obsolete sections of law related to residential group care, including provisions dealing with equitable reimbursement for group care services and reimbursement methodology; and
- Makes conforming cross reference changes based on the provisions of the bill.

The bill provides for an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 39.01, F.S. relating to definitions.
Section 2: Amends s. 39.202, F.S., relating to confidentiality of reports and records in cases of child abuse or neglect.
Section 3: Amends s. 39.301, F.S., relating to initiation of protective investigations.
Section 4: Amends s. 39.302, F.S., relating to protective investigations of institutional child abuse, abandonment, or neglect.
Section 5: Amends s. 39.402, F.S., relating to placement in a shelter.
Section 6: Amends s. 39.503, F.S., relating to identity or location of parent unknown; special procedures.
Section 7: Amends s. 39.504, F.S., relating to injunction pending disposition of petition; penalty.
Section 8: Amends s. 39.507, F.S., relating to adjudicatory hearings; orders of adjudication.
Section 9: Amends s. 39.5085, F.S., relating to relative caregiver program.
Section 10: Amends s. 39.521, F.S., relating to disposition hearings; powers of disposition.
Section 11: Amends s. 39.522, F.S., relating to postdisposition change of custody.
Section 12: Amends s. 39.6011, F.S., relating to case plan development.
Section 13: Amends s. 39.6012, F.S., relating to case plan tasks; services
Section 14: Amends s. 39.6221, F.S., relating to permanent guardianship of a dependent child.
Section 15: Amends s. 39.701, F.S., relating to judicial review.
Section 16: Amends s. 39.801, F.S., relating to procedures and jurisdiction; notice; service of process.
Section 17: Amends s. 39.803, F.S., relating to identity or location of parent unknown after filing of termination of parental rights petition; special procedures.
Section 18: Amends s. 39.806, F.S., relating to grounds for termination of parental rights.
Section 19: Amends s. 39.811, F.S., relating to powers of disposition; order of disposition.
Section 20: Amends s. 395.3025, F.S., relating to patient and personnel records; copies; examination.
Section 21: Amends s. 402.40, F.S., relating to child welfare training and certification.
Section 22: Amends s. 456.057, F.S., relating to ownership and control of patient records; report or copies of records to be furnished; disclosure of information.
Section 23: Repeals s. 409.141, F.S., relating to equitable reimbursement methodology.
Section 24: Repeals s. 409.1677, F.S., relating to model comprehensive residential services programs.
Section 25: Amends s. 39.524, F.S., relating to safe-harbor placement.
Section 26: Amends s. 394.495, F.S., relating to child and adolescent mental health system of care; programs and services.
Section 27: Amends s. 409.1678, F.S., relating to specialized residential options for children who are victims of sexual exploitation.
Section 28: Amends s. 960.065, F.S., relating to eligibility for awards.
Section 29: Amends s. 409.1679, F.S., relating to additional requirements; reimbursement methodology.
Section 30: Amends s. 1002.3305, F.S., relating to College-Preparatory Boarding Academy Pilot Program for at-risk students.
Section 31: Amends s. 483.181, F.S., acceptance, collection, identification, and examination of specimens.
Section 32: Provides for an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill requires DCF to develop a process to perform abuse registry checks for residential group care employees. Statewide, there are slightly more than 300 group care providers. DCF estimates that existing staff can absorb the increased workload.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will have an indeterminate positive fiscal impact on the expenditures paid by CBCs for paternity testing where a prospective parent is determined to be the parent and assessed the cost of the testing.

The cost of a paternity test can range from $50-$500, depending on the type of test. During FY 2015-2016, DCF's Children's Legal Services served more than 52,414 children. It is unknown how many of those children were the subject of paternity testing. Assuming Children's Legal Services serves the same number of children each year:

- If only 5% of the children (2,620) required paternity testing and the testing identified the child's parent such that the testing cost could be assessed against that parent, DCF and its CBCs would save $131,000-$1,310,000 annually.

- If 10% of the children (5,241) required paternity testing and the testing identified the child's parent, DCF and its CBCs would save $262,050-$2,620,500 annually.

Conversely, the bill will have an indeterminate negative fiscal impact on those parents assessed the cost of testing.

D. FISCAL COMMENTS:

The bill does not appear to have a fiscal impact on the court system, as the provisions in the bill enhance or modify existing court procedures without increasing workload.

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:

The bill grants DCF sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 13, 2017, the Children, Families, and Seniors Subcommittee adopted two amendments and reported the bill favorably as a committee substitute. The amendments:

- Moved language regarding the use of abuse registry information for group home staff employment screening, to align with foster home screening requirements, to a more appropriate section of statute; and
- Specified that criminal record checks do not involve DCF's child welfare information system.

This analysis is drafted to the committee substitute as passed by the Children, Families, and Seniors Subcommittee.

A bill to be entitled

An act relating to child welfare; amending s. 39.01, F.S.; defining the term "legal father" and redefining the term "parent"; amending s. 39.202, F.S.; providing that confidential records held by the department concerning reports of child abandonment, abuse, or neglect, including reports made to the central abuse hotline and all records generated as a result of such reports, may be accessed for employment screening of residential group home caregivers; amending s. 39.301, F.S.; requiring a safety plan to be issued for a perpetrator of domestic violence only if the perpetrator can be located; specifying what constitutes reasonable efforts; requiring that a child new to a family under investigation be added to the investigation and assessed for safety; amending s. 39.302, F.S.; conforming a cross-reference; providing that central abuse hotline information may be used for certain employment screenings; amending s. 39.402, F.S.; requiring a court to inquire as to the identity and location of a child's legal father at the shelter hearing; specifying what types of information fall within the scope of such inquiry; amending s. 39.503, F.S.; requiring a court to conduct under oath the inquiry to determine the identity or location of an

unknown parent; requiring a court to seek additional information relating to a legal father's identity in such inquiry; requiring the diligent search to determine a parent's or prospective parent's location to include a search of the Florida Putative Father Registry; authorizing the court to order scientific testing to determine parentage if certain conditions exist; amending s. 39.504, F.S.; requiring the same judge to hear a pending dependency proceeding and an injunction proceeding; providing that the court may enter an injunction based on specified evidence; amending s. 39.507, F.S.; requiring a court to consider maltreatment allegations against a parent in an evidentiary hearing relating to a dependency petition; amending s. 39.5085, F.S.; revising eligibility guidelines for the Relative Caregiver Program with respect to relative and nonrelative caregivers; amending s. 39.521, F.S.; providing new time guidelines for filing with the court and providing copies of case plans and family functioning assessments; providing for assessment and program compliance for a parent who caused harm to a child by exposing the child to a controlled substance; providing in-home safety plan requirements; providing requirements for family functioning assessments;

providing supervision requirements after reunification; amending s. 39.522, F.S.; providing conditions for returning a child home with an in-home safety plan; amending s. 39.6011, F.S.; providing requirements for confidential information in a case planning conference; providing restrictions; amending s. 39.6012, F.S.; providing for assessment and program compliance for a parent who caused harm to a child by exposing the child to a controlled substance; amending s. 39.6221, F.S.; providing that relocation requirements for parents in dissolution proceedings do not apply to permanent guardianships; amending s. 39.701, F.S.; providing safety assessment requirements for children coming into a home under court jurisdiction; granting rulemaking authority; amending s. 39.801, F.S.; providing an exception to the notice requirement regarding the advisory hearing for a petition to terminate parental rights; amending s. 39.803, F.S.; requiring a court to conduct under oath the inquiry to determine the identity or location of an unknown parent after the filing of a termination of parental rights petition; requiring a court to seek additional information relating to a legal father's identity in such inquiry; revising minimum requirements for the diligent search to determine the

location of a parent or prospective parent; authorizing the court to order scientific testing to determine parentage if certain conditions exist; amending s. 39.806, F.S.; revising circumstances under which grounds for the termination of parental rights may be established; amending s. 39.811, F.S.; revising circumstances under which the rights of one parent may be terminated without terminating the rights of the other parent; amending s. 395.3025, F.S.; revising requirements for access to patient records; amending s. 402.40, F.S.; defining the term "child welfare trainer"; providing rulemaking authority; amending s. 456.057, F.S.; revising requirements for access to patient records; repealing s. 409.141, F.S., relating to equitable reimbursement methodology; repealing s. 409.1677, F.S., relating to model comprehensive residential services programs; amending ss. 39.524, 394.495, 409.1678, and 960.065, F.S.; conforming cross-references; amending ss. 409.1679 and 1002.3305, F.S.; conforming provisions to changes made by the act; reenacting s. 483.181(2), F.S., relating to acceptance, collection, identification, and examination of specimens, to incorporate the amendment made to s. 456.057, F.S., in a reference thereto; providing an effective date.

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

Section 1. Present subsections (35) through (80) of section 39.01, Florida Statutes, are redesignated as subsections (36) through (81), respectively, a new subsection (35) is added to that section, and subsections (10) and (32) and present subsection (49) of that section are amended, to read:

39.01 Definitions.—When used in this chapter, unless the context otherwise requires:

(10) "Caregiver" means the parent, legal custodian, permanent guardian, adult household member, or other person responsible for a child's welfare as defined in subsection (48) ~~(47)~~.

(32) "Institutional child abuse or neglect" means situations of known or suspected child abuse or neglect in which the person allegedly perpetrating the child abuse or neglect is an employee of a private school, public or private day care center, residential home, institution, facility, or agency or any other person at such institution responsible for the child's care as defined in subsection (48) ~~(47)~~.

(35) "Legal father" means a man married to the mother at the time of conception or birth of their child, unless paternity has been otherwise determined by a court of competent jurisdiction. If no man was married to the mother at the time of

birth or conception of the child, the term "legal father" means a man named on the birth certificate of the child pursuant to s. 382.013(2), a man determined by a court order to be the father of the child, or a man determined by an administrative proceeding to be the father of the child.

(50) ~~(49)~~ "Parent" means a woman who gives birth to a child and a man whose consent to the adoption of the child would be required under s. 63.062(1). "Parent" also means a man married to the mother at the time of conception or birth of their child, unless paternity has been otherwise determined by a court of competent jurisdiction. If no man was married to the mother at the time of birth or conception of the child, the term "legal father" means a man named on the birth certificate of the child pursuant to s. 382.013(2), a man determined by court order to be the father of the child, or a man determined by an administrative proceeding to be the father of the child. If a child has been legally adopted, the term "parent" means the adoptive mother or father of the child. For purposes of this chapter only, when the phrase "parent or legal custodian" is used, it refers to rights or responsibilities of the parent and, only if there is no living parent with intact parental rights, to the rights or responsibilities of the legal custodian who has assumed the role of the parent. The term does not include an individual whose parental relationship to the child has been legally terminated, or an alleged or prospective parent, unless:

(a) The parental status falls within the terms of s. 39.503(1) or s. 63.062(1); or

(b) Parental status is applied for the purpose of determining whether the child has been abandoned.

Section 2. Paragraph (a) of subsection (2) of section 39.202, Florida Statutes, is amended to read:

39.202 Confidentiality of reports and records in cases of child abuse or neglect.—

(2) Except as provided in subsection (4), access to such records, excluding the name of the reporter which shall be released only as provided in subsection (5), shall be granted only to the following persons, officials, and agencies:

(a) Employees, authorized agents, or contract providers of the department, the Department of Health, the Agency for Persons with Disabilities, the Office of Early Learning, or county agencies responsible for carrying out:

1. Child or adult protective investigations;

2. Ongoing child or adult protective services;

3. Early intervention and prevention services;

4. Healthy Start services;

5. Licensure or approval of adoptive homes, foster homes, child care facilities, facilities licensed under chapter 393, family day care homes, providers who receive school readiness funding under part VI of chapter 1002, or other homes used to provide for the care and welfare of children; ~~or~~

6. Employment screening for caregivers in residential group homes; or

7.~~6.~~ Services for victims of domestic violence when provided by certified domestic violence centers working at the department's request as case consultants or with shared clients.

Also, employees or agents of the Department of Juvenile Justice responsible for the provision of services to children, pursuant to chapters 984 and 985.

Section 3. Paragraph (a) of subsection (9) of section 39.301, Florida Statutes, is amended, and subsection (23) is added to that section, to read:

39.301 Initiation of protective investigations.—

(9)(a) For each report received from the central abuse hotline and accepted for investigation, the department or the sheriff providing child protective investigative services under s. 39.3065, shall perform the following child protective investigation activities to determine child safety:

1. Conduct a review of all relevant, available information specific to the child and family and alleged maltreatment; family child welfare history; local, state, and federal criminal records checks; and requests for law enforcement assistance provided by the abuse hotline. Based on a review of available information, including the allegations in the current report, a determination shall be made as to whether immediate consultation

should occur with law enforcement, the child protection team, a domestic violence shelter or advocate, or a substance abuse or mental health professional. Such consultations should include discussion as to whether a joint response is necessary and feasible. A determination shall be made as to whether the person making the report should be contacted before the face-to-face interviews with the child and family members.

2. Conduct face-to-face interviews with the child; other siblings, if any; and the parents, legal custodians, or caregivers.

3. Assess the child's residence, including a determination of the composition of the family and household, including the name, address, date of birth, social security number, sex, and race of each child named in the report; any siblings or other children in the same household or in the care of the same adults; the parents, legal custodians, or caregivers; and any other adults in the same household.

4. Determine whether there is any indication that any child in the family or household has been abused, abandoned, or neglected; the nature and extent of present or prior injuries, abuse, or neglect, and any evidence thereof; and a determination as to the person or persons apparently responsible for the abuse, abandonment, or neglect, including the name, address, date of birth, social security number, sex, and race of each such person.

5. Complete assessment of immediate child safety for each child based on available records, interviews, and observations with all persons named in subparagraph 2. and appropriate collateral contacts, which may include other professionals. The department's child protection investigators are hereby designated a criminal justice agency for the purpose of accessing criminal justice information to be used for enforcing this state's laws concerning the crimes of child abuse, abandonment, and neglect. This information shall be used solely for purposes supporting the detection, apprehension, prosecution, pretrial release, posttrial release, or rehabilitation of criminal offenders or persons accused of the crimes of child abuse, abandonment, or neglect and may not be further disseminated or used for any other purpose.

6. Document the present and impending dangers to each child based on the identification of inadequate protective capacity through utilization of a standardized safety assessment instrument. If present or impending danger is identified, the child protective investigator must implement a safety plan or take the child into custody. If present danger is identified and the child is not removed, the child protective investigator shall create and implement a safety plan before leaving the home or the location where there is present danger. If impending danger is identified, the child protective investigator shall create and implement a safety plan as soon as necessary to

protect the safety of the child. The child protective investigator may modify the safety plan if he or she identifies additional impending danger.

a. If the child protective investigator implements a safety plan, the plan must be specific, sufficient, feasible, and sustainable in response to the realities of the present or impending danger. A safety plan may be an in-home plan or an out-of-home plan, or a combination of both. A safety plan may include tasks or responsibilities for a parent, caregiver, or legal custodian. However, a safety plan may not rely on promissory commitments by the parent, caregiver, or legal custodian who is currently not able to protect the child or on services that are not available or will not result in the safety of the child. A safety plan may not be implemented if for any reason the parents, guardian, or legal custodian lacks the capacity or ability to comply with the plan. If the department is not able to develop a plan that is specific, sufficient, feasible, and sustainable, the department shall file a shelter petition. A child protective investigator shall implement separate safety plans for the perpetrator of domestic violence, if the investigator is able to locate the perpetrator to implement a safety plan, and for the parent who is a victim of domestic violence as defined in s. 741.28. Reasonable efforts to locate a perpetrator include, but are not limited to, a diligent search pursuant to the same requirements as in s. 39.503. If the

perpetrator of domestic violence is not the parent, guardian, or legal custodian of any child in the home and if the department does not intend to file a shelter petition or dependency petition that will assert allegations against the perpetrator as a parent of a child in the home ~~the child~~, the child protective investigator shall seek issuance of an injunction authorized by s. 39.504 to implement a safety plan for the perpetrator and impose any other conditions to protect the child. The safety plan for the parent who is a victim of domestic violence may not be shared with the perpetrator. If any party to a safety plan fails to comply with the safety plan resulting in the child being unsafe, the department shall file a shelter petition.

b. The child protective investigator shall collaborate with the community-based care lead agency in the development of the safety plan as necessary to ensure that the safety plan is specific, sufficient, feasible, and sustainable. The child protective investigator shall identify services necessary for the successful implementation of the safety plan. The child protective investigator and the community-based care lead agency shall mobilize service resources to assist all parties in complying with the safety plan. The community-based care lead agency shall prioritize safety plan services to families who have multiple risk factors, including, but not limited to, two or more of the following:

(I) The parent or legal custodian is of young age;

(II) The parent or legal custodian, or an adult currently living in or frequently visiting the home, has a history of substance abuse, mental illness, or domestic violence;

(III) The parent or legal custodian, or an adult currently living in or frequently visiting the home, has been previously found to have physically or sexually abused a child;

(IV) The parent or legal custodian or an adult currently living in or frequently visiting the home has been the subject of multiple allegations by reputable reports of abuse or neglect;

(V) The child is physically or developmentally disabled; or

(VI) The child is 3 years of age or younger.

c. The child protective investigator shall monitor the implementation of the plan to ensure the child's safety until the case is transferred to the lead agency at which time the lead agency shall monitor the implementation.

(23) If, at any time during a child protective investigation, a child is born into a family under investigation or a child moves into the home under investigation, the child protective investigator shall add the child to the investigation and assess the child's safety pursuant to subsection (7) and paragraph (9)(a).

Section 4. Subsections (1) and (7) of section 39.302, Florida Statutes, are amended to read:

39.302 Protective investigations of institutional child abuse, abandonment, or neglect.—

(1) The department shall conduct a child protective investigation of each report of institutional child abuse, abandonment, or neglect. Upon receipt of a report that alleges that an employee or agent of the department, or any other entity or person covered by s. 39.01(32) or (48) ~~s. 39.01(32) or (47)~~, acting in an official capacity, has committed an act of child abuse, abandonment, or neglect, the department shall initiate a child protective investigation within the timeframe established under s. 39.201(5) and notify the appropriate state attorney, law enforcement agency, and licensing agency, which shall immediately conduct a joint investigation, unless independent investigations are more feasible. When conducting investigations or having face-to-face interviews with the child, investigation visits shall be unannounced unless it is determined by the department or its agent that unannounced visits threaten the safety of the child. If a facility is exempt from licensing, the department shall inform the owner or operator of the facility of the report. Each agency conducting a joint investigation is entitled to full access to the information gathered by the department in the course of the investigation. A protective investigation must include an interview with the child's parent or legal guardian. The department shall make a full written report to the state attorney within 3 working days after making

the oral report. A criminal investigation shall be coordinated, whenever possible, with the child protective investigation of the department. Any interested person who has information regarding the offenses described in this subsection may forward a statement to the state attorney as to whether prosecution is warranted and appropriate. Within 15 days after the completion of the investigation, the state attorney shall report the findings to the department and shall include in the report a determination of whether or not prosecution is justified and appropriate in view of the circumstances of the specific case.

(7) When an investigation of institutional abuse, neglect, or abandonment is closed and a person is not identified as a caregiver responsible for the abuse, neglect, or abandonment alleged in the report, the fact that the person is named in some capacity in the report may not be used in any way to adversely affect the interests of that person. This prohibition applies to any use of the information in employment screening, licensing, child placement, adoption, or any other decisions by a private adoption agency or a state agency or its contracted providers.

(a) However, if such a person is a licensee of the department and is named in any capacity in three or more reports within a 5-year period, the department may review those reports and determine whether the information contained in the reports is relevant for purposes of determining whether the person's license should be renewed or revoked. If the information is

relevant to the decision to renew or revoke the license, the department may rely on the information contained in the report in making that decision.

(b) Likewise, if a person is employed as a caregiver in a residential group home licensed pursuant to s. 409.175 and is named in any capacity in three or more reports within a 5-year period, all reports may be reviewed for the purposes of the employment screening required pursuant to s. 409.145(2)(e).

Section 5. Paragraph (c) of subsection (8) of section 39.402, Florida Statutes, is amended to read:

39.402 Placement in a shelter.—

(8)

(c) At the shelter hearing, the court shall:

1. Appoint a guardian ad litem to represent the best interest of the child, unless the court finds that such representation is unnecessary;

2. Inform the parents or legal custodians of their right to counsel to represent them at the shelter hearing and at each subsequent hearing or proceeding, and the right of the parents to appointed counsel, pursuant to the procedures set forth in s. 39.013; ~~and~~

3. Give the parents or legal custodians an opportunity to be heard and to present evidence; and

4. Inquire of those present at the shelter hearing as to the identity and location of the legal father. In determining

who the legal father of the child may be, the court shall inquire under oath of those present at the shelter hearing whether they have any of the following information:

a. Whether the mother of the child was married at the probable time of conception of the child or at the time of birth of the child.

b. Whether the mother was cohabiting with a male at the probable time of conception of the child.

c. Whether the mother has received payments or promises of support with respect to the child or because of her pregnancy from a man who claims to be the father.

d. Whether the mother has named any man as the father on the birth certificate of the child or in connection with applying for or receiving public assistance.

e. Whether any man has acknowledged or claimed paternity of the child in a jurisdiction in which the mother resided at the time of or since conception of the child or in which the child has resided or resides.

f. Whether a man is named on the birth certificate of the child pursuant to s. 382.013(2).

g. Whether a man has been determined by a court order to be the father of the child.

h. Whether a man has been determined by an administrative proceeding to be the father of the child.

Section 6. Subsections (1), (6), and (8) of section

39.503, Florida Statutes, are amended, subsection (9) is added to that section, and subsection (7) of that section is republished, to read:

39.503 Identity or location of parent unknown; special procedures.—

(1) If the identity or location of a parent is unknown and a petition for dependency or shelter is filed, the court shall conduct under oath the following inquiry of the parent or legal custodian who is available, or, if no parent or legal custodian is available, of any relative or custodian of the child who is present at the hearing and likely to have any of the following information:

(a) Whether the mother of the child was married at the probable time of conception of the child or at the time of birth of the child.

(b) Whether the mother was cohabiting with a male at the probable time of conception of the child.

(c) Whether the mother has received payments or promises of support with respect to the child or because of her pregnancy from a man who claims to be the father.

(d) Whether the mother has named any man as the father on the birth certificate of the child or in connection with applying for or receiving public assistance.

(e) Whether any man has acknowledged or claimed paternity of the child in a jurisdiction in which the mother resided at

the time of or since conception of the child, or in which the child has resided or resides.

(f) Whether a man is named on the birth certificate of the child pursuant to s. 382.013(2).

(g) Whether a man has been determined by a court order to be the father of the child.

(h) Whether a man has been determined by an administrative proceeding to be the father of the child.

(6) The diligent search required by subsection (5) must include, at a minimum, inquiries of all relatives of the parent or prospective parent made known to the petitioner, inquiries of all offices of program areas of the department likely to have information about the parent or prospective parent, inquiries of other state and federal agencies likely to have information about the parent or prospective parent, inquiries of appropriate utility and postal providers, a thorough search of at least one electronic database specifically designed for locating persons, a search of the Florida Putative Father Registry, and inquiries of appropriate law enforcement agencies. Pursuant to s. 453 of the Social Security Act, 42 U.S.C. s. 653(c)(4), the department, as the state agency administering Titles IV-B and IV-E of the act, shall be provided access to the federal and state parent locator service for diligent search activities.

(7) Any agency contacted by a petitioner with a request for information pursuant to subsection (6) shall release the

requested information to the petitioner without the necessity of a subpoena or court order.

(8) If the inquiry and diligent search identifies a prospective parent, that person must be given the opportunity to become a party to the proceedings by completing a sworn affidavit of parenthood and filing it with the court or the department. A prospective parent who files a sworn affidavit of parenthood while the child is a dependent child but no later than at the time of or before ~~prior to~~ the adjudicatory hearing in any termination of parental rights proceeding for the child shall be considered a parent for all purposes under this section unless the other parent contests the determination of parenthood. If the prospective parent does not file a sworn affidavit of parenthood or if the other parent contests the determination of parenthood, the court may, after considering the best interest of the child, order scientific testing to determine the maternity or paternity of the child. The court shall assess the cost of the maternity or paternity determination as a cost of litigation. If the court finds the prospective parent to be a parent as a result of the scientific testing, the court shall enter a judgment of maternity or paternity, shall assess the cost of the scientific testing to the parent, and shall enter an amount of child support to be paid by the parent as determined under s. 61.30. If the known parent contests the recognition of the prospective parent as a

parent, the prospective parent shall not be recognized as a parent until proceedings to determine maternity or paternity ~~under chapter 742~~ have been concluded. However, the prospective parent shall continue to receive notice of hearings as a participant until ~~pending results of the chapter 742~~ proceedings to determine maternity or paternity have been concluded.

(9) If the diligent search under subsection (5) fails to identify and locate a prospective parent, the court shall so find and may proceed without further notice.

Section 7. Section 39.504, Florida Statutes, is amended to read:

39.504 Injunction ~~pending disposition of petition~~; penalty.—

(1) At any time after a protective investigation has been initiated pursuant to part III of this chapter, the court, upon the request of the department, a law enforcement officer, the state attorney, or other responsible person, or upon its own motion, may, if there is reasonable cause, issue an injunction to prevent any act of child abuse. Reasonable cause for the issuance of an injunction exists if there is evidence of child abuse or if there is a reasonable likelihood of such abuse occurring based upon a recent overt act or failure to act. If there is a pending dependency proceeding regarding the child whom the injunction is sought to protect, the judge hearing the dependency proceeding must also hear the injunction proceeding

regarding the child.

(2) The petitioner seeking the injunction shall file a verified petition, or a petition along with an affidavit, setting forth the specific actions by the alleged offender from which the child must be protected and all remedies sought. Upon filing the petition, the court shall set a hearing to be held at the earliest possible time. Pending the hearing, the court may issue a temporary ex parte injunction, with verified pleadings or affidavits as evidence. The temporary ex parte injunction pending a hearing is effective for up to 15 days and the hearing must be held within that period unless continued for good cause shown, which may include obtaining service of process, in which case the temporary ex parte injunction shall be extended for the continuance period. The hearing may be held sooner if the alleged offender has received reasonable notice.

(3) Before the hearing, the alleged offender must be personally served with a copy of the petition, all other pleadings related to the petition, a notice of hearing, and, if one has been entered, the temporary injunction. If the petitioner is unable to locate the alleged offender for service after a diligent search pursuant to the same requirements as in s. 39.503 and the filing of an affidavit of diligent search, the court may enter the injunction based on the sworn petition and any affidavits. At the hearing, the court may base its determination on a sworn petition, testimony, or an affidavit

and may hear all relevant and material evidence, including oral and written reports, to the extent of its probative value even though it would not be competent evidence at an adjudicatory hearing. Following the hearing, the court may enter a final injunction. The court may grant a continuance of the hearing at any time for good cause shown by any party. If a temporary injunction has been entered, it shall be continued during the continuance.

(4) If an injunction is issued under this section, the primary purpose of the injunction must be to protect and promote the best interests of the child, taking the preservation of the child's immediate family into consideration.

(a) The injunction applies to the alleged or actual offender in a case of child abuse or acts of domestic violence. The conditions of the injunction shall be determined by the court, which may include ordering the alleged or actual offender to:

1. Refrain from further abuse or acts of domestic violence.

2. Participate in a specialized treatment program.

3. Limit contact or communication with the child victim, other children in the home, or any other child.

4. Refrain from contacting the child at home, school, work, or wherever the child may be found.

5. Have limited or supervised visitation with the child.

6. Vacate the home in which the child resides.

7. Comply with the terms of a safety plan implemented in the injunction pursuant to s. 39.301.

(b) Upon proper pleading, the court may award the following relief in a temporary ex parte or final injunction:

1. Exclusive use and possession of the dwelling to the caregiver or exclusion of the alleged or actual offender from the residence of the caregiver.

2. Temporary support for the child or other family members.

3. The costs of medical, psychiatric, and psychological treatment for the child incurred due to the abuse, and similar costs for other family members.

This paragraph does not preclude an adult victim of domestic violence from seeking protection for himself or herself under s. 741.30.

(c) The terms of the final injunction shall remain in effect until modified or dissolved by the court. The petitioner, respondent, or caregiver may move at any time to modify or dissolve the injunction. Notice of hearing on the motion to modify or dissolve the injunction must be provided to all parties, including the department. The injunction is valid and enforceable in all counties in the state.

(5) Service of process on the respondent shall be carried

out pursuant to s. 741.30. The department shall deliver a copy of any injunction issued pursuant to this section to the protected party or to a parent, caregiver, or individual acting in the place of a parent who is not the respondent. Law enforcement officers may exercise their arrest powers as provided in s. 901.15(6) to enforce the terms of the injunction.

(6) Any person who fails to comply with an injunction issued pursuant to this section commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(7) The person against whom an injunction is entered under this section does not automatically become a party to a subsequent dependency action concerning the same child.

Section 8. Paragraph (b) of subsection (7) of section 39.507, Florida Statutes, is amended to read:

39.507 Adjudicatory hearings; orders of adjudication.—

(7)

(b) However, the court must determine whether each parent or legal custodian identified in the case abused, abandoned, or neglected the child or engaged in conduct that placed the child at substantial risk of imminent abuse, abandonment, or neglect ~~in a subsequent evidentiary hearing~~. If a second parent is served and brought into the proceeding after the adjudication, and an ~~the~~ evidentiary hearing for the second parent is conducted ~~subsequent to the adjudication of the child~~, the court

shall supplement the adjudicatory order, disposition order, and the case plan, as necessary. The petitioner is not required to prove actual harm or actual abuse by the second parent in order for the court to make supplemental findings regarding the conduct of the second parent. The court is not required to conduct an evidentiary hearing for the second parent in order to supplement the adjudicatory order, the disposition order, and the case plan if the requirements of s. 39.506(3) or (5) are satisfied. With the exception of proceedings pursuant to s. 39.811, the child's dependency status may not be retried or readjudicated.

Section 9. Paragraph (a) of subsection (2) of section 39.5085, Florida Statutes, is amended to read:

39.5085 Relative Caregiver Program.—

(2)(a) The Department of Children and Families shall establish, ~~and~~ operate, and implement the Relative Caregiver Program ~~pursuant to eligibility guidelines established in this section as further implemented~~ by rule of the department. The Relative Caregiver Program shall, within the limits of available funding, provide financial assistance to:

1. Relatives who are within the fifth degree by blood or marriage to the parent or stepparent of a child and who are caring full-time for that dependent child in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement

with the relative under this chapter.

2. Relatives who are within the fifth degree by blood or marriage to the parent or stepparent of a child and who are caring full-time for that dependent child, and a dependent half-brother or half-sister of that dependent child, in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement with the relative under this chapter.

3. Nonrelatives who are willing to assume custody and care of a dependent child in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement with the nonrelative caregiver under this chapter. The court must find that a proposed placement under this subparagraph is in the best interest of the child.

4. The relative or nonrelative caregiver may not receive a Relative Caregiver Program payment if the parent or stepparent of the child resides in the home. However, a relative or nonrelative may receive the Relative Caregiver Program payment for a minor parent who is in his or her care, as well as for the minor parent's child, if both children have been adjudicated dependent and meet all other eligibility requirements. If the caregiver is currently receiving the payment, the Relative Caregiver Program payment must be terminated no later than the first of the following month after the parent or stepparent

moves into the home, allowing for 10-day notice of adverse action.

The placement may be court-ordered temporary legal custody to the relative or nonrelative under protective supervision of the department pursuant to s. 39.521(1)(c)3. ~~s. 39.521(1)(b)3.~~, or court-ordered placement in the home of a relative or nonrelative as a permanency option under s. 39.6221 or s. 39.6231 or under former s. 39.622 if the placement was made before July 1, 2006. The Relative Caregiver Program shall offer financial assistance to caregivers who would be unable to serve in that capacity without the caregiver payment because of financial burden, thus exposing the child to the trauma of placement in a shelter or in foster care.

Section 10. Subsections (1), (2), (6), and (7) of section 39.521, Florida Statutes, are amended to read:

39.521 Disposition hearings; powers of disposition.—

(1) A disposition hearing shall be conducted by the court, if the court finds that the facts alleged in the petition for dependency were proven in the adjudicatory hearing, or if the parents or legal custodians have consented to the finding of dependency or admitted the allegations in the petition, have failed to appear for the arraignment hearing after proper notice, or have not been located despite a diligent search having been conducted.

(a) A written case plan and a family functioning assessment ~~predisposition study~~ prepared by an authorized agent of the department must be approved by ~~filed with~~ the court. The department must file the case plan and the family functioning assessment with the court, serve a copy of the case plan on~~,~~ ~~served upon~~ the parents of the child, and provide a copy of the case plan ~~provided~~ to the representative of the guardian ad litem program, if the program has been appointed, and provide a copy ~~provided~~ to all other parties:

1. Not less than 72 hours before the disposition hearing, if the disposition hearing occurs on or after the 60th day after the child was placed in out-of-home care. All such case plans must be approved by the court.

2. Not less than 72 hours before the case plan acceptance hearing, if the disposition hearing occurs before the 60th day after the date the child was placed in out-of-home care and a case plan has not been submitted pursuant to this paragraph, or if the court does not approve the case plan at the disposition hearing.~~,~~ The case plan acceptance hearing must occur ~~the court must set a hearing~~ within 30 days after the disposition hearing to review and approve the case plan.

(b) The court may grant an exception to the requirement for a family functioning assessment ~~predisposition study~~ by separate order or within the judge's order of disposition upon finding that all the family and child information required by

subsection (2) is available in other documents filed with the court.

(c) ~~(b)~~ When any child is adjudicated by a court to be dependent, the court having jurisdiction of the child has the power by order to:

1. Require the parent and, when appropriate, the legal custodian and the child to participate in treatment and services identified as necessary. The court may require the person who has custody or who is requesting custody of the child to submit to a mental health or substance abuse disorder assessment or evaluation. The order may be made only upon good cause shown and pursuant to notice and procedural requirements provided under the Florida Rules of Juvenile Procedure. The mental health assessment or evaluation must be administered by a qualified professional as defined in s. 39.01, and the substance abuse assessment or evaluation must be administered by a qualified professional as defined in s. 397.311. The court may also require such person to participate in and comply with treatment and services identified as necessary, including, when appropriate and available, participation in and compliance with a mental health court program established under chapter 394 or a treatment-based drug court program established under s. 397.334. Adjudication of a child as dependent based upon evidence of harm as defined in s. 39.01(30)(g) demonstrates good cause, and the court shall require the parent whose actions caused the harm to

submit to a substance abuse disorder assessment or evaluation and to participate and comply with treatment and services identified in the assessment or evaluation as being necessary. In addition to supervision by the department, the court, including the mental health court program or the treatment-based drug court program, may oversee the progress and compliance with treatment by a person who has custody or is requesting custody of the child. The court may impose appropriate available sanctions for noncompliance upon a person who has custody or is requesting custody of the child or make a finding of noncompliance for consideration in determining whether an alternative placement of the child is in the child's best interests. Any order entered under this subparagraph may be made only upon good cause shown. This subparagraph does not authorize placement of a child with a person seeking custody of the child, other than the child's parent or legal custodian, who requires mental health or substance abuse disorder treatment.

2. Require, if the court deems necessary, the parties to participate in dependency mediation.

3. Require placement of the child either under the protective supervision of an authorized agent of the department in the home of one or both of the child's parents or in the home of a relative of the child or another adult approved by the court, or in the custody of the department. Protective supervision continues until the court terminates it or until the

child reaches the age of 18, whichever date is first. Protective supervision shall be terminated by the court whenever the court determines that permanency has been achieved for the child, whether with a parent, another relative, or a legal custodian, and that protective supervision is no longer needed. The termination of supervision may be with or without retaining jurisdiction, at the court's discretion, and shall in either case be considered a permanency option for the child. The order terminating supervision by the department must set forth the powers of the custodian of the child and include the powers ordinarily granted to a guardian of the person of a minor unless otherwise specified. Upon the court's termination of supervision by the department, further judicial reviews are not required if permanency has been established for the child.

(d) ~~(c)~~ At the conclusion of the disposition hearing, the court shall schedule the initial judicial review hearing which must be held no later than 90 days after the date of the disposition hearing or after the date of the hearing at which the court approves the case plan, whichever occurs earlier, but in no event shall the review hearing be held later than 6 months after the date of the child's removal from the home.

(e) ~~(d)~~ The court shall, in its written order of disposition, include all of the following:

1. The placement or custody of the child.

2. Special conditions of placement and visitation.

3. Evaluation, counseling, treatment activities, and other actions to be taken by the parties, if ordered.

4. The persons or entities responsible for supervising or monitoring services to the child and parent.

5. Continuation or discharge of the guardian ad litem, as appropriate.

6. The date, time, and location of the next scheduled review hearing, which must occur within the earlier of:

a. Ninety days after the disposition hearing;

b. Ninety days after the court accepts the case plan;

c. Six months after the date of the last review hearing; or

d. Six months after the date of the child's removal from his or her home, if no review hearing has been held since the child's removal from the home.

7. If the child is in an out-of-home placement, child support to be paid by the parents, or the guardian of the child's estate if possessed of assets which under law may be disbursed for the care, support, and maintenance of the child. The court may exercise jurisdiction over all child support matters, shall adjudicate the financial obligation, including health insurance, of the child's parents or guardian, and shall enforce the financial obligation as provided in chapter 61. The state's child support enforcement agency shall enforce child support orders under this section in the same manner as child

support orders under chapter 61. Placement of the child shall not be contingent upon issuance of a support order.

8.a. If the court does not commit the child to the temporary legal custody of an adult relative, legal custodian, or other adult approved by the court, the disposition order shall include the reasons for such a decision and shall include a determination as to whether diligent efforts were made by the department to locate an adult relative, legal custodian, or other adult willing to care for the child in order to present that placement option to the court instead of placement with the department.

b. If no suitable relative is found and the child is placed with the department or a legal custodian or other adult approved by the court, both the department and the court shall consider transferring temporary legal custody to an adult relative approved by the court at a later date, but neither the department nor the court is obligated to so place the child if it is in the child's best interest to remain in the current placement.

For the purposes of this section, "diligent efforts to locate an adult relative" means a search similar to the diligent search for a parent, but without the continuing obligation to search after an initial adequate search is completed.

9. Other requirements necessary to protect the health,

safety, and well-being of the child, to preserve the stability of the child's educational placement, and to promote family preservation or reunification whenever possible.

(f) ~~(e)~~ If the court finds that an in-home safety plan prepared or approved by the department ~~the prevention or reunification efforts of the department~~ will allow the child to remain safely at home or that conditions for return have been met and an in-home safety plan prepared or approved by the department will allow the child to be safely returned to the home, the court shall allow the child to remain in or return to the home after making a specific finding of fact that ~~the reasons for removal have been remedied to the extent that~~ the child's safety, well-being, and physical, mental, and emotional health will not be endangered.

(g) ~~(f)~~ If the court places the child in an out-of-home placement, the disposition order must include a written determination that the child cannot safely remain at home with reunification or family preservation services and that removal of the child is necessary to protect the child. If the child is removed before the disposition hearing, the order must also include a written determination as to whether, after removal, the department made a reasonable effort to reunify the parent and child. Reasonable efforts to reunify are not required if the court finds that any of the acts listed in s. 39.806(1)(f)-(l) have occurred. The department has the burden of demonstrating

that it made reasonable efforts.

1. For the purposes of this paragraph, the term "reasonable effort" means the exercise of reasonable diligence and care by the department to provide the services ordered by the court or delineated in the case plan.

2. In support of its determination as to whether reasonable efforts have been made, the court shall:

a. Enter written findings as to whether prevention or reunification efforts were indicated.

b. If prevention or reunification efforts were indicated, include a brief written description of what appropriate and available prevention and reunification efforts were made.

c. Indicate in writing why further efforts could or could not have prevented or shortened the separation of the parent and child.

3. A court may find that the department made a reasonable effort to prevent or eliminate the need for removal if:

a. The first contact of the department with the family occurs during an emergency;

b. The appraisal by the department of the home situation indicates a substantial and immediate danger to the child's safety or physical, mental, or emotional health which cannot be mitigated by the provision of preventive services;

c. The child cannot safely remain at home, because there are no preventive services that can ensure the health and safety

of the child or, even with appropriate and available services being provided, the health and safety of the child cannot be ensured; or

d. The parent is alleged to have committed any of the acts listed as grounds for expedited termination of parental rights under s. 39.806(1)(f)-(l).

4. A reasonable effort by the department for reunification has been made if the appraisal of the home situation by the department indicates that the severity of the conditions of dependency is such that reunification efforts are inappropriate. The department has the burden of demonstrating to the court that reunification efforts were inappropriate.

5. If the court finds that the prevention or reunification effort of the department would not have permitted the child to remain safely at home, the court may commit the child to the temporary legal custody of the department or take any other action authorized by this chapter.

(2) The family functioning assessment ~~predisposition study~~ must provide the court with the following documented information:

(a) Evidence of maltreatment and the circumstances accompanying the maltreatment.

(b) Identification of all danger threats active in the home.

(c) An assessment of the adult functioning of the parents.

(d) An assessment of general parenting practices and the parent's disciplinary approach and behavior management methods.

(e) An assessment of the parent's behavioral, emotional, and cognitive protective capacities.

(f) An assessment of child functioning.

(g) A safety analysis describing the capacity for an in-home safety plan to control the conditions that result in the child being unsafe and the specific actions necessary to keep the child safe.

(h) Identification of the conditions for return which would allow the child to be placed safely back into the home with an in-home safety plan and any safety management services necessary to ensure the child's safety.

~~(a) The capacity and disposition of the parents to provide the child with food, clothing, medical care, or other remedial care recognized and permitted under the laws of this state in lieu of medical care, and other material needs.~~

~~(b) The length of time the child has lived in a stable, satisfactory environment and the desirability of maintaining continuity.~~

~~(c) The mental and physical health of the parents.~~

~~(d) The home, school, and community record of the child.~~

(i) ~~(e)~~ The reasonable preference of the child, if the court deems the child to be of sufficient intelligence, understanding, and experience to express a preference.

~~(f) Evidence of domestic violence or child abuse.~~

~~(g) An assessment defining the dangers and risks of returning the child home, including a description of the changes in and resolutions to the initial risks.~~

~~(h) A description of what risks are still present and what resources are available and will be provided for the protection and safety of the child.~~

~~(i) A description of the benefits of returning the child home.~~

~~(j) A description of all unresolved issues.~~

(j)~~(k)~~ Child welfare ~~A Florida Abuse Hotline Information System (FAHIS)~~ history from the Statewide Automated Child Welfare Information System (SACWIS) and criminal records check for all caregivers, family members, and individuals residing within the household from which the child was removed.

(k)~~(l)~~ The complete report and recommendation of the child protection team of the Department of Health or, if no report exists, a statement reflecting that no report has been made.

(l)~~(m)~~ All opinions or recommendations from other professionals or agencies that provide evaluative, social, reunification, or other services to the parent and child.

(m)~~(n)~~ A listing of appropriate and available safety management ~~prevention and reunification~~ services for the parent and child to prevent the removal of the child from the home or to reunify the child with the parent after removal~~, including~~

~~the availability of family preservation services~~ and an explanation of the following:

1. If the services were or were not provided.

2. If the services were provided, the outcome of the services.

3. If the services were not provided, why they were not provided.

4. If the services are currently being provided and if they need to be continued.

~~(o) A listing of other prevention and reunification services that were available but determined to be inappropriate and why.~~

~~(p) Whether dependency mediation was provided.~~

(n) ~~(q)~~ If the child has been removed from the home and there is a parent who may be considered for custody pursuant to this section, a recommendation as to whether placement of the child with that parent would be detrimental to the child.

(o) ~~(r)~~ If the child has been removed from the home and will be remaining with a relative, parent, or other adult approved by the court, a home study report concerning the proposed placement shall be provided to the court ~~included in the predisposition report~~. Before recommending to the court any out-of-home placement for a child other than placement in a licensed shelter or foster home, the department shall conduct a study of the home of the proposed legal custodians, which must

include, at a minimum:

1. An interview with the proposed legal custodians to assess their ongoing commitment and ability to care for the child.

2. Records checks through the State Automated Child Welfare Information System (SACWIS), and local and statewide criminal and juvenile records checks through the Department of Law Enforcement, on all household members 12 years of age or older. In addition, the fingerprints of any household members who are 18 years of age or older may be submitted to the Department of Law Enforcement for processing and forwarding to the Federal Bureau of Investigation for state and national criminal history information. The department has the discretion to request State Automated Child Welfare Information System (SACWIS) and local, statewide, and national criminal history checks and fingerprinting of any other visitor to the home who is made known to the department. Out-of-state criminal records checks must be initiated for any individual who has resided in a state other than Florida if that state's laws allow the release of these records. The out-of-state criminal records must be filed with the court within 5 days after receipt by the department or its agent.

3. An assessment of the physical environment of the home.

4. A determination of the financial security of the proposed legal custodians.

5. A determination of suitable child care arrangements if the proposed legal custodians are employed outside of the home.

6. Documentation of counseling and information provided to the proposed legal custodians regarding the dependency process and possible outcomes.

7. Documentation that information regarding support services available in the community has been provided to the proposed legal custodians.

8. The reasonable preference of the child, if the court deems the child to be of sufficient intelligence, understanding, and experience to express a preference.

The department may not place the child or continue the placement of the child in a home under shelter or postdisposition placement if the results of the home study are unfavorable, unless the court finds that this placement is in the child's best interest.

(p) ~~(s)~~ If the child has been removed from the home, a determination of the amount of child support each parent will be required to pay pursuant to s. 61.30.

~~(t) If placement of the child with anyone other than the child's parent is being considered, the predisposition study shall include the designation of a specific length of time as to when custody by the parent will be reconsidered.~~

Any other relevant and material evidence, including other written or oral reports, may be received by the court in its effort to determine the action to be taken with regard to the child and may be relied upon to the extent of its probative value, even though not competent in an adjudicatory hearing. Except as otherwise specifically provided, nothing in this section prohibits the publication of proceedings in a hearing.

(6) With respect to a child who is the subject in proceedings under this chapter, the court may issue to the department an order to show cause why it should not return the child to the custody of the parents upon the presentation of evidence that the conditions for return of the child have been met ~~expiration of the case plan, or sooner if the parents have substantially complied with the case plan~~.

(7) The court may enter an order ending its jurisdiction over a child when a child has been returned to the parents, provided the court shall not terminate its jurisdiction or the department's supervision over the child until 6 months after the child's return. The department shall supervise the placement of the child after reunification for at least 6 months with each parent or legal custodian from whom the child was removed. The court shall determine whether its jurisdiction should be continued or terminated in such a case based on a report of the department or agency or the child's guardian ad litem, and any other relevant factors; if its jurisdiction is to be terminated,

the court shall enter an order to that effect.

Section 11. Subsections (2) and (3) of section 39.522, Florida Statutes, are amended to read:

39.522 Postdisposition change of custody.—The court may change the temporary legal custody or the conditions of protective supervision at a postdisposition hearing, without the necessity of another adjudicatory hearing.

(2) In cases where the issue before the court is whether a child should be reunited with a parent, the court shall review the conditions for return and determine whether the circumstances that caused the out-of-home placement and issues subsequently identified have been remedied ~~parent has substantially complied with the terms of the case plan~~ to the extent that the return of the child to the home with an in-home safety plan prepared or approved by the department will not be detrimental to the child's safety, well-being, and physical, mental, and emotional health ~~of the child is not endangered by the return of the child to the home~~.

(3) In cases where the issue before the court is whether a child who is placed in the custody of a parent should be reunited with the other parent upon a finding that the circumstances that caused the out-of-home placement and issues subsequently identified have been remedied to the extent that the return of the child to the home of the other parent with an in-home safety plan prepared or approved by the department will

not be detrimental to the child ~~of substantial compliance with the terms of the case plan~~, the standard shall be that the safety, well-being, and physical, mental, and emotional health of the child would not be endangered by reunification and that reunification would be in the best interest of the child.

Section 12. Subsection (1) of section 39.6011, Florida Statutes, is amended to read:

39.6011 Case plan development.—

(1) The department shall prepare a draft of the case plan for each child receiving services under this chapter. A parent of a child may not be threatened or coerced with the loss of custody or parental rights for failing to admit in the case plan of abusing, neglecting, or abandoning a child. Participating in the development of a case plan is not an admission to any allegation of abuse, abandonment, or neglect, and it is not a consent to a finding of dependency or termination of parental rights. The case plan shall be developed subject to the following requirements:

(a) The case plan must be developed in a face-to-face conference with the parent of the child, any court-appointed guardian ad litem, and, if appropriate, the child and the temporary custodian of the child.

(b) Notwithstanding s. 39.202, the department may discuss confidential information during the case planning conference in the presence of individuals who participate in the conference.

All individuals who participate in the conference shall maintain the confidentiality of all information shared during the case planning conference.

(c) ~~(b)~~ The parent may receive assistance from any person or social service agency in preparing the case plan. The social service agency, the department, and the court, when applicable, shall inform the parent of the right to receive such assistance, including the right to assistance of counsel.

(d) ~~(c)~~ If a parent is unwilling or unable to participate in developing a case plan, the department shall document that unwillingness or inability to participate. The documentation must be provided in writing to the parent when available for the court record, and the department shall prepare a case plan conforming as nearly as possible with the requirements set forth in this section. The unwillingness or inability of the parent to participate in developing a case plan does not preclude the filing of a petition for dependency or for termination of parental rights. The parent, if available, must be provided a copy of the case plan and be advised that he or she may, at any time before the filing of a petition for termination of parental rights, enter into a case plan and that he or she may request judicial review of any provision of the case plan with which he or she disagrees at any court hearing set for the child.

Section 13. Subsection (1) of section 39.6012, Florida Statutes, is amended to read:

39.6012 Case plan tasks; services.—

(1) The services to be provided to the parent and the tasks that must be completed are subject to the following:

(a) The services described in the case plan must be designed to improve the conditions in the home and aid in maintaining the child in the home, facilitate the child's safe return to the home, ensure proper care of the child, or facilitate the child's permanent placement. The services offered must be the least intrusive possible into the life of the parent and child, must focus on clearly defined objectives, and must provide the most efficient path to quick reunification or permanent placement given the circumstances of the case and the child's need for safe and proper care.

(b) The case plan must describe each of the tasks with which the parent must comply and the services to be provided to the parent, specifically addressing the identified problem, including:

1. The type of services or treatment.

2. The date the department will provide each service or referral for the service if the service is being provided by the department or its agent.

3. The date by which the parent must complete each task.

4. The frequency of services or treatment provided. The frequency of the delivery of services or treatment provided shall be determined by the professionals providing the services

or treatment on a case-by-case basis and adjusted according to their best professional judgment.

5. The location of the delivery of the services.

6. The staff of the department or service provider accountable for the services or treatment.

7. A description of the measurable objectives, including the timeframes specified for achieving the objectives of the case plan and addressing the identified problem.

(c) If there is evidence of harm as defined in s. 39.01(30)(g), the case plan must include as a required task for the parent whose actions caused the harm that the parent submit to a substance abuse disorder assessment or evaluation and participate and comply with treatment and services identified in the assessment or evaluation as being necessary.

Section 14. Subsection (7) is added to section 39.6221, Florida Statutes, to read:

39.6221 Permanent guardianship of a dependent child.—

(7) The requirements of s. 61.13001 do not apply to permanent guardianships established under this section.

Section 15. Paragraph (h) is added to subsection (1) of section 39.701, Florida Statutes, to read:

39.701 Judicial review.—

(1) GENERAL PROVISIONS.—

(h) If a child is born into a family that is under the court's jurisdiction or a child moves into a home that is under

the court's jurisdiction, the department shall assess the child's safety and provide notice to the court.

1. The department shall complete an assessment to determine how the addition of a child will impact family functioning. The assessment must be completed at least 30 days before a child is expected to be born or to move into a home, or within 72 hours after the department learns of the pregnancy or addition if the child is expected to be born or to move into the home in less than 30 days. The assessment shall be filed with the court.

2. Once a child is born into a family or a child moves into the home, the department shall complete a progress update and file it with the court.

3. The court has the discretion to hold a hearing on the progress update filed by the department.

4. The department shall adopt rules to implement this subsection.

Section 16. Subsection (3) of section 39.801, Florida Statutes, is amended to read:

39.801 Procedures and jurisdiction; notice; service of process.—

(3) Before the court may terminate parental rights, in addition to the other requirements set forth in this part, the following requirements must be met:

(a) Notice of the date, time, and place of the advisory

hearing for the petition to terminate parental rights and a copy of the petition must be personally served upon the following persons, specifically notifying them that a petition has been filed:

1. The parents of the child.

2. The legal custodians of the child.

3. If the parents who would be entitled to notice are dead or unknown, a living relative of the child, unless upon diligent search and inquiry no such relative can be found.

4. Any person who has physical custody of the child.

5. Any grandparent entitled to priority for adoption under s. 63.0425.

6. Any prospective parent who has been identified under s. 39.503 or s. 39.803, unless a court order has been entered pursuant to s. 39.503(4) or (9) or s. 39.803(4) or (9) which indicates no further notice is required. Except as otherwise provided in this section, if there is not a legal father, notice of the petition for termination of parental rights must be provided to any known prospective father who is identified under oath before the court or who is identified by a diligent search of the Florida Putative Father Registry. Service of the notice of the petition for termination of parental rights may not be required if the prospective father executes an affidavit of nonpaternity or a consent to termination of his parental rights which is accepted by the court after notice and opportunity to

be heard by all parties to address the best interests of the child in accepting such affidavit.

7. The guardian ad litem for the child or the representative of the guardian ad litem program, if the program has been appointed.

The document containing the notice to respond or appear must contain, in type at least as large as the type in the balance of the document, the following or substantially similar language: "FAILURE TO PERSONALLY APPEAR AT THIS ADVISORY HEARING CONSTITUTES CONSENT TO THE TERMINATION OF PARENTAL RIGHTS OF THIS CHILD (OR CHILDREN). IF YOU FAIL TO APPEAR ON THE DATE AND TIME SPECIFIED, YOU MAY LOSE ALL LEGAL RIGHTS AS A PARENT TO THE CHILD OR CHILDREN NAMED IN THE PETITION ATTACHED TO THIS NOTICE."

(b) If a party required to be served with notice as prescribed in paragraph (a) cannot be served, notice of hearings must be given as prescribed by the rules of civil procedure, and service of process must be made as specified by law or civil actions.

(c) Notice as prescribed by this section may be waived, in the discretion of the judge, with regard to any person to whom notice must be given under this subsection if the person executes, before two witnesses and a notary public or other officer authorized to take acknowledgments, a written surrender

of the child to a licensed child-placing agency or the department.

(d) If the person served with notice under this section fails to personally appear at the advisory hearing, the failure to personally appear shall constitute consent for termination of parental rights by the person given notice. If a parent appears for the advisory hearing and the court orders that parent to personally appear at the adjudicatory hearing for the petition for termination of parental rights, stating the date, time, and location of said hearing, then failure of that parent to personally appear at the adjudicatory hearing shall constitute consent for termination of parental rights.

Section 17. Section 39.803, Florida Statutes, is amended, to read:

39.803 Identity or location of parent unknown after filing of termination of parental rights petition; special procedures.—

(1) If the identity or location of a parent is unknown and a petition for termination of parental rights is filed, the court shall conduct <u>under oath</u> the following inquiry of the parent who is available, or, if no parent is available, of any relative, caregiver, or legal custodian of the child who is present at the hearing and likely to have the information:

(a) Whether the mother of the child was married at the probable time of conception of the child or at the time of birth of the child.

(b) Whether the mother was cohabiting with a male at the probable time of conception of the child.

(c) Whether the mother has received payments or promises of support with respect to the child or because of her pregnancy from a man who claims to be the father.

(d) Whether the mother has named any man as the father on the birth certificate of the child or in connection with applying for or receiving public assistance.

(e) Whether any man has acknowledged or claimed paternity of the child in a jurisdiction in which the mother resided at the time of or since conception of the child, or in which the child has resided or resides.

(f) Whether a man is named on the birth certificate of the child pursuant to s. 382.013(2).

(g) Whether a man has been determined by a court order to be the father of the child.

(h) Whether a man has been determined by an administrative proceeding to be the father of the child.

(2) The information required in subsection (1) may be supplied to the court or the department in the form of a sworn affidavit by a person having personal knowledge of the facts.

(3) If the inquiry under subsection (1) identifies any person as a parent or prospective parent, the court shall require notice of the hearing to be provided to that person.

(4) If the inquiry under subsection (1) fails to identify

any person as a parent or prospective parent, the court shall so find and may proceed without further notice.

(5) If the inquiry under subsection (1) identifies a parent or prospective parent, and that person's location is unknown, the court shall direct the petitioner to conduct a diligent search for that person before scheduling an adjudicatory hearing regarding the petition for termination of parental rights to the child unless the court finds that the best interest of the child requires proceeding without actual notice to the person whose location is unknown.

(6) The diligent search required by subsection (5) must include, at a minimum, inquiries of all known relatives of the parent or prospective parent, inquiries of all offices of program areas of the department likely to have information about the parent or prospective parent, inquiries of other state and federal agencies likely to have information about the parent or prospective parent, inquiries of appropriate utility and postal providers, a thorough search of at least one electronic database specifically designed for locating persons, a search of the Florida Putative Father Registry, and inquiries of appropriate law enforcement agencies. Pursuant to s. 453 of the Social Security Act, 42 U.S.C. s. 653(c)(4), the department, as the state agency administering Titles IV-B and IV-E of the act, shall be provided access to the federal and state parent locator service for diligent search activities.

(7) Any agency contacted by petitioner with a request for information pursuant to subsection (6) shall release the requested information to the petitioner without the necessity of a subpoena or court order.

(8) If the inquiry and diligent search identifies a prospective parent, that person must be given the opportunity to become a party to the proceedings by completing a sworn affidavit of parenthood and filing it with the court or the department. A prospective parent who files a sworn affidavit of parenthood while the child is a dependent child but no later than at the time of or before ~~prior to~~ the adjudicatory hearing in the termination of parental rights proceeding for the child shall be considered a parent for all purposes under this section. If the prospective parent does not file a sworn affidavit of parenthood or if the other parent contests the determination of parenthood, the court may, after considering the best interests of the child, order scientific testing to determine the maternity or paternity of the child. The court shall assess the cost of the paternity determination as a cost of litigation. If the court finds the prospective parent to be a parent as a result of the scientific testing, the court shall enter a judgment of maternity or paternity, shall assess the cost of the scientific testing to the parent, and shall enter an amount of child support to be paid by the parent as determined under s. 61.30. If the known parent contests the recognition of

the prospective parent as a parent, the prospective parent shall not be recognized as a parent until proceedings to establish paternity have been concluded. However, the prospective parent shall continue to receive notice of hearings as a participant until proceedings to establish paternity have been concluded.

(9) If the diligent search under subsection (5) fails to identify and locate a prospective parent, the court shall so find and may proceed without further notice.

Section 18. Paragraph (l) of subsection (1) of section 39.806, Florida Statutes, is amended, and subsections (2) and (3) are republished, to read:

39.806 Grounds for termination of parental rights.—

(1) Grounds for the termination of parental rights may be established under any of the following circumstances:

(l) On three or more occasions the child or another child of the parent or parents has been placed in out-of-home care pursuant to this chapter or the law of any state, territory, or jurisdiction of the United States which is substantially similar to this chapter, and the conditions that led to the child's out-of-home placement were caused by the parent or parents.

(2) Reasonable efforts to preserve and reunify families are not required if a court of competent jurisdiction has determined that any of the events described in paragraphs (1)(b)-(d) or paragraphs (1)(f)-(m) have occurred.

(3) If a petition for termination of parental rights is

filed under subsection (1), a separate petition for dependency need not be filed and the department need not offer the parents a case plan having a goal of reunification, but may instead file with the court a case plan having a goal of termination of parental rights to allow continuation of services until the termination is granted or until further orders of the court are issued.

Section 19. Subsection (6) of section 39.811, Florida Statutes, is amended to read:

39.811 Powers of disposition; order of disposition.—

(6) The parental rights of one parent may be severed without severing the parental rights of the other parent only under the following circumstances:

(a) If the child has only one surviving parent;

(b) If the identity of a prospective parent has been established as unknown after sworn testimony;

(c) If the parent whose rights are being terminated became a parent through a single-parent adoption;

(d) If the protection of the child demands termination of the rights of a single parent; or

(e) If the parent whose rights are being terminated meets any of the criteria specified in s. 39.806(1)(c), (d), (f), (g), (h), (i), (j), (k), (l), (m), or (n) ~~and (f)-(m)~~.

Section 20. Paragraph (g) of subsection (4) of section 395.3025, Florida Statutes, is amended, and subsection (8) of

that section is republished, to read:

395.3025 Patient and personnel records; copies; examination.—

(4) Patient records are confidential and must not be disclosed without the consent of the patient or his or her legal representative, but appropriate disclosure may be made without such consent to:

(g) The Department of Children and Families, ~~or~~ its agent, or its contracted entity, for the purpose of investigations of or services for cases of abuse, neglect, or exploitation of children or vulnerable adults.

(8) Patient records at hospitals and ambulatory surgical centers are exempt from disclosure under s. 119.07(1), except as provided by subsections (1)-(5).

Section 21. Subsections (2) and (6) of section 402.40, Florida Statutes, are amended to read:

402.40 Child welfare training and certification.—

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

(a) "Child welfare certification" means a professional credential awarded by a department-approved third-party credentialing entity to individuals demonstrating core competency in any child welfare practice area.

(b) "Child welfare services" means any intake, protective investigations, preprotective services, protective services, foster care, shelter and group care, and adoption and related

services program, including supportive services and supervision provided to children who are alleged to have been abused, abandoned, or neglected or who are at risk of becoming, are alleged to be, or have been found dependent pursuant to chapter 39.

(c) "Child welfare trainer" means any person providing training for the purposes of child welfare professionals earning certification.

(d) ~~(c)~~ "Core competency" means the minimum knowledge, skills, and abilities necessary to carry out work responsibilities.

(e) ~~(d)~~ "Person providing child welfare services" means a person who has a responsibility for supervisory, direct care, or support-related work in the provision of child welfare services pursuant to chapter 39.

(f) ~~(e)~~ "Preservice curriculum" means the minimum statewide training content based upon the core competencies which is made available to all persons providing child welfare services.

(g) ~~(f)~~ "Third-party credentialing entity" means a department-approved nonprofit organization that has met nationally recognized standards for developing and administering professional certification programs.

(6) ADOPTION OF RULES.—The Department of Children and Families shall adopt rules necessary to carry out ~~the provisions of~~ this section, including the requirements for child welfare

trainers.

Section 22. Paragraph (a) of subsection (7) of section 456.057, Florida Statutes, is amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished; disclosure of information.—

(7)(a) Except as otherwise provided in this section and in s. 440.13(4)(c), such records may not be furnished to, and the medical condition of a patient may not be discussed with, any person other than the patient, the patient's legal representative, or other health care practitioners and providers involved in the patient's care or treatment, except upon written authorization from the patient. However, such records may be furnished without written authorization under the following circumstances:

1. To any person, firm, or corporation that has procured or furnished such care or treatment with the patient's consent.

2. When compulsory physical examination is made pursuant to Rule 1.360, Florida Rules of Civil Procedure, in which case copies of the medical records shall be furnished to both the defendant and the plaintiff.

3. In any civil or criminal action, unless otherwise prohibited by law, upon the issuance of a subpoena from a court of competent jurisdiction and proper notice to the patient or the patient's legal representative by the party seeking such

records.

4. For statistical and scientific research, provided the information is abstracted in such a way as to protect the identity of the patient or provided written permission is received from the patient or the patient's legal representative.

5. To a regional poison control center for purposes of treating a poison episode under evaluation, case management of poison cases, or compliance with data collection and reporting requirements of s. 395.1027 and the professional organization that certifies poison control centers in accordance with federal law.

6. To the Department of Children and Families, its agent, or its contracted entity, for the purpose of investigations of or services for cases of abuse, neglect, or exploitation of children or vulnerable adults.

Section 23. Section 409.141, Florida Statutes, is repealed.

Section 24. Section 409.1677, Florida Statutes, is repealed.

Section 25. Subsection (1) of section 39.524, Florida Statutes, is amended to read:

39.524 Safe-harbor placement.—

(1) Except as provided in s. 39.407 or s. 985.801, a dependent child 6 years of age or older who has been found to be a victim of sexual exploitation as defined in s. 39.01 ~~s.~~

~~39.01(70)(g)~~ must be assessed for placement in a safe house or safe foster home as provided in s. 409.1678 using the initial screening and assessment instruments provided in s. 409.1754(1). If such placement is determined to be appropriate for the child as a result of this assessment, the child may be placed in a safe house or safe foster home, if one is available. However, the child may be placed in another setting, if the other setting is more appropriate to the child's needs or if a safe house or safe foster home is unavailable, as long as the child's behaviors are managed so as not to endanger other children served in that setting.

Section 26. Paragraph (p) of subsection (4) of section 394.495, Florida Statutes, is amended to read:

394.495 Child and adolescent mental health system of care; programs and services.—

(4) The array of services may include, but is not limited to:

(p) Trauma-informed services for children who have suffered sexual exploitation as defined in s. 39.01 ~~s. 39.01(70)(g)~~.

Section 27. Paragraph (c) of subsection (1) and paragraphs (a) and (b) of subsection (6) of section 409.1678, Florida Statutes, are amended to read:

409.1678 Specialized residential options for children who are victims of sexual exploitation.—

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

(c) "Sexually exploited child" means a child who has suffered sexual exploitation as defined in s. 39.01 ~~s. 39.01(70)(g)~~ and is ineligible for relief and benefits under the federal Trafficking Victims Protection Act, 22 U.S.C. ss. 7101 et seq.

(6) LOCATION INFORMATION.—

(a) Information about the location of a safe house, safe foster home, or other residential facility serving victims of sexual exploitation, as defined in s. 39.01 ~~s. 39.01(70)(g)~~, which is held by an agency, as defined in s. 119.011, is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. This exemption applies to such confidential and exempt information held by an agency before, on, or after the effective date of the exemption.

(b) Information about the location of a safe house, safe foster home, or other residential facility serving victims of sexual exploitation, as defined in s. 39.01 ~~s. 39.01(70)(g)~~, may be provided to an agency, as defined in s. 119.011, as necessary to maintain health and safety standards and to address emergency situations in the safe house, safe foster home, or other residential facility.

Section 28. Subsection (5) of section 960.065, Florida Statutes, is amended to read:

960.065 Eligibility for awards.—

(5) A person is not ineligible for an award pursuant to paragraph (2)(a), paragraph (2)(b), or paragraph (2)(c) if that person is a victim of sexual exploitation of a child as defined in s. 39.01 ~~s. 39.01(70)(g)~~.

Section 29. Section 409.1679, Florida Statutes, is amended to read:

409.1679 Additional requirements; reimbursement methodology.—

(1) Each program established under s. 409.1676 ~~ss. 409.1676 and 409.1677~~ must meet the following expectations, which must be included in its contracts with the department or lead agency:

(a) No more than 10 percent of the children served may move from one living environment to another, unless the child is returned to family members or is moved, in accordance with the treatment plan, to a less-restrictive setting. Each child must have a comprehensive transitional plan that identifies the child's living arrangement upon leaving the program and specific steps and services that are being provided to prepare for that arrangement. Specific expectations as to the time period necessary for the achievement of these permanency goals must be included in the contract.

(b) Each child must receive a full academic year of appropriate educational instruction. No more than 10 percent of the children may be in more than one academic setting in an

academic year, unless the child is being moved, in accordance with an educational plan, to a less-restrictive setting. Each child must demonstrate academic progress and must be performing at grade level or at a level commensurate with a valid academic assessment.

(c) Siblings must be kept together in the same living environment 100 percent of the time, unless that is determined by the provider not to be in the children's best interest. When siblings are separated in placement, the decision must be reviewed and approved by the court within 30 days.

(d) The program must experience a caregiver turnover rate and an incidence of child runaway episodes which are at least 50 percent below the rates experienced in the rest of the state.

(e) In addition to providing a comprehensive assessment, the program must provide, 100 percent of the time, any or all of the following services that are indicated through the assessment: residential care; transportation; behavioral health services; recreational activities; clothing, supplies, and miscellaneous expenses associated with caring for these children; necessary arrangements for or provision of educational services; and necessary and appropriate health and dental care.

(f) The children who are served in this program must be satisfied with the services and living environment.

(g) The caregivers must be satisfied with the program.

(2) ~~Notwithstanding the provisions of s. 409.141,~~ The

Department of Children and Families shall fairly and reasonably reimburse the programs established under s. 409.1676 ~~ss. 409.1676 and 409.1677~~ based on a prospective per diem rate, which must be specified annually in the General Appropriations Act. Funding for these programs shall be made available from resources appropriated and identified in the General Appropriations Act.

Section 30. Subsection (11) of section 1002.3305, Florida Statutes, is amended to read:

1002.3305 College-Preparatory Boarding Academy Pilot Program for at-risk students.—

(11) STUDENT HOUSING.—Notwithstanding s. 409.176 ~~ss. 409.1677(3)(d) and 409.176~~ or any other provision of law, an operator may house and educate dependent, at-risk youth in its residential school for the purpose of facilitating the mission of the program and encouraging innovative practices.

Section 31. For the purpose of incorporating the amendment made by this act to section 456.057, Florida Statutes, in a reference thereto, subsection (2) of section 483.181, Florida Statutes, is reenacted to read:

483.181 Acceptance, collection, identification, and examination of specimens.—

(2) The results of a test must be reported directly to the licensed practitioner or other authorized person who requested it, and appropriate disclosure may be made by the clinical

laboratory without a patient's consent to other health care practitioners and providers involved in the care or treatment of the patient as specified in s. 456.057(7)(a). The report must include the name and address of the clinical laboratory in which the test was actually performed, unless the test was performed in a hospital laboratory and the report becomes an integral part of the hospital record.

Section 32. This act shall take effect July 1, 2017.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1195 Health Care Facility Regulation
SPONSOR(S): Miller and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1760

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	12 Y, 0 N	Roth	Poche
2) Health Care Appropriations Subcommittee		Clark	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 1195 amends various authorizing and licensing statutes for entities regulated by the Agency for Health Care Administration (AHCA). The bill clarifies existing licensure and enforcement requirements, amends certain provisions to eliminate conflict among licensure statutes in Part I of Chapter 395, F.S., Chapter 400, F.S., and Part II of Chapter 408, F.S., increases administrative efficiency at AHCA, and repeals redundant or obsolete statutes. Specifically, the bill:

- Repeals Part I of ch. 483, F.S. regulating clinical laboratories. Clinical laboratories that perform testing on specimens derived from within Florida will no longer be required to obtain state licensure. Clinical laboratories will continue to be certified by the federal Clinical Laboratory Improvement Amendments program.
- Repeals the health care risk manager licensure requirements and the Health Care Risk Manager Advisory Council.
- Addresses unlicensed assisted living facilities (ALF) by strengthening the enforcement capabilities of AHCA. The statutory changes help protect residents of ALFs, and individuals seeking care in an ALF.
- Repeals the Subscriber Assistance Program, which resolves disputes between health maintenance organizations and subscribers. Subscribers have several other options in state and federal law to resolve such disputes.
- Eliminates the mobile surgical facility license. To date, no license has been issued for a mobile surgical facility.
- Repeals obsolete special designations of rural hospitals.
- Eliminates conflict between part II of chapter 408, F.S., and home health agency licensure statutes.
- Protects vulnerable adults receiving health or custodial care by deeming unlicensed activity as abuse and neglect for purpose of triggering adult protective services under chapter 415, F.S.
- Repeals the Statewide Managed Care Ombudsman Committee. The last activity on record was in 2010, and there are currently no active committees.
- Eliminates the special procedures for investigating emergency access complaints against hospitals, allowing AHCA to use existing hospital complaint investigation procedures used for all other types of complaints.
- Repeals an exemption to licensure for any facility that was providing obstetrical and gynecological surgical services and was owned and operated by a board-certified obstetrician on June 15, 1984. There are currently no providers who meet the definition.
- Removes broad language that prevents nurse registries from marketing their services.
- Makes necessary conforming changes throughout the statutes to reflect the changes proposed in the bill.

The bill has a significant, negative fiscal impact on AHCA due to a decrease in revenues from the repeal of certain licensure application fees; however, regulatory trust fund revenues are sufficient to absorb this loss. In addition, AHCA should experience administrative efficiencies including a decreased need for full-time equivalent (FTE) positions associated with this legislation that will have a positive fiscal impact.

Except where expressly provided otherwise, the bill has an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Agency for Health Care Administration – Division of Health Quality Assurance

The Division of Health Quality Assurance (HQA), housed within the Agency for Health Care Administration (AHCA), licenses, certifies, and regulates 40 different types of health care providers. In total, HQA regulates more than 42,000 individual providers.[1] Regulated providers include:

- Laboratories performing testing under the Drug-Free Workplace program, pursuant to s. 440.102(9), F.S.
- Birth centers, as provided under chapter 383, F.S.
- Abortion clinics, as provided under chapter 390, F.S.
- Crisis stabilization units, as provided under parts I and IV of chapter 394, F.S.
- Short-term residential treatment facilities, as provided under parts I and IV of chapter 394, F.S.
- Residential treatment facilities, as provided under part IV of chapter 394, F.S.
- Residential treatment centers for children and adolescents, as provided under part IV of chapter 394, F.S.
- Hospitals, as provided under part I of chapter 395, F.S.
- Ambulatory surgical centers, as provided under part I of chapter 395, F.S.
- Mobile surgical facilities, as provided under part I of chapter 395, F.S.
- Health care risk managers, as provided under part I of chapter 395, F.S.
- Nursing homes, as provided under part II of chapter 400, F.S.
- Assisted living facilities, as provided under part I of chapter 429, F.S.
- Home health agencies, as provided under part III of chapter 400, F.S.
- Nurse registries, as provided under part III of chapter 400, F.S.
- Companion services or homemaker services providers, as provided under part III of chapter 400, F.S.
- Adult day care centers, as provided under part III of chapter 429, F.S.
- Hospices, as provided under part IV of chapter 400, F.S.
- Adult family-care homes, as provided under part II of chapter 429, F.S.
- Homes for special services, as provided under part V of chapter 400, F.S.
- Transitional living facilities, as provided under part XI of chapter 400, F.S.
- Prescribed pediatric extended care centers, as provided under part VI of chapter 400, F.S.
- Home medical equipment providers, as provided under part VII of chapter 400, F.S.
- Intermediate care facilities for persons with developmental disabilities, as provided under part VIII of chapter 400, F.S.
- Health care services pools, as provided under part IX of chapter 400, F.S.
- Health care clinics, as provided under part X of chapter 400, F.S.
- Clinical laboratories, as provided under part I of chapter 483, F.S.
- Multiphasic health testing centers, as provided under part II of chapter 483, F.S.
- Organ, tissue, and eye procurement organizations, as provided under part V of chapter 765, F.S.

[1] Agency for Health Care Administration, *Health Quality Assurance*, 2017, available at http://ahca.myflorida.com/MCHQ/ (last viewed March 8, 2017).

Clinical Laboratories

Background

A clinical laboratory is the physical location in which services are performed to provide information or materials for use in the diagnosis, prevention, or treatment of a disease or the identification or assessment of a medical or physical condition.[2] Services performed in clinical labs include:

- The examination of fluids or other materials taken from the human body.[3]
- The examination of tissue taken from the human body.[4]
- The examination of cells from individual tissues or fluid taken from the human body.[5]

Clinical labs are regulated under Part I of ch. 483, F.S. In keeping with federal law and regulations, clinical laboratories must meet appropriate standards.[6] Such standards include overall standards of performance that comply with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA), and the federal rules adopted thereunder, for a comprehensive quality assurance program[7] and standards of performance in the examination of specimens for clinical laboratory proficiency testing programs using external quality control procedures.[8] AHCA may impose an administrative fine of no more than $1,000 per violation of any statute or rule.[9] In determining the penalty to be imposed for a violation, the following factors must be considered:

- The severity of the violation.
- Actions taken by the licensee to correct the violation or to remedy the complaint.
- Any previous violation by the licensee.
- The financial benefit to the licensee of committing or continuing the violation.[10]

Clinical Laboratory Improvement Amendments of 1988

The Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing performed on humans in the United States through the CLIA.[11] The CLIA program was established to ensure quality laboratory testing. The Division of Laboratory Services, within the Survey and Certification Group, under the Center for Clinical Standards and Quality (CCSQ) in CMS has the responsibility for implementing the CLIA Program.[12] In total, CLIA covers approximately 254,000 laboratory entities.[13]

In October 1993, Florida passed legislation requiring all facilities, including doctor's offices, performing clinical laboratory testing to be licensed.[14] AHCA first adopted rules regulating clinical laboratories in 1994, in what is now Chapter 59A-7, F.A.C. Previously, in September 1992, the federal government required all facilities, including doctor's offices, performing clinical laboratory testing to register with the CLIA program.[15]

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[2] S. 483.041, F.S.
[3] S. 483.041(2)(a), F.S.
[4] S. 483.041(2)(b), F.S.
[5] S. 483.041(2)(c), F.S.
[6] S. 483.021, F.S.
[7] S. 483.051(2)(a), F.S.
[8] S. 483.051(2)(b), F.S.
[9] S. 483.221(1), F.S.
[10] S. 483.221(2)(a)-(d), F.S.
[11] Centers for Medicare & Medicaid Services, *Clinical Laboratory Improvement Amendments (CLIA)*, available at https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html?redirect=/CLIA/10_Categorization_of_Tests.asp (last viewed March 7, 2017).
[12] Id.
[13] Id.
[14] Agency for Health Care Administration, *Clinical Laboratory Regulation in Florida*, pg. 2, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Laboratory_Licensure/docs/clin_lab/OverviewBrochure_lab.pdf (last viewed March 7, 2017).
[15] Id.

AHCA previously issued two types of clinical laboratory licenses: waived and non-waived.[16] A waived test is a test that CMS has determined qualifies for a certificate of waiver under the CLIA program and associated federal rules.[17] Examples of waived tests include dip stick urinalysis, urine pregnancy tests, and blood glucose.[18] Any laboratory conducting waived tests must have a valid CLIA certificate of waiver.[19]

The CLIA program issues four types of certificates:

- Certificate of Waiver – Issued to a laboratory to perform only waived tests.
- Certificate of Provider-Performed Microscopy Procedures (PPMP)[20] - Issued to a laboratory in which a physician, midlevel practitioner or dentist performs no tests other than the microscopy procedures. This certificate permits the laboratory to also perform waived tests.
- Certificate of Compliance - Issued to a laboratory after an inspection that finds the laboratory to be in compliance with all applicable CLIA requirements.
- Certificate of Accreditation - Issued to a laboratory on the basis of the laboratory's accreditation by an accreditation organization approved by the Centers for Medicare and Medicaid.[21]

Facilities performing any non-waived clinical laboratory testing or testing using microscopes must obtain a clinical laboratory license before the laboratory is authorized to perform testing.[22] In July 2009, the requirement for laboratories that performed waived testing to obtain a state license was repealed. After July 2009, the state issued only the non-waived clinical laboratory license.[23] Rule 59A-7.021, F.A.C., sets out the application process for non-waived state licensure.

Currently, all clinical laboratories performing non-waived testing in Florida must hold both a valid state license and federal CLIA certificate.[24]

Alternate Site Laboratory Testing

Generally, clinical laboratory testing may be done at a hospital' s main or central laboratory or satellite laboratories, which are licensed clinical laboratories established on the same or adjoining grounds of a hospital licensed under Chapter 395. Testing at satellite labs must be done by licensed clinical laboratory personnel. Section 483.051(9), F.S., allows for alternate-site testing, which is any laboratory testing done under the administrative control of a hospital, but performed out of the physical or administrative confines of the hospital's central laboratory. This allows tests to be performed bedside, at a nurse station, in an operating room or the emergency room, or anywhere else under the administrative control of a hospital. Alternate-site testing is regulated under rule 59A-7.034, F.A.C.

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[16] Id.
[17] S. 483.041(10), F.S.
[18] Supra, FN 19.
[19] Agency for Health Care Administration, *Waived Laboratories*, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Laboratory_Licensure/waived_apps.shtml (last viewed March 7, 2017).
[20] Center for Surveillance, Epidemiology, and Laboratory Services, *Provider-Performed Microscopy Procedures: A Focus on Quality Practices*, February 2016, available at https://wwwn.cdc.gov/clia/Resources/PPMP/pdf/15_258020-A_Stang_PPMP_Booklet_FINAL.pdf (last reviewed March 7, 2017). PPMPs are a select group of moderately complex microscopy tests commonly performed by health care providers during patient office visits. Tests included in PPMP do not meet the criteria for waiver because they are not simple procedures, but rather require training and specific skills to conduct such tests.
[21] Id.
[22] Agency for Health Care Administration, *Clinical Laboratories*, 2017, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Laboratory_Licensure/non-waived_apps.shtml (last viewed March 7, 2017).
[23] Supra, FN 14.
[24] Id. In July 2006, Florida enacted comprehensive basic licensure requirements under Part II of Chapter 408, F.S. that impacted all facilities licensed by AHCA, including clinical laboratories, in an effort streamline the licensing process. Health care facility licensing procedures can also be found in Chapter 59A-35, F.A.C.

Effect of Proposed Changes

The bill repeals Part I of ch. 483, F.S., which regulates clinical laboratories. Clinical laboratories that perform testing on specimens from within the state will no longer be required to obtain state licensure, which duplicated the federal regulatory scheme. Clinical laboratories must continue to be certified by the CLIA program.[25] The bill moves the language which grants AHCA rulemaking authority, in consultation with the Board of Clinical Laboratory Personnel, to adopt criteria for alternate-site testing to be performed under the supervision of a clinical laboratory director, from s. 483.051, F.S., which is being repealed, and puts it in s. 395.0091, F.S., to continue AHCA's rulemaking authority.

The bill also makes conforming changes to the following statutes to reflect the repeal of state licensure requirements for clinical laboratories: ss. 20.43(3)(g), 381.0034, 381.0031(2), 381.004, 383.313(1), 384.31, 395.009, 395.7015(2)(b), 400.9905(4), 400.0625(1), 408.033(2)(a), 408.07(11), 408.802, 408.806, 408.820(26), 409.905(7), 456.001, 456.057, 483.294, 483.801(3), 483.803, 483.813, 491.003, F.S., 627.351(4)(h), 766.202(4), and 945.36(1), F.S.

Health Care Risk Managers

Background

A health care risk manager assesses and minimizes various risks to staff, patients and the public in a health care organization,[26] and can play a role in reducing safety, finance, and patient problems in the organization or facility.[27] Health care risk managers are trained to handle public relations, personnel, operations, or financial problems.[28] Health care risk managers also assist with managing minor, daily problems and major, unexpected events.[29]

Every hospital and ambulatory surgical center (ASC) licensed under part I of chapter 395, F.S., is required to establish and maintain an internal risk management program.[30] The purpose of the risk management program is to control and prevent medical accidents and injuries.[31] The internal risk management program must include:

- A process to investigate and analyze the frequency and causes of adverse incidents to patients.
- Appropriate measures to minimize the risk of adverse incidents to patients.
- The analysis of patient grievances that relate to patient care and the quality of medical services.
- A system for informing a patient or an individual that she or he was the subject of an adverse incident.
- An incident reporting system which allows for the reporting of adverse incidents to the risk manager within 3 business days after their occurrence.[32]

Each licensed facility must hire a licensed health care risk manager who is responsible for implementation and oversight of the facility's internal risk management program.[33]

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[25] Agency for Health Care Administration, *2017 Agency Legislative Bill Analysis*, December 2016, pg. 7 (on file with the Health Innovation Subcommittee).
[26] Healthcare Administration Degree Programs, *What is a Health Care Risk Manager?*, available at http://www.healthcare-administration-degree.net/faq/what-is-a-health-care-risk-manager/ (last viewed March 8, 2017).
[27] Id.
[28] Id.
[29] Id.
[30] S. 395.0197(1), F.S.
[31] S. 395.10971, F.S.
[32] S. 395.0197(1)(a)-(d), F.S.
[33] S. 395.0197(2), F.S.

Licensure

Health care risk managers must be licensed by AHCA. In order to qualify for licensure, an applicant must demonstrate competence, by education or experience, in:

- Applicable standards of health care risk management.
- Applicable federal, state, and local health and safety laws and rules.
- General risk management administration.
- Patient care.
- Medical care.
- Personal and social care.
- Accident prevention.
- Departmental organization and management.
- Community interrelationships.
- Medical terminology.[34]

A license must be issued if an applicant can affirmatively prove that he or she is:

- 18 years of age or over;
- A high school graduate or equivalent; and
    - Has fulfilled the requirements of a 1-year program or its equivalent in health care risk management training which may be developed or approved by AHCA;
    - Has completed 2 years of college-level studies which would prepare the applicant for health care risk management, to be further defined by rule; or
    - Has obtained 1 year of practical experience in health care risk management.[35]

AHCA currently licenses 2,458 health care risk managers and 602, or 24.5 percent, report working in a licensed capacity for at least one hospital or ASC.[36] On average, for the past five years, approximately 174 initial applications for licensure are received and 181 licensees fail to renew each year.[37]

Denial, Suspension, or Revocation of a License

AHCA may deny, suspend, revoke, or refuse to renew or continue the license of an applicant or health care risk manager if any one or more of the following grounds exist:

- Any cause for which issuance of the license could have been refused had it then existed and been known to AHCA.
- Giving false or forged evidence to AHCA for the purpose of obtaining a license.
- Having been found guilty of, or having pleaded guilty or nolo contendere to, a crime in this state or any other state relating to the practice of risk management or the ability to practice risk management, whether or not a judgment or conviction has been entered.
- Having been found guilty of, or having pleaded guilty or nolo contendere to, a felony, or a crime involving moral turpitude punishable by imprisonment of 1 year or more under the law of the United States, any state, or any other country, without regard to whether a judgment of conviction has been entered by the court having jurisdiction of such cases.
- Making or filing a report or record which the licensee knows to be false; or intentionally failing to file a report or record required by state or federal law; or willfully impeding or obstructing, or inducing another person to impede or obstruct, the filing of a report or record required by state or federal law.

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[34] S. 395.10974(1), F.S.
[35] S. 395.10974(2). F.S.
[36] Supra, FN 25 at pg. 3.
[37] Id.

- Fraud or deceit, negligence, incompetence, or misconduct in the practice of health care risk management.
- Violation of any provision of this part or any other law applicable to the business of health care risk management.
- Violation of any lawful AHCA order or rule or failure to comply with a lawful subpoena issued by the Department of Health.
- Practicing with a revoked or suspended health care risk manager license.
- Repeatedly acting in a manner inconsistent with the health and safety of the patients of the licensed facility in which the licensee is the health care risk manager.
- Being unable to practice health care risk management with reasonable skill and safety to patients by reason of illness; drunkenness; or use of drugs, narcotics, chemicals, or any other material or substance or as a result of any mental or physical condition.
- Willfully permitting unauthorized disclosure of information relating to a patient or a patient's records.
- Discriminating against patients, employees, or staff on account of race, religion, color, sex, or national origin.[38]

When a health care risk manager fails to complete his or her tasks, the licensed facility is cited for any applicable violations, not the health care risk manager. Health care risk managers are exempt from monetary liability for any act or proceeding performed within the scope of the internal risk management program if the risk manager acts without intent to defraud.[39]

Health Care Risk Manager Advisory Council

The Secretary of AHCA may appoint a seven-member Health Care Risk Manager Advisory Council (Council) to advise AHCA on health care risk manager issues.[40] The Council must consist of:

- Two active health care risk managers, including one risk manager who is recommended by and a member of the Florida Society of Healthcare Risk Management.
- One active hospital administrator.
- One employee of an insurer or self-insurer of medical malpractice coverage.
- One public representative.
- Two licensed health care practitioners, one of whom must be a physician licensed under chapter 458 or chapter 459.[41]

Currently, there are no appointed Council members and there have been no Council meetings for at least ten years.[42]

Effect of Proposed Changes

The bill repeals the health care risk manager program and the Council. Licensed facilities must maintain an internal risk management program, but may hire any risk manager to run the program who meets criteria established by each facility. Florida is the only state to require the licensure of health care risk managers.[43] Repeal of the Council is appropriate as it has no members and has not met in over ten years.

[38] S. 395.10975(1), F.S.
[39] S. 395.0197(16), F.S.
[40] S. 395.10972, F.S.
[41] S. 395.10972(1)-(5), F.S.
[42] Supra, FN 25 at pg. 3.
[43] American Society for Healthcare Risk Management, *A Brief History of ASHRM 1980-2010... 30 Years and Counting!*, 2010, pg. 7., available at http://www.ashrm.org/about/files/A_Brief_History_of_ASHRM.pdf (last viewed March 15, 2017).

The bill also makes conforming changes to the following statutes to reflect the repeal of the health care risk manager program and the Council: ss. 395.0197(2)(c), 395.10973, 408.802, 408.820(10) & (11), 458.307, and 641.55, F.S.

Assisted Living Facilities

Background

Licensure

An assisted living facility (ALF) is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[44] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[45] Activities of daily living include ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[46]

ALFs are licensed and regulated by AHCA under part I of ch. 429, F.S., and part II of ch. 408, F.S. ALFs are also regulated by Department of Elder Affairs (DOEA) under ch. 58A-5, F.A.C. DOEA is responsible for developing and enforcing training requirements for ALF administrators and staff.

An administrator is an individual who is at least 21 years of age and is responsible for the operation and maintenance of an ALF.[47] Administrators must meet minimum training and education requirements established by the Department of Elder Affairs (DOEA). The training and education requirements allow administrators to assist ALFs to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements.[48] DOEA must establish a competency test and a minimum required score to indicate successful completion of the training and educational requirements. The required training and education must cover, at least, the following topics:

- State law and rules applicable to ALFs.
- Resident rights and identifying and reporting abuse, neglect, and exploitation.
- Special needs of elderly persons, persons with mental illness, and persons with developmental disabilities, and how to meet those needs.
- Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.
- Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication.
- Fire safety requirements, including fire evacuation drill procedures and other emergency procedures.
- Care of persons with Alzheimer's disease and related disorders.[49]

Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.[50] Effective October 1, 2015, each new ALF employee, who has not previously completed core training, must attend a preservice orientation provided by the ALF before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of ALF residents.[51] The ALF core training

[44] S. 429.02(5), F.S. An ALF does not include an adult family-care home or a non-transient public lodging establishment.
[45] S. 429.02(16), F.S.
[46] S. 429.02(1), F.S.
[47] S. 429.02(2), F.S.
[48] S. 429.52(2), F.S.
[49] S. 429.52(3), F.S.
[50] S. 429.52(5), F.S.
[51] S. 429.52(1), F.S.

requirements must consist of a minimum of 26 hours of training plus a competency test.[52] Administrators must successfully complete the ALF core training requirements within 3 months from the date of becoming an ALF administrator. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75 percent.[53]

An ALF is required to provide care and services that are appropriate for the needs of the residents admitted to the facility.[54] The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on certain criteria.[55] If a resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or a health care provider, the resident must be discharged in accordance with the Resident Bill of Rights.[56]

As of March 12, 2017, there are 3,101 licensed ALFs in Florida with 96,933 beds.[57]

Specialty Licensed Facilities

In addition to a standard license, an ALF may have one or more specialty licenses that allow the ALF to provide additional care. These specialty licenses include limited nursing services,[58] limited mental health services,[59] and extended congregate care services.[60]

Limited Mental Health License

A mental health resident is an individual who receives social security disability income due to a mental disorder as determined by the Social Security Administration or receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation.[61] A limited mental health (LMH) license is required for any ALF serving three or more mental health residents.[62] To obtain this license, the ALF may not have any current uncorrected deficiencies or violations, and the facility administrator and staff providing direct care to residents must complete six hours of training related to LMH duties, which is either provided by or approved by the Department of Children and Families (DCF).[63] A LMH license can be obtained during initial licensure, during relicensure, or upon request of the licensee.[64] Of the 3,101 licensed ALFs in the state, there are 837 facilities with LMH licenses, providing 13,598 beds.[65]

Extended Congregate Care License

The Extended Congregate Care License (ECC) allows an ALF to provide, directly or through contract, services performed by licensed nurses and supportive services to individuals who would otherwise be disqualified from continued residency in an ALF.[66] AHCA must first determine that all requirements in

[52] Rule 58A-5.0191(a), F.A.C.
[53] Rule 58A-5.0191(b), F.A.C.
[54] For specific minimum standards, see Rule 58A-5.0182, F.A.C.
[55] S. 429.26, F.S., and Rule 58A-5.0181, F.A.C.
[56] S. 429.28, F.S.
[57] Agency for Health Care Administration, *Facility/Provider Search Results-Assisted Living Facilities*, available at http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (report generated on March 12. 2017).
[58] S. 429.07(3)(c), F.S.
[59] S. 429.075, F.S.
[60] S. 429.07(3)(b), F.S.
[61] S. 429.02, F.S.
[62] S. 429.075, F.S.
[63] Id.
[64] Id.
[65] Agency for Health Care Administration, *Assisted Living Facilities with Limited Mental Health*, as of March 12, 2017, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/docs/alf/LMH_Directory_02-9-2017.pdf (last viewed on March 12, 2017).
[66] S. 429.07(3)(b), F.S.

law and rule are met before an ALF can be licensed to provide ECC services. Such licensure is regulated pursuant to s. 429.07, F.S., and Chapter 58A-5, F.A.C.

The primary purpose of ECC services is to allow residents, as their acuity level rises, to remain in a familiar setting. An ALF licensed to provide ECC services may also admit an individual who exceeds the admission criteria for a facility with a standard license, if the individual is determined appropriate for admission to the ECC facility. A licensed facility must adopt its own requirements within guidelines for continued residency set forth by rule. However, the facility may not serve residents who require 24-hour supervision.

Licensed ECC facilities may provide the following additional services:

- Total help with bathing, dressing, grooming, and toileting;
- Nursing assessments conducted more frequently than monthly;
- Measuring and recording basic vital functions and weight;
- Dietary management, including providing special diets, monitoring nutrition, and observing the resident's food and fluid intake and output;
- Assisting with self-administered medications;
- Supervising residents with dementia and cognitive impairments;
- Health education, counseling, and implementing health-promoting programs;
- Rehabilitative services; and
- Escort services to health-related appointments.[67]

Before being admitted to an ECC licensed facility to receive services, the prospective resident must undergo a medical examination.[68] The ALF must develop a service plan that sets forth how the facility will meet the resident's needs and must maintain a written progress report on each resident who receives ECC services.

ALFs with an ECC license must meet the following staffing requirements:

- Specify a staff member to serve as the ECC supervisor if the administrator does not perform this function;
- The administrator of an ECC licensed facility must have a minimum of two years of managerial, nursing, social work, therapeutic recreation, or counseling experience in a residential, long-term care, or acute care setting; and
- A baccalaureate degree may be substituted for one year of the required experience and a nursing home administrator licensed under chapter 468, F.S., shall be considered qualified.[69]

An ECC administrator or a supervisor, if different from the administrator, must complete the core training required of a standard licensed ALF administrator[70], and four hours of initial training in ECC care within 3 months of beginning employment. The administrator must complete a minimum of four hours of continued education every two years.[71]

All staff providing direct ECC care to residents must complete at least two hours of initial service training, provided by the administrator, within six months of beginning employment.[72]

ALFs with a standard license must pay a biennial license fee of $300 per license, with an additional fee of $50 per resident. The total fee may not exceed $10,000. In addition to the total fee assessed for

[67] Rule 58A-5.030(8)(b), F.A.C.
[68] Rule 58A-5.030(6), F.A.C.
[69] Rule 58A-5.030(4), F.A.C.
[70] 26 hours of training plus satisfactory performance on a competency test.
[71] Rule 58A-5.0191(7), F.A.C.
[72] Id.

standard licensed ALFs, facilities providing ECC services must pay an additional fee of $400 per license, with an additional fee of $10 per resident.[73] Of the 3,101 licensed ALFs in Florida, there are 253 facilities with ECC licenses, providing 18,163 beds.[74]

Limited Nursing Services License

Limited nursing services (LNS) are services beyond those provided by standard licensed ALFs. A licensed registered nurse in a facility with a LNS specialty license may only perform certain acts, as specified by rule.[75] Pursuant to Rule 58A-5.031, F.A.C., a licensed registered nurse may provide the following services in an ALF with an LNS license:

- Passive range of motion exercises;
- Ice caps or heat relief;
- Cutting toenails of diabetic residents;
- Ear and eye irrigations;
- Urine dipstick tests;
- Replacement of urinary catheters;
- Digital stool removal therapies;
- Applying and changing routine dressings that do not require packing or irrigation;
- Care for stage 2 pressure sores;
- Caring for casts, braces and splints;
- Conducting nursing assessments;
- Caring for and monitoring the application of anti-embolism stockings or hosiery;
- Administration and regulation of portable oxygen;
- Applying, caring for and monitoring a transcutaneous electric nerve stimulator; and
- Catheter, colostomy, and ileostomy care and maintenance.

A facility holding only a standard or LNS license must meet the following admission and continued residency criteria contained in Rule 59A-5.0181, F.A.C:[76] Potential residents must:

- Be at least 18 years of age;
- Be free from signs and symptoms of any communicable disease;
- Be able to perform the activities of daily living;
- Be able to transfer, with assistance if necessary;
- Be capable of taking their own medications with assistance from staff, if necessary;
- Not be a danger to themselves or others;
- Not require licensed professional mental health treatment on a 24-hour per day basis;
- Not be bedridden;
- Not have any stage 3 or 4 pressure sores;
- Not require nursing services for oral or other suctioning, assistance with tube feeding, monitoring of blood gases, intermittent positive pressure breathing therapy, or treatment of surgical incisions or wounds;
- Not require 24-hour nursing supervision;
- Not require skilled rehabilitative services; and
- Have been determined by the administrator to be appropriate for admission to the facility.[77]

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[73] S. 429.07(4), F.S.
[74] Agency for Health Care Administration, *Assisted Living Facilities with Extended Congregate Care,* as of March 12, 2017, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/docs/alf/ECC_Directory_02-9-2017.pdf (last viewed on March 12, 2017).
[75] S. 429.02(13), F.S.
[76] Rule 58A-5.031(2), F.A.C.
[77] Rule 58A-5.0181(1), F.A.C.

Facilities licensed to provide LNS must employ or contract with a nurse to provide necessary services to facility residents.[78] Licensed LNS facilities must maintain written progress reports on each resident receiving LNS. A registered nurse representing AHCA must visit these facilities at least twice a year to monitor residents and determine compliance.[79] A nursing assessment must be conducted at least monthly on each resident receiving LNS.[80]
Facilities licensed to provide LNS must pay the standard licensure fee of $300 per license, with an additional fee of $50 per resident and the total fee may not exceed $10,000. In addition to the standard fee, in order to obtain the LNS specialty license, facilities must pay an additional biennial fee of $250 per license, with an additional fee of $10 per bed.[81] Of the 3,101 licensed ALFs in Florida, there are 566 facilities with LNS licenses, providing 31,904 beds.[82]

Inspections and Surveys

AHCA must inspect each licensed ALF at least once every 24 months to determine compliance with statutes and rules. If an ALF is cited for a class I violation or three or more class II violations arising from separate surveys within a 60-day period or due to unrelated circumstances during the same survey, AHCA must conduct an additional licensure inspection within six months.[83]

Abbreviated Surveys

An applicant for licensure renewal is eligible for an abbreviated biennial survey by AHCA if the applicant does not have any:

- Class I or class II violations or uncorrected class III violations.
- Confirmed long-term care ombudsman council complaints reported to AHCA by the council.
- Confirmed licensing complaints within the two licensing periods immediately preceding the current renewal date.[84]

AHCA is required to expand an abbreviated survey or conduct a full survey if violations which threaten or potentially threaten the health, safety, or welfare of residents are identified during an abbreviated survey.[85]

Monitoring Visits

Facilities with LNS or ECC licenses are subject to monitoring visits by AHCA in which AHCA inspects the facility for compliance with the requirements of the specialty license type. An LNS licensee is subject to monitoring inspections at least twice a year. At least one registered nurse must be included in the inspection team to monitor residents receiving LNS and to determine if the facility is complying with applicable regulatory requirements. An ECC licensee is subject to quarterly monitoring inspections. At least one registered nurse must be included in the inspection team. AHCA may waive one of the required yearly monitoring visits for an ECC facility that has been licensed for at least 24 months, if the registered nurse who participated in the monitoring inspections determines that the ECC services are being provided appropriately, and there are no serious violations or substantiated complaints about the quality of service or care.

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[78] Rule 58A-5.031(2), F.A.C.
[79] S. 429.07(2)(c), F.S.
[80] Id.
[81] S. 429.07(4)(c), F.S.
[82] Agency for Health Care Administration, *Assisted Living Facilities with Limited Nursing Services*, as of March 12, 2017, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/docs/alf/LNS_Directory_02-9-2017.pdf (last viewed on March 12, 2017).
[83] S. 429.34(2), F.S.
[84] Rule 58A-5.033(1)(a), F.A.C.
[85] Rule 58A-5.033(1)(c), F.A.C.

Violations and Penalties

Under s. 408.813, F.S., ALFs may be subject to administrative fines imposed by AHCA for certain types of violations. Violations are categorized into four classes according to the nature of the violation and the gravity of its probable effect on residents.

- **Class I violations** are those conditions that AHCA determines present an imminent danger to residents or a substantial probability of death or serious physical or emotional harm. Examples include resident death due to medical neglect, risk of resident death due to inability to exit in an emergency, and the suicide of a mental health resident in an ALF licensed for Limited Mental Health. AHCA must issue a fine between $5,000 and $10,000 for each violation.
- **Class II violations** are those conditions that AHCA determines directly threaten the physical or emotional health, safety, or security of the clients. Examples include having no qualified staff in the facility, the failure to call 911 in a timely manner for resident in a semi-comatose state, and rodents in the food storage area. AHCA must issue a fine between $1,000 and $5,000 for each violation.
- **Class III violations** are those conditions that AHCA determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients. Examples include missing or incomplete resident assessments, erroneous documentation of medication administration, and failure to correct unsatisfactory DOH food service inspection findings in a timely manner. AHCA must issue a fine between $500 and $1,000 for each violation, but no fine may be imposed if the facility corrects the violation.
- **Class IV violations** are those conditions that do not have the potential of negatively affecting clients. Examples include failure to file an adverse incident report, incorrect phone numbers posted for advocacy resources, and failure to post current menus. AHCA can only fine a facility (between $100 and $200 for each violation) if the problem is not corrected. [86,87]

In addition to financial penalties, AHCA can take other actions against a facility. AHCA may deny, revoke, or suspend any license for any of the actions listed in s. 429.14(1)(a)-(k), F.S., such as an intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility or a determination by AHCA that the owner lacks the financial responsibility to provide continuing adequate care to residents. AHCA is required to deny or revoke the license of an ALF that has two or more class I violations that are similar to violations identified during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years.[88] AHCA may also impose an immediate moratorium or emergency suspension on any provider if it determines that any condition presents a threat to the health, safety, or welfare of a client.[89] AHCA is required to publicly post notification of a license suspension or revocation, or denial of a license renewal, at the facility.[90] Finally, Florida's Criminal Code, under ch. 825, F.S., provides criminal penalties for the abuse, neglect, and exploitation of elderly persons[91] and disabled adults.[92]

[86] When determining the amount of the fine, AHCA must consider the following factors: the gravity of the violation and the extent to which any laws or rules were violated, actions taken to correct the violations, any previous violations, the financial benefit of committing or continuing the violation, and the licensed capacity of the facility. S. 429.19(3), F.S.
[87] S. 429.19(2), F.S.
[88] S. 429.14(4), F.S.
[89] S. 408.814(1), F.S.
[90] S. 429.14(7), F.S.
[91] "Elderly person" means a person 60 years of age or older who is suffering from the infirmities of aging as manifested by advanced age or organic brain damage, or other physical, mental, or emotional dysfunction, to the extent that the ability of the person to provide adequately for the person's own care or protection is impaired. S. 825.101(5), F.S. It does not constitute a defense to a prosecution for any violation of Chapter 825, F.S., that the accused did not know the age of the victim. S. 825.104, F.S.
[92] "Disabled adult" means a person 18 years of age or older who suffers from a condition of physical or mental incapacitation due to a developmental disability, organic brain damage, or mental illness, or who has one or more physical or mental limitations that restrict the person's ability to perform the normal activities of daily living. S. 825.101(4), F.S.

Unlicensed Assisted Living Facilities

A person who owns, operates, or maintains an unlicensed ALF commits a felony of the third degree.[93] Any person found guilty of operating an unlicensed ALF a second or subsequent time commits a felony of the second degree.[94] Health care practitioners are mandatory reporters and must report an unlicensed ALF to AHCA.[95] Any provider who knowingly discharges a patient to an unlicensed ALF is subject to sanction by AHCA.[96]

AHCA has been concerned with the operation of unlicensed ALFs for years. AHCA works with the DCF, the Attorney General's Medicaid Fraud Control Unit, Medicaid Program Integrity, and DOEA when unlicensed activity is discovered.[97]

Effect of Proposed Changes

The bill makes several statutory changes to address unlicensed ALF activity:

- AHCA may immediately refer unlicensed activity to the state attorney's office in each judicial district.
- AHCA may impose immediate sanctions if the operator of an unlicensed ALF has previously applied for or held a license from AHCA to operate any health care provider.
- The state may criminally pursue any person who owns, operates, or maintains an unlicensed ALF as soon as the person receives notice from AHCA, instead of granting a 10-day grace period to cease the unlawful activity.
- The state may criminally pursue penalties against the property owners where the ALF is located, in addition to the operators, if the location is found to host unlicensed activity on more than one occasion.
- An unlicensed ALF asserting an exemption from licensure has the burden of providing documentation proving that it is entitled to the licensure exemption.
- An ALF is prohibited from providing personnel services to individuals who are not residents of the facility, with the exception of facilities that are licensed to provide adult day care services.
- An ALF is prohibited from operating for more than 120 consecutive days without an administrator who has completed the core educational requirements.

Each proposed change should deter individuals from operating unlicensed ALFs, protect the residents of facilities, and strengthen AHCA enforcement capabilities against unlicensed operators.

Subscriber Assistance Program

Background

Managed Health Care

Managed care refers to a variety of methods of financing and organizing the delivery of comprehensive health care in an effort to control costs and improve quality by controlling the provision of services. Managed care, in varying degrees, integrates the financing and delivery of medical care through contracts with selected physicians, hospitals, and other health care providers that provide comprehensive health care services to enrolled members for a predetermined monthly premium. The term "managed care organization" or "entity" includes health maintenance organizations, exclusive

[93] S. 429.08(1)(b), F.S.
[94] S. 429.08(1)(c), F.S.
[95] S. 429.08(2)(a), F.S.
[96] S. 429.08(2)(b), F.S.
[97] Supra, at FN 25 at pg. 4.

provider organizations, prepaid health clinics and Medicaid prepaid health plans. In addition, a health insurer that sells a preferred provider contract may be considered to be a "managed care" plan.[98]

Since 1973, under federal law,[99] HMOs have been required to establish and provide meaningful procedures for hearing and resolving grievances between the HMO and members of the organization. Medical groups and other health care delivery entities providing health care services for the organization must also be afforded grievance procedures under the federal law. Grievance procedures provide a mechanism to ensure that subscribers have a means of receiving further consideration of a HMO's decisions that deny care, treatment, or services. Under state law, such mechanisms are extended to adverse decisions of other types of managed care entities.[100]

Health insurance regulators have also had a substantial role in helping to resolve disputes arising between consumers and their health insurance carriers and health plans.[101] The types of disputes that regulators consider relate to decisions to deny or limit coverage and judgments about medical necessity or appropriateness of care.[102]

External Review Process

Section 641.47(1), F.S., defines the term "adverse determination" to mean a coverage determination by a HMO or prepaid health clinic that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the organization's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated. An adverse determination may be the basis for a grievance. A subscriber who chooses to challenge an adverse determination or file another type of grievance is required to first go through the managed care entity's internal grievance procedure. Once a final decision is rendered through this process, if the decision is unsatisfactory to the subscriber, then the subscriber may appeal through a binding arbitration process provided by the managed care entity or to the SAP.[103]

Subscriber Assistance Program

In 1985, Florida became the second state, following Michigan, to provide a mechanism for consumers to resolve managed care disputes through a state-administered external review process. The Florida program was moved from the Department of Health and Rehabilitative Services (HRS) to AHCA in 1993, and renamed the Statewide Provider and Subscriber Assistance Program (SAP).[104]

Section 408.7056, F.S., requires AHCA to implement the SAP to assist consumers of managed care entities with grievances that have not been satisfactorily resolved through the managed care entity's internal grievance process. The program can hear grievances of subscribers of HMOs, prepaid health clinics and exclusive provider organizations.[105]

Section 408.7056(11), F.S., provides that the panel must consist of:

- Members employed by AHCA and members employed by the Department of Insurance (DOI), chosen by their respective agencies;

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[98] The Florida Senate, *Review of the Implementation of the Statewide Provider and Subscriber Assistance Program*, September 2001, pg. 1-2, available at http://archive.flsenate.gov/data/Publications/2002/Senate/reports/interim_reports/pdf/2002-138hc.pdf (last viewed March 7, 2017).
[99] Health Maintenance Organization Act of 1973, Title 42, Sec. 300e, et seq.
[100] Supra, FN 98 at pg. 2.
[101] Pollitz, K., Dallek, G., et al., *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare*, (prepared for Kaiser Family Foundation) Institute for Health Care Research and Policy, November 1998.
[102] Supra, FN 98 at pg. 2.
[103] Id.
[104] Id.
[105] Id.

- A consumer appointed by the Governor;
- A physician appointed by the Governor, as a standing member; and
- Physicians who have expertise relevant to the case to be heard, on a rotating basis.

The agency may contract with a medical director and a primary care physician who may provide additional expertise. The medical director must be selected from a Florida licensed HMO.[106]

SAP hearings are public, unless a closed hearing is requested by the subscriber. A portion of a hearing may be closed by the panel when deliberating information of a sensitive personal nature, such as medical records.[107] In addition to hearings, the panel must meet as often as necessary to timely review, consider, and hear grievances about disputes between a subscriber, or a provider on behalf of a subscriber, and a managed care entity. Following its review, the panel must make a recommendation to AHCA or DOI. The recommendation may include specific actions the managed care entity must take to comply with state laws or rules. AHCA or DOI may adopt all or some of the panel's recommendations and may impose administrative sanctions on the managed care entity.[108] The following chart shows the number of cases received by the SAP, the number of cases heard by the panel, and the outcome of each case heard since FY 2009-2010.

Number of Cases Received by SAP FY 2009-2010 through FY 2016-2017 (YTD)[109]

SAP Cases	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016	FY 2016-2017 (YTD)
Cases Received	498	506	415	213	160	238	350	134
Cases Heard	124	96	74	17	19	29	53	15
Outcomes of Cases	**FY 2009-2010**	**FY 2010-2011**	**FY 2011-2012**	**FY 2012-2013**	**FY 2013-**	**FY 2009-2010**	**FY 2010-2011**	**FY 2011-2012**
Determined Non-jurisdictional	246	260	224	145	115	166	221	84
Incomplete Application	39	37	40	24	11	27	31	8
Request Withdrawn	27	21	20	9	6	11	26	5
Resolved Prior to Hearing	68	82	55	18	9	7	19	16
Found in Favor of Subscriber	23	23	19	5	7	7	27	1
Found in Favor of Plan	95	83	57	12	12	17	25	14

Effect of Proposed Changes

The bill repeals s. 408.7056, F.S. which established the SAP. Consumers will no longer be able to use the SAP as an alternative appeal option after exhausting the managed care entity's grievance process. However, the number of cases received by the SAP and the number of cases heard by the panel have steadily decreased over the past eight years. Subscribers have access to other grievance resolution programs; for example, Medicaid beneficiaries enrolled in a managed care plan may challenge an adverse decision by the plan through the Medicaid Fair Hearing process. Also, AHCA has contracted

[106] S. 408.7056(11)(a), F.S.
[107] S. 408.7056(14)(b), F.S.
[108] Supra, FN 98 at pg. 3.
[109] Email from Tony Guzzo, Deputy Legislative Affairs Director, Agency for Health Care Administration, RE: SAP stats, (February 28, 2017)(on file with the Health Innovation Subcommittee staff).

with MAXIMUS, an independent dispute resolution organization, to provide assistance to health care providers and health plans for resolving claim disputes.[110]

The Patient Protection and Affordable Care Act (PPACA) governs how insurance companies handle initial appeals and how consumers can request reconsideration of a payment denial.[111] If an insurance company upholds its decision to deny payment, the law provides consumers with the right to appeal the decision to an outside, independent decision-maker. Managed care plans that elected to participate in the federal program established by PPACA are no longer required to participate in the SAP.[112] Following enactment of PPACA, the majority of the health plans elected to use the federal program, and as a result, the SAP is no longer an external appeal option for the majority of their members.[113] There will be an insignificant adverse effect to consumers as a result of repeal of the SAP because of the small percentage of people currently taking advantage of the program.

The bill also makes conforming changes to the following statutes to reflect repeal of the SAP: ss. 220.1845(2)(k), 376.30781(3)(f), 376.86(1), 627.602(1)(h), 627.6513, 641.185, 641.312, 641.3154, 641.51(5), 641.511, and 641.515(1), F.S.

Mobile Surgical Facilities

Background

Section 395.002(21), F.S., defines a "mobile surgical facility" as:

> [A] mobile facility in which licensed health care professionals provide elective surgical care under contract with the Department of Corrections or a private correctional facility operating pursuant to chapter 957 and in which inmate patients are admitted to and discharged from said facility within the same working day and are not permitted to stay overnight. However, mobile surgical facilities may only provide health care services to the inmate patients of the Department of Corrections, or inmate patients of a private correctional facility operating pursuant to chapter 957, and not to the general public.

In addition, section 395.002(3), F.S., defines "mobile surgical facility", along with "ambulatory surgical center", as:

> [A] facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003. Any structure or vehicle in which a physician maintains an office and practices

[110] Agency for Health Care Administration, *Statewide Provider and Health Plan Claim Dispute Resolution Program*, October 15, 2013, pg. 1, available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Commercial_Managed_Care/docs/SPHPClaimDRP/claimsdisputeprogramsummary.pdf (last viewed March 7, 2017).
[111] 42 U.S.C. 300gg-19.
[112] Centers for Medicaid and Medicare Services, *The Center for Consumer Information & Insurance Oversight*, available at https://www.cms.gov/cciio/Programs-and-Initiatives/Consumer-Support-and-Information/External-Appeals.html (last viewed March 15, 2017).
[113] Agency for Health Care Administration, *2017 Agency Legislative Bill Analysis*, March 2017, pg. 7 (on file with the Health Innovation Subcommittee).

surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, shall be construed to be a mobile surgical facility.

AHCA licenses and regulates mobile surgical facilities.[114] The initial application for licensure must include:

- Proof of fictitious name registration, if applicable;
- Articles of Incorporation or a similarly titled document registered by the applicant with the Florida Department of State; and
- The center's Zoning Certificate or proof of compliance with zoning requirements.[115]

After the initial application is filed, AHCA will perform an initial licensure inspection. Some of the documents that must be available for during the initial licensure inspection are:

- The governing board bylaws, rules and regulations, or other written organizational plan;
- Roster of medical staff members;
- Roster of registered nurses and licensed practical nurses with current license numbers; and
- The Comprehensive Emergency Management Plan, pursuant to Rule 59A-5.018, F.A.C.[116]

A license fee of $1,679.82 must accompany an application for an initial, renewal, or change of ownership license for a mobile surgical facility.[117] Upon receipt of the required information, AHCA will conduct a licensure inspection to determine compliance with both the applicable statutes and rules.[118] Once the mobile surgical facility is in compliance and has received all approvals, AHCA will issue a license, which identifies the licensee and the name and location of the center.[119] A license issued to a mobile surgical facility will be revoked or denied by AHCA in any case where AHCA finds there has been substantial failure to comply with the applicable statutes and rules.[120]

Rule 59A-3.081, F.A.C., sets out the physical plant requirements for a mobile surgical facility, which include staying in compliance with the requirements of the National Fire Protection Association, site requirements, architectural design requirements, mechanical requirements, and electrical system requirements.

Effect of Proposed Changes

The bill eliminates the "mobile surgical facility" license category from statute by deleting the definition of mobile surgical facility and all other references to such a facility. Since the enactment of the mobile surgical facility license in statute, no such license has been issued and no applications for the license are anticipated.[121]

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[114] S. 395.003, F.S. and Rule 59A-5.003, F.A.C., contain the licensure provisions for mobile surgical facilities.
[115] Rule 59A-5.003(4)(a)-(c), F.A.C.
[116] Rule 59A-5.003(5), F.A.C.
[117] Rule 59A-5.003(7), F.A.C.
[118] Rule 59A-5.003(12), F.A.C.
[119] Rule 59A-5.003(13), F.A.C.
[120] Rule 59A-5.003(15), F.A.C. A "substantial failure to comply" means that there has been a major, or significant, breach of a requirement in law or rule. If a licensee fails to pay its renewal fee after receiving notice, AHCA may find that there is a substantial failure to comply and may suspend or revoke the license.
[121] Supra, FN 25 at pg. 2.

The bill also makes conforming changes to the following statutes to reflect the repeal of "mobile surgical facility" definitions from statute: ss. 385.211(2), 395.001, 394.4787(7), 395.0161(1)(f), 395.0163(3), 395.1055(2), 395.7015(2)(b), 408.036(3)(e), 408.802, and 408.820(10) & (11), 409.975(1), 627.64194(1), 766.118(6)(b), and 766.202(4), F.S.

Rural Hospital Programs

Background

A rural hospital is an acute care hospital that has 100 or fewer licensed beds and an emergency room which is:[122]

- The sole provider within a county with a population density of up to 100 persons per square mile;[123]
- An acute care hospital in a county with a population density of up to 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;[124]
- A hospital supported by a tax district or subdistrict whose boundaries encompass a population of up to 100 persons per square mile;[125]
- A hospital classified as a sole community hospital under 42 C.F.R. § 412.92 which has up to 175 licensed beds;[126]
- A hospital with a service area that has a population of up to 100 persons per square mile;[127] or
- A hospital designated as a critical access hospital, as defined in s. 408.07.[128]

Rural hospitals are usually the only source of emergency medical care in rural areas.[129] Rural hospitals provide emergency department services, inpatient care, outpatient care, long-term care, and care coordination services for a population of people who do not live in an urban setting.[130] Rural hospitals face specific challenges that other hospitals may not experience:

- Rural residents are older, poorer, and more likely to have chronic diseases than urban residents.
- Rural hospitals are typically smaller than urban hospitals.
- Rural hospitals provide a higher percentage of care in outpatient settings and are more likely to offer home health, skilled nursing, and assisted living; all of which have lower Medicare margins than inpatient care.
- Rural hospitals rely more heavily on reimbursement from public programs whose payments fall short of costs.[131]

Health care spending in a community has a significant impact on the local economy. Rural hospitals impact communities in both their capacity to attract new businesses and the wages generated through the facility. Quality rural health services are needed in rural communities to attract business and industry, as well as retirees. On average, nationwide, the health sector constitutes 14 percent of total employment in rural communities, with rural hospitals typically being one of the largest employers in the

[122] S. 395.602(2)(e), F.S.
[123] S. 395.602(2)(e)1., F.S.
[124] S. 395.602(2)(e)2., F.S.
[125] S. 395.602(2)(e)3., F.S.
[126] S. 395.602(2)(e)4., F.S.
[127] S. 395.602(2)(e)5., F.S. 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 at the Florida Center for Health Information and Transparency.
[128] S. 395.602(2)(e)6., F.S.
[129] S. 395.602(1)(a), F.S.
[130] Rural Health Information Hub, *Rural Hospitals*, April 29, 2015, available at https://www.ruralhealthinfo.org/topics/hospitals (last viewed March 5, 2017).
[131] Id.

area. A Critical Access Hospital, the federal designation for a rural hospital, on average maintains a payroll of $6.8 million and employs 141 people.[132]

Some of the ways in which the legislature has supported rural hospitals is by providing financial incentives under the Medical Education Tuition Reimbursement Program for primary care physicians and nurses in rural areas; extending Medicaid reimbursements to rural hospital swing-beds; and promoting the location and relocation of health care practitioners in rural areas.[133]

Special Designations for Rural Hospitals

AHCA licenses four classes of hospital.[134] Class I licenses are considered general hospitals and include rural hospitals.[135] All licensed hospitals must have:

- Inpatient beds;
- A governing authority legally responsible for the conduct of the hospital;
- A chief executive officer or others similarly titled official to who the governing authority delegates the full-time authority for the operation of the hospital in accordance with the established policy of the governing authority;
- An organized medical staff to which the governing authority delegates responsibility for maintaining proper standards for medical and other health care;
- A current and complete medical record for each patient admitted to the hospital;
- A policy requiring that all patients be admitted on the authority of and under the care of a member of the organized medical staff;
- Facilities and professional staff available to provide food to patients to meet their nutritional needs;
- A procedure for providing care in emergency cases;
- A method and policy for infection control; and
- An on-going organized program to enhance the quality of patient care and review the appropriateness of utilization of services.[136]

In addition, Class I hospitals must have:

- One licensed registered nurse on duty at all times on each floor or similarly titled part of the hospital for rendering patient care services;
- A pharmacy supervised by a licensed pharmacist either in the facility or by contract sufficient to meet patient needs;
- Diagnostic imaging services either in the facility or by contract sufficient to meet patient needs;
- Clinical laboratory services either in the facility or by contract sufficient to meet patient needs;
- Operating room services; and
- Anesthesia service.[137]

Though not used in rule or statute for licensure of hospitals or otherwise, there are several designations of "rural hospitals" based on their services, bed capacity, and location. These designations are "emergency care hospital," "essential access community hospital," and "rural primary care hospital."

An emergency care hospital is a medical facility which provides:

- Emergency medical treatment; and
- Inpatient care to ill or injured person prior to their transportation to another hospital; or

[132] Id.
[133] S. 395.602(1)(b), F.S.
[134] Rule 59A-3.252(1), F.A.C.
[135] Rule 59A-3.252(1)(a)3., F.A.C.
[136] Rule 59A-3.252(2), F.A.C.
[137] Rule 59A-3.252(3), F.A.C.

- Inpatient medical care to persons needing such care up to 96 hours.[138]

An essential access community hospital is a facility which:

- Has at least 100 beds;
- Is located more than 35 miles from any other essential access community hospital, rural referral center, or urban hospital meeting the criteria for classification as a regional referral center;[139]
- Is part of a network that includes rural primary care hospitals;
- Provides emergency and medical backup services to rural primary care hospitals in its rural health network;
- Extends staff privileges to rural primary care hospital physicians in its network; and
- Accepts patients transferred from rural primary care hospitals in its network.[140]

A rural primary care hospital is any facility meeting the criteria for a rural hospital or emergency care hospital which:

- Provides twenty-four-hour emergency medical care;
- Provides temporary inpatient care for 72 hours or less to patients requiring stabilization before discharge or transfer to another hospital; and
- Has no more than six licensed acute care inpatient beds.[141]

Florida does not have any emergency care hospitals, essential access community hospitals, or rural primary care hospitals.[142] The essential access community hospital and rural primary care hospital designations were established under federal programs that were implemented in 1993 and subsequently replaced in 1997 by the Critical Access Hospital program.[143]

Effect of Proposed Changes

The bill repeals the definitions of emergency care hospital, essential access community hospital, and rural primary care hospital. There are no rural hospitals with those designations, and the federal Critical Access Hospital program has replaced the essential access community hospital and rural primary care hospital designations. Rural hospitals will continue to operate as normal without the special designations, and the repeal will have no adverse effect on the application process for certificate of need or licensure of rural hospitals. The bill also repeals other rural hospital programs as those programs are obsolete once the special designations for rural hospitals are removed from statute.

An inactive rural hospital bed is a licensed acute care hospital bed, as defined in s. 395.002(13), that cannot be occupied by an acute care inpatient.[144] There is no longer a need for hospitals to track inactive beds because AHCA no longer maintains a list of facilities with inactive beds for the purpose of publishing the need for additional acute care beds under the CON program.[145]

The bill also makes conforming changes to the following statutes to reflect the repeal of "emergency care hospital," "essential access community hospital," "inactive rural hospital bed," and "rural primary care hospital" definitions from statute, as well as the repeal of other rural hospital programs and emergency care hospitals: ss. 395.603, 409.9116(6), 409.975(1), 458.345(1), 1009.65(2)(b), F.S.

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[138] S. 395.602(2)(a), F.S.
[139] Rural Referral Centers are high-volume acute care rural hospitals that treat a large number of complicated cases.
[140] S. 395.602(2)(b), F.S.
[141] S. 395.602(2)(f), F.S.
[142] Email from Tony Guzzo, Deputy Legislative Affairs Director, Agency for Health Care Administration, RE: HB 1195 (March 8, 2017) (on file with the Health Innovation Subcommittee staff).
[143] Id.
[144] S. 395.602(2)(c), F.S.
[145] Email from Tony Guzzo, Deputy Legislative Affairs Director, Agency for Health Care Administration, RE: another HB 1195 question (March 7, 2017) (on file with the Health Innovation Subcommittee staff).

Home Health Agency

Background

Home Health Agencies (HHAs) are organizations licensed AHCA to provide home health services and staffing services.[146] Home health services are health and medical services and medical supplies furnished to an individual in the individual's home or place of residence. These services include:

- Nursing care;
- Physical, occupational, respiratory, or speech therapy;
- Home health aide services (assistance with daily living such as bathing, dressing, eating, personal hygiene, and ambulation);
- Dietetics and nutrition practice and nutrition counseling; and
- Medical supplies, restricted to drugs and biologicals prescribed by a physician.[147]

Staffing services are provided to health care facilities, schools, or other business entities on a temporary or school-year basis by licensed health care personnel and by certified nursing assistants and home health aides who are employed by, or work under the umbrella of, a licensed HHA.[148]

A HHA may also provide homemaker[149] and companion[150] services without additional licensing or registration. These services do not involve hands-on personal care to a client and typically include housekeeping, meal planning and preparation, shopping assistance, routine household activities, and accompanying the client on outings. Personnel providing homemaker or companion services are employed by or under contract with a HHA.[151]

Licensure and Exceptions

Since 1975, HHAs operating in Florida have been required to obtain a state license.[152] HHAs must meet the general health care licensing provisions of part II of ch. 408, F.S., the specific HHA licensure provisions in part III of ch. 400, F.S., and the minimum standards for HHAs in chapter 59A-8, F.A.C. A HHA license is valid for 2 years, unless revoked.[153] If a HHA operates related offices, each related office outside the health service planning district where the main office is located must be separately licensed.[154] As of March 12, 2017, there are 1,951 licensed HHAs in Florida.[155]

A HHA may obtain an initial license by submitting to AHCA a signed, complete, and accurate application and the $1,705 licensure fee.[156] The HHA must also submit the results of a survey conducted by AHCA.[157] The application must identify the geographic service areas[158] and counties in which the HHA will provide services.

An applicant for initial or renewal licensure must file with the application:

- A listing of services to be provided.

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[146] S. 400.462(12), F.S.
[147] S. 400.462(14), F.S.
[148] S. 400.462(30), F.S.
[149] S. 400.462(16), F.S.
[150] S. 400.462(7), F.S.
[151] S. 400.462(13), F.S.
[152] SS. 36 – 51 of ch. 75-233, Laws of Fla.
[153] S. 408.808(1), F.S.
[154] S. 400.464(2), F.S. There are eleven health service planning districts grouped by county.
[155] Florida Health Finder, *Facility/Provider Search Results-Home Health Agencies*, available at http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (report generated March 12, 2017).
[156] S. 400.471(5) and Rule 59A-8.003(12).
[157] Id.
[158] S. 408.032(5), F.S. lists the eleven health service planning districts grouped by county.

- The number and discipline of professional staff to be employed.
- Information concerning volume data on the renewal application, as determined by rule.
- A business plan, which details the HHAs methods to obtain patients and its plan to recruit and maintain staff.
- Evidence of contingency funding equal to one month's average operating expenses during the first year of operation.
- A balance sheet, income and expense statement, and statement of cash flow for the first two years of operation showing evidence of sufficient assets, credit, and projected revenues to cover liabilities and expenses.
- All other ownership interests in health care entities for each controlling interest, as defined in part II of chapter 408.
- For initial licensure, documentation of accreditation, or an application for accreditation, from an accrediting organization that is recognized by the agency as having standards comparable to those required by this part and part II of chapter 408.[159]

A HHA must obtain malpractice and liability insurance for at least $250,000 per claim, and submit proof of coverage with its initial application for renewal.[160]

Section 400.464, F.S., exempts certain entities, individuals, and services from the HHA licensure requirements, including:

- A HHA operated by the Federal Government.
- A home health aide or certified nursing assistant who is acting in his or her individual capacity, within the definitions and standards of his or her occupation, and who provides hands-on care to patients in their homes.
- The delivery of nursing home services for which the nursing home is licensed under part II of Chapter 400, F.S., to serve its residents.
- A not-for-profit, community-based agency that provides early intervention services to infants and toddlers.[161]

For licensure renewal, the HHA must submit a signed renewal application and licensure fee.[162] AHCA may not issue a renewal license to a HHA in any county where there is at least one licensed HHA and that has more than one HHA per 5,000 persons, if the applicant has been sanctioned by AHCA within two years prior to submitting the license renewal application for one or more of the following acts:

- An intentional or negligent act that materially affects the health or safety of a client;
- Preparing or maintaining fraudulent patient records, such as, but not limited to, charting ahead, recording vital signs or symptoms which were not personally obtained or observed by the HHA's staff at the time indicated, borrowing patients or patient records from other HHAs to pass a survey or inspection, or falsifying signatures;
- Demonstrating a pattern of falsifying documents relating to the training of home health aides or certified nursing assistants or demonstrating a pattern of falsifying health statements for staff who provide direct care to patients; and
- Giving cash, or its equivalent, to a Medicare or Medicaid beneficiary.[163]

AHCA conducts unannounced licensure surveys every 36.9 months, unless a HHA has requested an exemption from such surveys based on accreditation by an approved accrediting organization.[164] The Home Health Agency State Regulation Set that is used in conducting surveys contains over 100

[159] S. 400.471(2), F.S.
[160] S. 400.471(3), F.S.
[161] S. 400.464(5)(a)-(n), F.S.
[162] Rules 59A-8.003(2) and (12), F.A.C.
[163] S. 400.471(10), F.S.
[164] Rule 59A-8.003(3)(a), F.A.C.

standards and surveyor guidelines, which are based on regulations found in Chapter 59A-8, F.A.C.[165] AHCA also conducts inspections related to complaints.[166]

Each HHA is required to employ an administrator.[167] The administrator[168] must be a licensed physician, physician assistant, or registered nurse licensed to practice in this state or an individual having at least one year of supervisory or administrative experience in home health care in a facility licensed under ch. 395, F.S.,[169] part II of ch. 400, F.S.,[170] or part I of ch. 429, F.S.[171] The administrator may manage a maximum of five licensed HHAs if the HHAs have identical controlling interests and are located within one geographic service area or within an immediately contiguous county.[172] An employee of a retirement community that provides multiple levels of care may administer a HHA and up to a maximum of four entities licensed under ch. 400, F.S.,[173] or ch. 429, F.S.,[174] if they are owned, operated, or managed by the same corporate entity. The administrator must designate an alternate administrator to serve during the administrator's absence.[175]

A HHA providing skilled nursing services for more than 30 days is required to employ a director of nursing[176] who is a Florida licensed registered nurse with at least one year of supervisory experience.[177] The director of nursing is responsible for overseeing the delivery of professional nursing and home health aide services[178] and must be readily available at the HHA or by phone for any eight consecutive hours between 7 a.m. to 6 p.m.[179] The director of nursing is also responsible for establishing and conducting an ongoing quality assurance program for services provided by the HHA.[180]

A director of nursing may be the director for a maximum of five licensed HHAs if the HHAs have identical controlling interests, are located within one geographic service area or within an immediately contiguous county, and each HHA has a registered nurse who meets the qualifications of a director of nursing and has been delegated by the director of nursing to serve in the stead of the director. An employee of a retirement community that provides multiple levels of care may serve as the director of nursing of a HHA and of up to four entities licensed under ch. 400, F.S., or ch. 429, F.S., if they are owned, operated, or managed by the same corporate entity.[181]

Effect of Proposed Changes

The bill requires that any HHA license obtained after June 30, 2017, must specify the home health services the HHA is authorized to perform and must indicate whether the specified services are considered "skilled care." In addition, the bill permits any person or HHA providing home health services that is exempt from licensure to apply for a certificate of exemption. The proposed changes to s. 400.464, F.S., will simplify existing licensure requirements and should not have an adverse effect on AHCA or HHA licensees.

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[165] Agency for Health Care Administration, *ASPEN: Regulation Set (RS): Home Health Agencies*, available at, http://ahca.myflorida.com/MCHQ/Current_Reg_Files/Home_Health_Agencies_ST_H.pdf (last viewed March 1, 2017).
[166] Rule 59A-8.003(4), F.A.C.
[167] S. 400.476(1)(a), F.S.
[168] S. 400.462(1), F.S.
[169] Facilities licensed under ch. 395, F.S., include hospitals, ambulatory surgical centers, and mobile surgical facilities.
[170] Facilities licensed under part II of ch. 400, F.S., include nursing homes.
[171] Facilities licensed under part I of ch. 429, F.S., include assisted living facilities.
[172] S. 400.476(1), F.S.
[173] Entities licensed under ch. 400, F.S., include nursing homes, home health agencies, nurse registries, hospices, intermediate care facilities, homes for special services, transitional living facilities, prescribed pediatric extended care centers, home medical equipment providers, intermediate care facilities for developmentally disabled persons, health care services pools, and health care clinics.
[174] Entities licensed under ch. 429, F.S., include assisted living facilities, adult family care homes, and adult day care centers.
[175] S. 400.476(1)(a), F.S.
[176] S. 400.462(10), F.S.
[177] S. 400.476(2), F.S.
[178] S. 400.462(10), F.S.
[179] Rule 59A-8.003(11)(a), F.A.C.
[180] Rule 59A-8.0095(2)(e), F.A.C.
[181] S. 400.476(2), F.S.

The bill requires a HHA that provides skilled nursing care to have a director of nursing. The provision ensures that skilled nursing care services are overseen by a registered nurse, and ensures recipients of such services are receiving appropriate care.

The bill removes the definitions of Class I, II, III, and IV violations from s. 400.484(2), F.S., and instead references the definitions of the violations found in s. 408.813, F.S. This change eliminates any conflicts between part II of ch. 408, F.S., and part III of ch. 400, F.S.

The bill deletes the federal certification requirement from the home health licensure statute. The proposed changes should eliminate confusion among providers and consumers, and should not have an adverse effect on AHCA or home health agency licensees.

The bill repeals the requirement that a HHA, for purpose of license renewal, report the volume of patients serviced during the previous licensure period. The repeal will ease the administrative burden for HHA associated with applying for license renewal.

The bill provides that any HHA which provides skilled nursing services to any patient for any amount of time must have a director of nursing. The 30-day threshold for providing such services before a HHA must hire a director of nursing is eliminated.

The bill also makes conforming changes to s. 400.497(4), F.S., to reflect the provisions of the bill.

Health Care Facility Licensing

Health Care Licensing Procedures Act

Certain health care providers[182] are regulated under Part II of chapter 408, F.S., which is the Health Care Licensing Procedures Act (Act). The Act provides uniform licensing procedures and standards applicable to most AHCA-regulated entities. The Act contains basic licensing standards for 29 provider types, such as birth centers, abortion clinics, crisis stabilization units, and short-term residential treatment facilities.[183] In addition to the Act, each provider type has an authorizing statute which includes unique provisions for licensure beyond the uniform criteria. In the case of conflict between the Act and an individual authorizing statute, the Act prevails.[184]

Effect of Proposed Changes

The bill defines "relative" for purposes of the Act as any individual who is related to a patient or client in the following manner:

> [f]ather, mother, stepfather, stepmother, son, daughter, brother, sister, grandmother, grandfather, great-grandmother, great-grandfather, grandson, granddaughter, uncle, aunt, first cousin, nephew, niece, husband, wife, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepson, stepdaughter, stepbrother, stepsister, half-brother, or half-sister.

The term "relative" is not currently defined in the Act, and the proposed definition clarifies who qualifies as a relative for certain purposes. For example, the bill grants AHCA rule-making authority to govern the circumstances under which a controlling interest of a licensed facility, an administrator, an employee, a contractor, or a representative thereof, who is not a relative of the patient or client, can act as the patient's or client's legal representative, agent, health care surrogate, power of attorney, or guardian. The bill requires the rules to include disclosure requirements, bonding, restrictions, and patient or client protections.

[182] "Provider" means any activity, service, agency, or facility regulated by the agency and listed in s. 408.802, F.S.
[183] S. 408.802, F.S.
[184] S. 408.832, F.S.

The bill deems any unlicensed activity, which constitutes harm that materially affects the health, safety, and welfare of clients, as abuse and neglect as defined under ch. 415, F.S. The change allows vulnerable adults receiving health or custodial care from an unlicensed provider to be eligible for adult protective services from DCF.

The bill exempts an applicant seeking a change of ownership license from demonstrating proof of financial ability to operate if the current licensee has been operational for five years and:

- Due to a corporate reorganization, the controlling interest does not change, or
- Due to the death of a controlling interest, the licensee changes but the remaining ownership holds more than 51 percent after the change.

The bill removes the requirement for an existing licensed health care provider to provide a copy of the most recent profit-loss statement and licensure inspection report with his or her application for hospice licensure. Such information is collected at other steps in the application process and does not need to be collected again.

The bill allows a licensee that holds a license for multiple providers to request alignment of all license expiration dates. AHCA is permitted to prorate a licensure fee for an abbreviated licensure period resulting from the alignment. AHCA and licensees with multiple provider licenses should realize greater efficiency in the licensure process.

The bill requires a licensee, during the license application process, to ensure that no person applying for a license has held or currently holds ownership interest in another licensed provider that has had a license or change of ownership application denied, revoked, or excluded. This patient safety provision allows AHCA exclude bad actors from owning, directly or indirectly, a licensed facility.

The bill makes conforming changes to ss. 400.933 and 400.980, F.S., to reflect the new requirements of health care facility licensing proposed by the bill.

Statewide Managed Care Ombudsman Committee

Background

The Statewide Managed Care Ombudsman Committee (Committee) is established by s. 641.60, F.S., and was created to serve as a consumer protection and advocacy organization on behalf of health care consumers receiving services through managed care organizations.[185] In addition to the statewide Committee, district committees are established to protect consumers receiving managed care services at a more local level. The districts are established by each health service planning district, composed of the following counties:

- District 1—Escambia, Santa Rosa, Okaloosa, and Walton Counties.
- District 2—Holmes, Washington, Bay, Jackson, Franklin, Gulf, Gadsden, Liberty, Calhoun, Leon, Wakulla, Jefferson, Madison, and Taylor Counties.
- District 3—Hamilton, Suwannee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Union, Bradford, Putnam, Alachua, Marion, Citrus, Hernando, Sumter, and Lake Counties.
- District 4—Baker, Nassau, Duval, Clay, St. Johns, Flagler, and Volusia Counties.
- District 5—Pasco and Pinellas Counties.
- District 6—Hillsborough, Manatee, Polk, Hardee, and Highlands Counties.
- District 7—Seminole, Orange, Osceola, and Brevard Counties.
- District 8—Sarasota, DeSoto, Charlotte, Lee, Glades, Hendry, and Collier Counties.
- District 9—Indian River, Okeechobee, St. Lucie, Martin, and Palm Beach Counties.

[185] S. 641.60(2), F.S.

- District 10—Broward County.
- District 11—Miami-Dade and Monroe Counties.[186]

Each district committee must have at least nine members and no more than 16 members,[187] with the AHCA secretary appointing the first three committee members in each district.[188] Each committee is required to have:

- Multiple licensed physicians:
  - one physician licensed under chapter 458;
  - one osteopathic physician licensed under chapter 459;
  - one chiropractor licensed under chapter 460; and
  - one podiatrist licensed under chapter 461;
- One licensed psychologist;
- One registered nurse;
- One clinical social worker;
- One attorney; and
- One consumer.[189]

Each district committee or member of the committee:

- Must serve to protect the health, safety, and rights of all enrollees participating in managed care programs in this state.
- Must receive complaints regarding quality of care from the agency, and may assist the agency with the resolution of complaints.
- May conduct site visits with the agency, as the agency determines is appropriate.
- Must submit an annual report to the statewide committee concerning activities, recommendations, and complaints reviewed or developed by the district committee during the year.
- Must conduct meetings as required at the call of its chairperson, the call of the agency director, the call of the statewide committee, or by written request of a majority of the district committee members.[190]

Effect of Proposed Changes

The bill repeals the Statewide Managed Care Ombudsman Committee. Due to the very stringent committee requirements, the Committee could not meet the requirements in the majority of the districts and the program was never fully implemented. The last activity on record was in 2010, and there are currently no active committees.[191]

The bill makes conforming changes to the following statutes to reflect the repeal of the Statewide Managed Care Ombudsman Committee: ss. 408.20, 641.70, and 641.75, F.S.

[186] S. 408.032(5), F.S.
[187] S. 641.65(2), F.S.
[188] S. 641.65(3)(a), F.S.
[189] S. 641.65(2), F.S.
[190] S. 641.65(6), F.S.
[191] Supra, FN 25 at pg. 6.

Hospital Regulation

Background

Licensure

Hospitals in Florida must be licensed by AHCA. Hospital licensure is governed by part II of ch. 408, F.S., part I of ch. 395, F.S., and associated rules. An application for hospital licensure must include:

- The name, address, and social security number of the applicant, the administrator, the financial officer, and each controlling interest.
- The name, address, and federal employer identification number or taxpayer identification number of the applicant and each controlling interest.
- The name by which the provider is to be known.
- The total number of beds or capacity requested, as applicable.
- The name of the person or persons under whose management or supervision the provider will operate and the name of the administrator.
- Proof that the applicant has obtained a certificate of authority if the applicant offers continuing care agreements.
- Other information, including satisfactory inspection results that the agency finds necessary to determine the ability of the applicant to carry out its responsibilities.
- An attestation, under penalty of perjury, stating compliance with AHCA's provisions.[192]

AHCA has thirty days, from receipt of an application for a license, to examine the application and notify the applicant, in writing, of any apparent errors or omissions, and request any additional information required.[193] AHCA will then conduct an initial inspection.[194]

AHCA licenses four classes of hospital.[195] Class I hospitals are general hospitals.[196] Class II hospitals are specialty hospitals offering the same range of medical services offered by general hospitals, but restricted to a defined age or gender group.[197] Class III hospitals are specialty hospitals offering a restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illness or disorders.[198] Class IV hospitals are specialty hospitals restricted to offering Intensive Residential Treatment Programs for Children and Adolescents.[199]

All licensed hospitals must have:

- Inpatient beds;
- A governing authority legally responsible for the conduct of the hospital;
- A chief executive officer or others similarly titled official to who the governing authority delegates the full-time authority for the operation of the hospital in accordance with the established policy of the governing authority;
- An organized medical staff to which the governing authority delegates responsibility for maintaining proper standards for medical and other health care;
- A current and complete medical record for each patient admitted to the hospital;
- A policy requiring that all patients be admitted on the authority of and under the care of a member of the organized medical staff;

[192] S. 408.806(1), F.S.
[193] S. 408.806(3)(a), F.S.
[194] S. 408.806(7)(a), F.S.
[195] Rule 59A-3.252(1), F.A.C.
[196] Rule 59A-3.252(1)(a), F.A.C.
[197] Rule 59A-3.252(1)(b), F.A.C.
[198] Rule 59A-3.252(1)(c), F.A.C.
[199] Rule 59A-3.252(1)(d), F.A.C.

- Facilities and professional staff available to provide food to patients to meet their nutritional needs;
- A procedure for providing care in emergency cases;
- A method and policy for infection control; and
- An on-going organized program to enhance the quality of patient care and review the appropriateness of utilization of services.[200]

State-Operated Hospitals

DCF operates seven hospitals and treatment centers statewide:

- Florida State Hospital in Chattahoochee;
- Northeast Florida State Hospital in Macclenny;
- South Florida State Hospital in Pembroke Pines;
- North Florida Evaluation and Treatment Center in Gainesville;
- South Florida Evaluation and Treatment Center in Florida City;
- Treasure Coast Forensic Treatment Center in Indiantown; and
- West Florida Community Care Center in Milton.[201]

The Department of Corrections (DOC) operates the Reception and Medical Center in Lake Butler, where newly committed male inmates are processed into the corrections system and medical care is provided to inmates.[202] Every state hospital is subject to the same licensure and reporting requirements as other licensed hospitals in the state.

Emergency Services

The federal Emergency Medical Treatment and Labor Act (EMTALA)[203] passed in 1986 after "patient dumping," the practice of refusing to treat uninsured patients in need of emergency care, came to the attention of the U.S. Congress.[204] Effective January 1, 1987, the Florida Legislature enacted the first statute requiring some degree of emergency services to be provided to a patient regardless of the patient's ability to pay.[205]

Currently, in Florida, every general hospital which has an emergency department must provide emergency services and care for any emergency medical condition when:

- A person requests emergency services and care; or
- Emergency services and care are requested on behalf of a person by:
  - An emergency medical services provider who is rendering care to or transporting the person; or
  - Another hospital, when such hospital is seeking a medically necessary transfer.[206]

If a medically necessary transfer is made, it must be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity.[207] Each hospital must retain records of each transfer made or received

[200] Rule 59A-3.252(2), F.A.C.
[201] Department of Children and Families, *State Mental Health Treatment Facilities*, 2014, available at http://www.myflfamilies.com/service-programs/mental-health/state-mental-health-treatment-facilities (last viewed March 15, 2017).
[202] Department of Corrections, *Reception and Medical Center (RMC)*, 2014, available at http://www.dc.state.fl.us/facilities/region2/209.html (last viewed March 15, 2017).
[203] 42 U.S.C. §1395
[204] Richard E. Mills, *Access to Emergency Services and Care in Florida*, The Florida Bar Journal, January 1998, available at http://www.floridabar.org/divcom/jn/jnjournal01.nsf/Author/1C3429F6216E4EA985256ADB005D6190 (last viewed March 8, 2017).
[205] Id.
[206] S. 395.1041(3)(a), F.S.
[207] S. 395.1041(3)(e), F.S.

for a period of five years.[208] Decisions about services and care provided to an individual cannot be based upon the individual's:

- Race;
- Ethnicity;
- Religion;
- National origin;
- Citizenship;
- Age;
- Sex;
- Preexisting medical condition;
- Physical or mental handicap;
- Insurance status;
- Economic status; or
- Ability to pay for medical services.[209]

AHCA may deny, revoke, or suspend a hospital's license or impose an administrative fine, not to exceed $10,000 per violation, for any violation of access to emergency service and care laws.[210]

Complaint Investigation Procedures

Section 395.1046, F.S., provides special procedures for complaints against hospitals regarding emergency access issues, such as a person being denied emergency services and care.[211] AHCA must investigate any complaint against a hospital for any violation which AHCA reasonably believes to be legally sufficient. A complaint is legally sufficient if it contains facts showing that a violation of ch. 395, F.S., or any rule adopted under ch. 395, F.S., has occurred.[212] AHCA may investigate emergency access complaints even if the complaint is withdrawn.[213] When the investigation is complete, AHCA prepares a report making a probable cause determination.[214]

Effect of Proposed Changes

The bill eliminates the special procedures for investigating hospital emergency access complaints and allows AHCA to employ existing hospital complaint investigation procedures used for all other types of complaints. Section 395.1046, F.S., duplicates the complaint investigation procedure found in s. 408.811, F.S. The elimination of the special procedures for investigating hospital emergency access complaints should not cause an adverse effect on patients or AHCA.

The bill amends the definition of "hospital" in s. 395.701, F.S., by removing the specific references to AHCA and DOC and replacing them with "a state agency." State agencies that run hospitals will be exempt from filing their financial experience for the fiscal year and from making AHCA's annual assessment payment. The provision will ease an unnecessary administrative burden for hospitals operated by state agencies.

The bill adds language to s. 395.1055(2), F.S. directing AHCA to implement standards for pediatric cardiovascular, neonatal intensive care units, transplant, psychiatric, and comprehensive medical rehab services. This rulemaking authority exists elsewhere in statute, but the bill consolidates the authority in the hospital licensure statute.

[208] S. 395.1041(4)(a)1., F.S.
[209] S. 395.1041(3)(f), F.S.
[210] S. 395.1041(5)(a), F.S.
[211] S. 395.1041(1), F.S.
[212] S. 395.1046(1), F.S.
[213] Id.
[214] S. 395.1046(2), F.S.

Birth Centers

Background

A birth center is any facility, institution, or place, which is not an ASC, a hospital or in a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.[215] A birth center must include:

- Birthing rooms;
- Bath and toilet facilities;
- Storage areas for supplies and equipment;
- Examination areas; and
- Reception or family areas.[216]

A birth center shall be equipped with those items needed to provide low-risk maternity care and readily available equipment to initiate emergency procedures in life-threatening events to mother and baby, as defined by rule.[217]

Effect of Proposed Changes

The bill repeals an exemption to birth center licensure for any facility that was providing obstetrical and gynecological surgical services and was owned and operated by a board-certified obstetrician on June 15, 1984. There are currently no providers who meet these criteria in s. 383.335, F.S.

Nurse Registries

Background

A nurse registry is defined in s. 400.462(21), F.S., as any person that procures, offers, promises, or attempts to secure healthcare-related contracts for registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers, who are compensated by fees as independent contractors, including, but not limited to, contracts for the provision of services to patients and contracts to provide private duty or staffing services to health care facilities licensed under ch. 395, F.S., ch. 400, F.S., or ch. 429, F.S., or other business entities. A nurse registry is exempt from the licensing requirements of a HHA, but must be licensed as a nurse registry.[218] A licensed nurse registry may operate a satellite office.[219] The application for licensure must be filed with AHCA along with a $2,000 licensure fee.[220] A license will not be granted to anyone less than 18 years of age,[221] and evidence of financial ability to operate for initial licensure and change of ownership must be submitted with the application.[222]

A nurse registry administrator must be available to the public for eight consecutive hours between 7:00 a.m. and 6:00 p.m., Monday through Friday of each week, excluding legal and religious holidays.[223] The nurse registry must provide to the patient a list of telephone numbers to be called if a replacement caregiver is needed, along with local emergency numbers.[224]

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[215] S. 383.302(2), F.S.
[216] S. 383.308(1), F.S.
[217] S. 383.308(2)(a), F.S.
[218] S. 400.506(1)(a), F.S.
[219] S. 400.506(1)(b), F.S.
[220] Rule 59A-18.004(1), F.A.C.
[221] Rule 59A-18.004(3), F.A.C.
[222] Rule 59A-18.004(4), F.A.C.
[223] Rule 59A-18.004(9)(a), F.A.C.
[224] Rule 59A-18.004(9)(d), F.A.C.

Any person who owns, operates, or maintains an unlicensed nurse registry and does not cease operation and apply for a license, within ten working days after receiving notification from AHCA, can be criminally charged.[225]

Effect of Proposed Changes

The bill repeals two grounds upon which AHCA may base the denial, suspension, or revocation of the license of a nurse registry, both of which relate to remuneration by the registry to health care providers, facility staff, or third party vendors. These grounds are broad and prevent nurse registries from marketing their business. Additionally, the bill clarifies language for penalties of unlicensed facilities, referring to provisions in s. 408.812, F.S., so that there is no contradicting language between part II of ch. 408, F.S., and the nurse registry provision in ch. 400, F.S. Lastly, the bill replaces the phrase "it is not the obligation," or "has no obligation" with the phrase "is not permitted" to clarify the actions a nurse registry cannot take, so as to avoid misperception by clients seeking or obtaining services from a nurse referred by a nurse registry.

Miscellaneous

Home Medical Equipment

A home medical equipment provider sells or rents, or offers to sell or rent, home medical equipment[226] and services or home medical equipment services[227] to or for a consumer. A home medical equipment provider must be licensed by AHCA.[228] Medical oxygen is defined as oxygen USP[229] which must be labeled in compliance with labeling requirements for oxygen under the federal act.[230] The Department of Business and Professional Regulation (DBPR) regulates medical equipment, including medical oxygen.[231] In 2014, Part III of ch. 499, F.S., was created for the regulation of medical gas, including medical oxygen, separate from other drugs and medical equipment.

Effect of Proposed Changes

The bill requires a licensee to notify AHCA within 21 days, rather than 45 days, when a change in the general manager of a home medical equipment provider occurs. The reduced notification timeframe matches other notification provision timeframes in Part II of ch. 408, F.S., resulting in regulatory uniformity. The bill makes changes to the home medical equipment exemption for a medical oxygen permit by correcting the reference in s. 400.933, F.S., from Department of Health (DOH) to DBPR, which is now responsible for such regulation.

Health Care Service Pools

A health care services pool is any person, firm, corporation, partnership, or association which provides temporary employment in health care facilities, residential facilities, and agencies for licensed, certified, or trained health care personnel, including nursing assistants, nurses' aides, and orderlies.[232]

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[225] S. 400.506(5)(a), F.S.
[226] S. 400.925(6), F.S., defines home medical equipment as any product as defined by the Federal Drug Administration, any products reimbursed under the Medicare Part B Durable Medical Equipment benefits or the Florida Medicaid durable medical equipment program. Such equipment includes oxygen and related respiratory equipment, wheelchairs and related seating and positioning, but does not include motorized scooters, personal transfer systems, specialty beds, prosthetics, orthotics, or custom-fabricated splints, braces, or aids.
[227] S. 400.925(9), F.S., defined home medical equipment services as equipment management and consumer instruction, including selection, delivery, setup, and maintenance of equipment, and other related services for the use of home medical equipment in the consumer's place of residence.
[228] See generally s. 400.931, F.S.
[229] The United States Pharmacopoeia (USP) is a list of drugs licensed for use in the U.S. with standards necessary to determine purity suitable for persons.
[230] S. 499.82(10), F.S.
[231] Chapter 499, F.S.
[232] S. 400.980(1), F.S.

Registration or a license issued by AHCA is required for the operation of a health care services pool.[233] Currently, if a health care services pool must change information contained its' original registration application, it must notify AHCA 14 days prior to the change.[234]

Effect of Proposed Changes

The bill requires a health care services pool to notify AHCA of a change of ownership at least 60 days before the effective date of the change. For any other change of information contained in a registration application, AHCA must be notified at least 60 days, but no more than 120 days, before the requested effective date. Health care service pools will be subject to the same reporting timeframe for these changes as other health care facilities licensed by AHCA.

B. SECTION DIRECTORY:

Section 1: Amends s. 20.43, F.S., relating to Department of Health.
Section 2: Amends s. 220.1845, F.S., relating to contaminated site rehabilitation tax credit.
Section 3: Amends s. 376.30781, F.S., relating to tax credits for rehabilitation of drycleaning-solvent-contaminated sites and brownfield sites in in designated brownfield areas; application process; rulemaking authority; revocation authority.
Section 4: Amends s. 376.86, F.S., relating to Brownfield Areas Loan Guarantee Program.
Section 5: Amends s. 381.0031, F.S., relating to epidemiological research; report of diseases of public health significance to department.
Section 6: Amends s. 381.0034, F.S., relating to requirement for instruction on HIV and AIDS.
Section 7: Amends s. 381.004, F.S., relating to HIV testing.
Section 8: Amends s. 383.313, F.S., relating to performance of laboratory and surgical services; use of anesthetic and chemical agents.
Section 9: Repeals s. 383.335, F.S., relating to partial exemptions.
Section 10: Amends s. 384.31, F.S., relating to testing of pregnant women; duty of the attendant.
Section 11: Amends s. 385.211, F.S., relating to refractory and intractable epilepsy treatment and research at recognized medical centers.
Section 12: Amends s. 394.4787, F.S., relating to definitions; ss. 394-4786, 394.4787, 394.4788, and 394.4789.
Section 13: Amends s. 395.001, F.S., relating to legislative intent.
Section 14: Amends s. 395.002, F.S., relating to definitions
Section 15: Amends s. 395.003, F.S., relating to licensure; denial, suspension, and revocation.
Section 16: Amends s. 395.009, F.S., relating to minimum standards for clinical laboratory test results and diagnostic X-ray results; prerequisite for issuance or renewal of license.
Section 17: Creates s. 395.0091, F.S., relating to alternate-site testing.
Section 18: Amends s. 395.0161, F.S., relating to licensure inspection.
Section 19: Amends s. 395.0163, F.S., relating to construction inspections; plan submission and approval; fees.
Section 20: Amends s. 395.0197, F.S., relating to internal risk management program.
Section 21: Repeals s. 395.1046, F.S., relating to complaint investigation procedures.
Section 22: Amends s. 395.1055, F.S., relating to rules and enforcement.
Section 23: Repeals s. 395.10971, F.S., relating to purpose.
Section 24: Repeals s. 395.10972, F.S., relating to Health Care Risk Manager Advisory Council.
Section 25: Amends s. 395.10973, F.S., relating to powers and duties of the agency.
Section 26: Repeals s. 395.10974, F.S., relating to health care risk managers; qualifications, licensure, fees.
Section 27: Repeals s. 395.10975, F.S., relating to grounds for denial, suspension, or revocation of a health care risk manager's license; administrative fine.
Section 28: Amends s. 395.602, F.S., relating to rural hospitals.

[233] S. 400.980(2), F.S.
[234] Id.

Section 29: Amends s. 395.603, F.S., relating to deactivation of general hospital beds; rural hospital impact statement.
Section 30: Repeals s. 395.604, F.S., relating to other rural hospital programs.
Section 31: Repeals s. 395.605, F.S., relating to emergency care hospitals.
Section 32: Amends s. 395.701, F.S., relating to annual assessments on net operating revenues for inpatient and outpatient services to fund public medical assistance; administrative fines for failure to pay assessments when due; exemption.
Section 33: Amends s. 395.7015, F.S., relating to annual assessment on health care entities.
Section 34: Amends s. 400.0625, F.S. relating to minimum standards for clinical laboratory test results and diagnostic X-ray results.
Section 35: Amends s. 400.464, F.S., relating to home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.
Section 36: Amends s. 400.471, F.S., relating to application for license; fee.
Section 37: Amends s. 400.474, F.S., relating to administrative penalties.
Section 38: Amends s. 400.476, F.S., relating to staffing requirements; notifications; limitations on staffing services.
Section 39: Amends s. 400.484, F.S., relating to right of inspection; deficiencies; fines.
Section 40: Amends s. 400.497, F.S., relating to rules establishing minimum standards.
Section 41: Amends 400.506, F.S., relating to licensure of nurse registries; requirements; penalties.
Section 42: Amends s. 400.606, F.S., relating to license; application; renewal; conditional license or permit; certificate of need.
Section 43: Amends s. 400.925, F.S. relating to definitions.
Section 44: Amends s. 400.931, F.S., relating to application for license; fee.
Section 45: Amends s. 400.933, F.S., relating to licensure inspections and investigations.
Section 46: Amends s. 400.980, F.S., relating to health care services pools.
Section 47: Amends s. 400.9905, F.S., relating to definitions.
Section 48: Amends s. 408.033, F.S., relating to local and state health planning.
Section 49: Amends s. 408.036, F.S., relating to projects subject to review; exemptions.
Section 50: Amends s. 408.061, F.S., relating to data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.
Section 51: Amends s. 408.07, F.S., relating to definitions.
Section 52: Amends s. 408.20, F.S., relating to assessments; Health Care Trust Fund.
Section 53: Repeals s. 408.7056, F.S., relating to Subscriber Assistance Program.
Section 54: Amends s. 408.802, F.S., relating to applicability.
Section 55: Creates s. 408.803, F.S., relating to definitions.
Section 56: Amends s. 408.806, F.S., relating to license application process.
Section 57: Amends s. 408.810, F.S., relating to minimum licensure requirements.
Section 58: Amends s. 408.812, F.S., relating to unlicensed activity.
Section 59: Amends s. 408.820, F.S., relating to exemptions.
Section 60: Amends s. 409.905, F.S., relating to mandatory Medicaid services.
Section 61: Amends s. 409.9116, F.S., relating to disproportionate share/financial assistance program for rural hospitals.
Section 62: Amends s. 409.975, F.S., relating to managed care plan accountability.
Section 63: Amends s. 429.02, F.S., relating to definitions.
Section 64: Amends s. 429.04, F.S. relating to facilities to be licensed; exemptions.
Section 65: Amends s. 429.08, F.S., relating to unlicensed facilities; referral of person for residency to unlicensed facility; penalties.
Section 66: Amends s. 429.176, F.S., relating to notice of change of administrator.
Section 67: Amends s. 429.41, F.S., relating to rules establishing standards.
Section 68: Amends s. 456.001, F.S., relating to definitions.
Section 69: Amends s. 456.057, F.S., relating to ownership and control of patient records; report or copies of records to be furnished; disclosure of information.
Section 70: Amends s. 458.307, F.S., relating to Board of Medicine.
Section 71: Amends s. 458.345, F.S., relating to registration of resident physicians, interns, and fellows; list of hospital employees; prescribing of medicinal drugs; penalty.

Section 72: Repeals Part I of ch. 483, F.S., relating to clinical laboratories.
Section 73: Amends s. 483.294, F.S., relating to inspection of centers.
Section 74: Amends s. 483.801, F.S., relating to exemptions.
Section 75: Amends s. 483.803, F.S., relating to definitions.
Section 76: Amends s. 483.813, F.S., relating to clinical laboratory personnel license.
Section 77: Amends s. 491.003, F.S., relating to definitions.
Section 78: Amends s. 627.351, F.S., relating to insurance risk apportionment plans.
Section 79: Amends s. 627.602, F.S., relating to scope, format of policy.
Section 80: Amends s. 627.64194, F.S., relating to coverage requirements for services provided by nonparticipating providers; payment collection limitations.
Section 81: Amends s. 627.6513, F.S., relating to scope.
Section 82: Effective January 1, 2018, amends s. 641.185, F.S., relating to health maintenance organization subscriber protections.
Section 83: Effective January 1, 2018, amends s. 641.312, F.S., relating to scope.
Section 84: Effective January 1, 2018, amends s. 641.3154, F.S., relating to organization liability; provider billing prohibited.
Section 85: Effective January 1, 2018, amends s. 641.51, F.S., relating to quality assurance program; second medical opinion requirement.
Section 86: Effective January 1, 2018, amends s. 641.511, F.S., relating to subscriber grievance reporting and resolution requirements.
Section 87: Effective January 1, 2018, amends s. 641.515, F.S., relating to investigation by the agency.
Section 88: Effective January 1, 2018, amends s. 641.55, F.S., relating to internal risk management program.
Section 89: Repeals s. 641.60, F.S., relating to Statewide Managed Care Ombudsman Committee.
Section 90: Amends s. 641.70, F.S., relating to agency duties relating to the Statewide Managed Care Ombudsman Committee and the district managed care ombudsman committees.
Section 91: Amends s. 641.75, F.S., relating to immunity from liability; limitation on testimony.
Section 92: Amends s. 766.118, F.S., relating to determination of noneconomic damages.
Section 93: Amends s. 766.202, F.S., relating to definitions; ss. 766.201-766.212.
Section 94: Amends s. 945.36, F.S., relating to exemption from health testing regulations for law enforcement personnel conducting drug tests on inmates and releasees.
Section 95: Amends s. 1009.65, F.S., relating to Medical Education Reimbursement and Loan Repayment Program.
Section 96: Provides an effective date of July 1, 2017, except as otherwise expressly provided in the act.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

AHCA will realize an annual decrease in revenue of approximately $64,866 from the repeal of the risk manager application licensure and licensure fees. There will be an annual decrease in revenue of approximately $1,383,400 from the repeal of AHCA's clinical laboratory licensure requirement and subsequent licensure application fees. However, revenues in the Health Care Trust Fund are currently sufficient to absorb any loss of revenue resulting from the implementation of the bill.

2. Expenditures:

The proposed House General Appropriations Act for Fiscal Year 2017-2018 includes a reduction of 12.5 FTE and $706,723 in budget authority related to vacancies and other administrative efficiencies.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

There appears to be a potential for economic impact to certain providers, including clinical labs and health care risk managers that no longer need to be licensed by the state or pay state licensure fees. Also, provisions in the bill that streamline the licensure process for various providers should ease the administrative burden on those providers to comply with licensing laws.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

At lines 214-215, the bill repeals the Board of Clinical Laboratory Personnel in part III of chapter 483, F.S. The repeal appears to be a scrivener's error as there was no intention to repeal the board, only to make a conforming change following the repeal of part I of chapter 483, F.S. The language should be revised to read:

22. The Board of Clinical Laboratory Personnel, created under part <u>II</u> ~~III~~ of chapter 483.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to health care facility regulation; amending ss. 381.0031, 381.004, 384.31, 395.009, and 409.905, F.S.; eliminating state licensure requirements for clinical laboratories; requiring clinical laboratories to be federally certified; amending s. 383.313, F.S.; revising requirements for a birth center to perform certain laboratory tests; repealing s. 383.335, F.S., relating to partial exemptions from licensure requirements for certain facilities that provide obstetrical and gynecological surgical services; amending s. 395.002, F.S.; revising and deleting definitions; creating s. 395.0091, F.S.; authorizing the Agency for Health Care Administration to adopt rules establishing criteria for alternate-site laboratory testing; defining the term "alternate-site testing"; amending ss. 395.0161 and 395.0163, F.S.; deleting licensure and inspection requirements for mobile surgical facilities to conform to changes made by the act; amending s. 395.0197, F.S.; requiring the manager of a hospital or ambulatory surgical center internal risk management program to demonstrate competence in certain administrative and health care service areas; conforming references; repealing s. 395.1046, F.S., relating to hospital complaint

investigation procedures; amending s. 395.1055, F.S.; requiring hospitals providing specified services to meet agency licensure requirements; conforming a reference; repealing ss. 395.10971 and 395.10972, F.S., relating to the purpose and establishment of the Health Care Risk Manager Advisory Council; amending s. 395.10973, F.S.; deleting duties of the agency relating to health care risk managers, to conform; repealing s. 395.10974, F.S., relating to licensure of health care risk managers; repealing s. 395.10975, F.S., relating to grounds for denial, suspension, or revocation of a health care risk manager's license; amending s. 395.602, F.S.; deleting definitions; amending s. 395.603, F.S.; deleting provisions relating to deactivation of general hospital beds by certain rural and emergency care hospitals; repealing s. 395.604, F.S., relating to other rural hospital programs; repealing s. 395.605, F.S., relating to emergency care hospitals; amending s. 395.701, F.S.; revising the definition of the term "hospital" to exclude hospitals operated by state agencies; amending s. 400.464, F.S.; revising licensure requirements for a home health agency; providing conditions for advertising certain services that require licensure; providing for a fine; providing conditions for

application for a certificate of exemption from licensure as a home health agency; specifying the duration of the certificate of exemption; authorizing a fee; amending s. 400.471, F.S.; revising home health agency licensure requirements; providing requirements for proof of accreditation for home health agencies applying for change of ownership or addition of skilled care services; amending s. 400.474, F.S.; revising conditions for the imposition of a fine against a home health agency; amending s. 400.476, F.S.; requiring a home health agency providing skilled nursing care to have a director of nursing; amending s. 400.484, F.S.; providing for the imposition of administrative fines on home health agencies for specified classes of violations; amending s. 400.497, F.S.; authorizing the agency to adopt rules establishing standards for certificate of exemption applications; amending s. 400.506, F.S.; revising penalties for a nurse registry directed by the agency to cease operation; providing that registered nurses, licensed practical nurses, certified nursing assistants, companions or homemakers, and home health aides are independent contractors and not employees of the nurse registries that referred them; requiring a nurse registry to inform the patient, the patient's

family, or a person acting on behalf of the patient that the referred caregiver is an independent contractor and that the nurse registry is not permitted to monitor, supervise, manage, or train the referred caregiver; revising provisions relating to activities for which the Agency for Health Care Administration is authorized to deny, suspend, or revoke a nurse registry license and impose fines; providing that a nurse registry is not permitted to review or act upon certain records except under certain circumstances; amending s. 400.606, F.S.; revising content requirements of the plan accompanying an initial or change-of-ownership application for a hospice; amending s. 400.925, F.S.; revising the definition of the term "home medical equipment"; amending s. 400.931, F.S.; providing a timeframe for a home medical equipment provider to notify the agency of certain personnel changes; amending s. 400.933, F.S.; authorizing the agency to accept certain medical oxygen permits issued by the Department of Business and Professional Regulation in lieu of agency licensure inspections; amending s. 400.980, F.S.; revising timeframe requirements for change of registration information submitted to the agency by a health care services pool; amending s. 408.061, F.S.;

excluding hospitals operated by state agencies from certain financial reporting requirements; conforming a cross-reference; amending s. 408.07, F.S.; deleting the definition of the term "clinical laboratory"; amending s. 408.20, F.S.; exempting hospitals operated by state agencies from assessments against the Health Care Trust Fund to fund certain agency activities; repealing s. 408.7056, F.S., relating to the Subscriber Assistance Program; amending s. 408.803, F.S.; defining the term "relative" for the Health Care Licensing Procedures Act; amending s. 408.806, F.S.; requiring additional information on a licensure application; authorizing the agency to issue licenses with an abbreviated licensure period and prorated fee for alignment of multiple provider license expiration dates; amending s. 408.810, F.S.; exempting an applicant for change of ownership from furnishing proof of ability to operate under certain conditions; authorizing the agency to adopt rules governing circumstances under which a controlling interest may act in certain legal capacities on behalf of a patient or client; amending s. 408.812, F.S.; citing failure to discharge residents by the license expiration date as unlicensed activity; providing that certain unlicensed activity by a provider constitutes abuse

and neglect; requiring the agency to refer certain findings to the state attorney; requiring the agency to impose a fine under certain circumstances; amending s. 429.02, F.S.; revising definitions; amending s. 429.04, F.S.; providing additional exemptions from licensure as an assisted living facility; imposing a burden of proof on the person or entity asserting the exemption; amending s. 429.08, F.S.; providing criminal penalties and fines for unlicensed ownership possession, or control of real property used as an unlicensed assisted living facility; providing that engaging a third party to provide certain services at an unlicensed location constitutes unlicensed activity; amending s. 429.176, F.S.; prohibiting an assisted living facility from operating without an administrator who has completed certain educational requirements beyond a specified period of time; amending s. 429.41, F.S.; prohibiting an assisted living facility from providing personal services to nonresidents; repealing part I of chapter 483, F.S., relating to clinical laboratories; amending s. 483.294, F.S.; revising agency inspection schedules for multiphasic heath testing centers; amending s. 483.801, F.S.; providing an exemption from regulation for persons employed by certain laboratories; amending

s. 483.803, F.S.; deleting definitions; conforming a reference; amending s. 641.511, F.S.; revising health maintenance organization subscriber grievance reporting requirements; repealing s. 641.60, F.S., relating to the Statewide Managed Care Ombudsman Committee; amending s. 945.36, F.S.; authorizing law enforcement personnel to conduct drug tests on certain inmates and releasees; amending ss. 20.43, 220.1845, 376.30781, 376.86, 381.0034, 385.211, 394.4787, 395.001, 395.003, 395.7015, 400.0625, 400.9905, 408.033, 408.036, 408.802, 408.820, 409.9116, 409.975, 456.001, 456.057, 458.307, 458.345, 483.813, 491.003, 627.351, 627.602, 627.64194, 627.6513, 641.185, 641.312, 641.3154, 641.51, 641.515, 641.55, 641.70, 641.75, 766.118, 766.202, and 1009.65, F.S.; conforming references and cross-references; providing effective dates.

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

Section 1. Paragraph (g) of subsection (3) of section 20.43, Florida Statutes, is amended to read:

20.43 Department of Health.—There is created a Department of Health.

(3) The following divisions of the Department of Health

are established:

(g) Division of Medical Quality Assurance, which is responsible for the following boards and professions established within the division:

1. The Board of Acupuncture, created under chapter 457.

2. The Board of Medicine, created under chapter 458.

3. The Board of Osteopathic Medicine, created under chapter 459.

4. The Board of Chiropractic Medicine, created under chapter 460.

5. The Board of Podiatric Medicine, created under chapter 461.

6. Naturopathy, as provided under chapter 462.

7. The Board of Optometry, created under chapter 463.

8. The Board of Nursing, created under part I of chapter 464.

9. Nursing assistants, as provided under part II of chapter 464.

10. The Board of Pharmacy, created under chapter 465.

11. The Board of Dentistry, created under chapter 466.

12. Midwifery, as provided under chapter 467.

13. The Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.

14. The Board of Nursing Home Administrators, created under part II of chapter 468.

15. The Board of Occupational Therapy, created under part III of chapter 468.

16. Respiratory therapy, as provided under part V of chapter 468.

17. Dietetics and nutrition practice, as provided under part X of chapter 468.

18. The Board of Athletic Training, created under part XIII of chapter 468.

19. The Board of Orthotists and Prosthetists, created under part XIV of chapter 468.

20. Electrolysis, as provided under chapter 478.

21. The Board of Massage Therapy, created under chapter 480.

~~22. The Board of Clinical Laboratory Personnel, created under part III of chapter 483.~~

22.~~23.~~ Medical physicists, as provided under part IV of chapter 483.

23.~~24.~~ The Board of Opticianry, created under part I of chapter 484.

24.~~25.~~ The Board of Hearing Aid Specialists, created under part II of chapter 484.

25.~~26.~~ The Board of Physical Therapy Practice, created under chapter 486.

26.~~27.~~ The Board of Psychology, created under chapter 490.

27.~~28.~~ School psychologists, as provided under chapter

490.

28.~~29.~~ The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.

29.~~30.~~ Emergency medical technicians and paramedics, as provided under part III of chapter 401.

Section 2. Paragraph (k) of subsection (2) of section 220.1845, Florida Statutes, is amended to read:

220.1845 Contaminated site rehabilitation tax credit.—

(2) AUTHORIZATION FOR TAX CREDIT; LIMITATIONS.—

(k) In order to encourage the construction and operation of a new health care facility as defined in s. 408.032 or s. 408.07, or a health care provider as defined in s. 408.07 ~~or s. 408.7056~~, on a brownfield site, an applicant for a tax credit may claim an additional 25 percent of the total site rehabilitation costs, not to exceed $500,000, if the applicant meets the requirements of this paragraph. In order to receive this additional tax credit, the applicant must provide documentation indicating that the construction of the health care facility or health care provider by the applicant on the brownfield site has received a certificate of occupancy or a license or certificate has been issued for the operation of the health care facility or health care provider.

Section 3. Paragraph (f) of subsection (3) of section 376.30781, Florida Statutes, is amended to read:

376.30781 Tax credits for rehabilitation of drycleaning-solvent-contaminated sites and brownfield sites in designated brownfield areas; application process; rulemaking authority; revocation authority.—

(3)

(f) In order to encourage the construction and operation of a new health care facility or a health care provider, as defined in s. 408.032 or~~,~~ s. 408.07, ~~or s. 408.7056,~~ on a brownfield site, an applicant for a tax credit may claim an additional 25 percent of the total site rehabilitation costs, not to exceed $500,000, if the applicant meets the requirements of this paragraph. In order to receive this additional tax credit, the applicant must provide documentation indicating that the construction of the health care facility or health care provider by the applicant on the brownfield site has received a certificate of occupancy or a license or certificate has been issued for the operation of the health care facility or health care provider.

Section 4. Subsection (1) of section 376.86, Florida Statutes, is amended to read:

376.86 Brownfield Areas Loan Guarantee Program.—

(1) The Brownfield Areas Loan Guarantee Council is created to review and approve or deny, by a majority vote of its membership, the situations and circumstances for participation in partnerships by agreements with local governments, financial

institutions, and others associated with the redevelopment of brownfield areas pursuant to the Brownfields Redevelopment Act for a limited state guaranty of up to 5 years of loan guarantees or loan loss reserves issued pursuant to law. The limited state loan guaranty applies only to 50 percent of the primary lenders loans for redevelopment projects in brownfield areas. If the redevelopment project is for affordable housing, as defined in s. 420.0004, in a brownfield area, the limited state loan guaranty applies to 75 percent of the primary lender's loan. If the redevelopment project includes the construction and operation of a new health care facility or a health care provider, as defined in s. 408.032 or~~,~~ s. 408.07, ~~or s. 408.7056,~~ on a brownfield site and the applicant has obtained documentation in accordance with s. 376.30781 indicating that the construction of the health care facility or health care provider by the applicant on the brownfield site has received a certificate of occupancy or a license or certificate has been issued for the operation of the health care facility or health care provider, the limited state loan guaranty applies to 75 percent of the primary lender's loan. A limited state guaranty of private loans or a loan loss reserve is authorized for lenders licensed to operate in the state upon a determination by the council that such an arrangement would be in the public interest and the likelihood of the success of the loan is great.

Section 5. Subsection (2) of section 381.0031, Florida

Statutes, is amended to read:

381.0031 Epidemiological research; report of diseases of public health significance to department.—

(2) Any practitioner licensed in this state to practice medicine, osteopathic medicine, chiropractic medicine, naturopathy, or veterinary medicine; any hospital licensed under part I of chapter 395; or any laboratory appropriately certified by the Centers for Medicare and Medicaid Services (CMS) under the federal Clinical Laboratory Improvement Amendments (CLIA) ~~licensed under chapter 483~~ that diagnoses or suspects the existence of a disease of public health significance shall immediately report the fact to the Department of Health.

Section 6. Subsection (3) of section 381.0034, Florida Statutes, is amended to read:

381.0034 Requirement for instruction on HIV and AIDS.—

(3) The department shall require, as a condition of granting a license under chapter 467 or part II ~~III~~ of chapter 483, that an applicant making initial application for licensure complete an educational course acceptable to the department on human immunodeficiency virus and acquired immune deficiency syndrome. Upon submission of an affidavit showing good cause, an applicant who has not taken a course at the time of licensure shall be allowed 6 months to complete this requirement.

Section 7. Paragraph (c) of subsection (4) of section 381.004, Florida Statutes, is amended to read:

381.004 HIV testing.—

(4) HUMAN IMMUNODEFICIENCY VIRUS TESTING REQUIREMENTS; REGISTRATION WITH THE DEPARTMENT OF HEALTH; EXEMPTIONS FROM REGISTRATION.—No county health department and no other person in this state shall conduct or hold themselves out to the public as conducting a testing program for acquired immune deficiency syndrome or human immunodeficiency virus status without first registering with the Department of Health, reregistering each year, complying with all other applicable provisions of state law, and meeting the following requirements:

(c) The program shall have all laboratory procedures performed in a laboratory <u>appropriately certified by the Centers for Medicare and Medicaid Services (CMS) under the federal Clinical Laboratory Improvement Amendments (CLIA)</u> ~~licensed under the provisions of chapter 483~~.

Section 8. Subsection (1) of section 383.313, Florida Statutes, is amended to read:

383.313 Performance of laboratory and surgical services; use of anesthetic and chemical agents.—

(1) LABORATORY SERVICES.—A birth center may collect specimens for those tests that are requested under protocol. A birth center may perform simple laboratory tests, as defined by rule of the agency, and is exempt from the requirements of chapter 483~~, provided no more than five physicians are employed by the birth center and testing is conducted exclusively in~~

~~connection with the diagnosis and treatment of clients of the birth center~~.

Section 9. Section 383.335, Florida Statutes, is repealed.

Section 10. Section 384.31, Florida Statutes, is amended to read:

384.31 Testing of pregnant women; duty of the attendant.—Every person, including every physician licensed under chapter 458 or chapter 459 or midwife licensed under part I of chapter 464 or chapter 467, attending a pregnant woman for conditions relating to pregnancy during the period of gestation and delivery shall cause the woman to be tested for sexually transmissible diseases, including HIV, as specified by department rule. Testing shall be performed by a laboratory appropriately certified by the Centers for Medicare and Medicaid Services (CMS) under the federal Clinical Laboratory Improvement Amendments (CLIA) ~~approved~~ for such purposes ~~under part I of chapter 483~~. The woman shall be informed of the tests that will be conducted and of her right to refuse testing. If a woman objects to testing, a written statement of objection, signed by the woman, shall be placed in the woman's medical record and no testing shall occur.

Section 11. Subsection (2) of section 385.211, Florida Statutes, is amended to read:

385.211 Refractory and intractable epilepsy treatment and research at recognized medical centers.—

(2) Notwithstanding chapter 893, medical centers recognized pursuant to s. 381.925, or an academic medical research institution legally affiliated with a licensed children's specialty hospital as defined in s. 395.002(27) ~~395.002(28)~~ that contracts with the Department of Health, may conduct research on cannabidiol and low-THC cannabis. This research may include, but is not limited to, the agricultural development, production, clinical research, and use of liquid medical derivatives of cannabidiol and low-THC cannabis for the treatment for refractory or intractable epilepsy. The authority for recognized medical centers to conduct this research is derived from 21 C.F.R. parts 312 and 316. Current state or privately obtained research funds may be used to support the activities described in this section.

Section 12. Subsection (7) of section 394.4787, Florida Statutes, is amended to read:

394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788, and 394.4789.—As used in this section and ss. 394.4786, 394.4788, and 394.4789:

(7) "Specialty psychiatric hospital" means a hospital licensed by the agency pursuant to s. 395.002(27) ~~395.002(28)~~ and part II of chapter 408 as a specialty psychiatric hospital.

Section 13. Section 395.001, Florida Statutes, is amended to read:

395.001 Legislative intent.—It is the intent of the

Legislature to provide for the protection of public health and safety in the establishment, construction, maintenance, and operation of hospitals and~~,~~ ambulatory surgical centers~~, and mobile surgical facilities~~ by providing for licensure of same and for the development, establishment, and enforcement of minimum standards with respect thereto.

Section 14. Subsection (22) and subsections (24) through (33) of section 395.002, Florida Statutes, are renumbered as subsection (21) and subsections (23) through (32), respectively, subsections (3) and (16) and present subsection (21) are amended, and present subsection (23) is renumbered as subsection (22) of that section and amended, to read:

395.002 Definitions.—As used in this chapter:

(3) "Ambulatory surgical center" ~~or "mobile surgical facility"~~ means a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an

ambulatory surgical center pursuant to s. 395.003. ~~Any structure or vehicle in which a physician maintains an office and practices surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, shall be construed to be a mobile surgical facility.~~

(16) "Licensed facility" means a hospital or~~,~~ ambulatory surgical center~~, or mobile surgical facility~~ licensed in accordance with this chapter.

~~(21) "Mobile surgical facility" is a mobile facility in which licensed health care professionals provide elective surgical care under contract with the Department of Corrections or a private correctional facility operating pursuant to chapter 957 and in which inmate patients are admitted to and discharged from said facility within the same working day and are not permitted to stay overnight. However, mobile surgical facilities may only provide health care services to the inmate patients of the Department of Corrections, or inmate patients of a private correctional facility operating pursuant to chapter 957, and not to the general public.~~

(22)~~(23)~~ "Premises" means those buildings, beds, and equipment located at the address of the licensed facility and all other buildings, beds, and equipment for the provision of hospital or~~,~~ ambulatory surgical~~, or mobile surgical~~ care located in such reasonable proximity to the address of the

licensed facility as to appear to the public to be under the dominion and control of the licensee. For any licensee that is a teaching hospital as defined in s. 408.07(44) ~~408.07(45)~~, reasonable proximity includes any buildings, beds, services, programs, and equipment under the dominion and control of the licensee that are located at a site with a main address that is within 1 mile of the main address of the licensed facility; and all such buildings, beds, and equipment may, at the request of a licensee or applicant, be included on the facility license as a single premises.

Section 15. Paragraphs (a) and (b) of subsection (1) and paragraph (b) of subsection (2) of section 395.003, Florida Statutes, are amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(1)(a) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to ss. 395.001-395.1065 and part II of chapter 408 and to entities licensed by or applying for such licensure from the Agency for Health Care Administration pursuant to ss. 395.001-395.1065. A license issued by the agency is required in order to operate a hospital or~~,~~ ambulatory surgical center~~, or mobile surgical facility~~ in this state.

(b)1. It is unlawful for a person to use or advertise to the public, in any way or by any medium whatsoever, any facility as a "hospital~~,~~" or "ambulatory surgical center~~,~~" ~~or "mobile~~

~~surgical facility"~~ unless such facility has first secured a license under the provisions of this part.

2. This part does not apply to veterinary hospitals or to commercial business establishments using the word "hospital~~,~~" or "ambulatory surgical center~~,~~" ~~or "mobile surgical facility"~~ as a part of a trade name if no treatment of human beings is performed on the premises of such establishments.

(2)

(b) The agency shall, at the request of a licensee that is a teaching hospital as defined in s. 408.07(44) ~~408.07(45)~~, issue a single license to a licensee for facilities that have been previously licensed as separate premises, provided such separately licensed facilities, taken together, constitute the same premises as defined in s. 395.002(22) ~~395.002(23)~~. Such license for the single premises shall include all of the beds, services, and programs that were previously included on the licenses for the separate premises. The granting of a single license under this paragraph shall not in any manner reduce the number of beds, services, or programs operated by the licensee.

Section 16. Subsection (1) of section 395.009, Florida Statutes, is amended to read:

395.009 Minimum standards for clinical laboratory test results and diagnostic X-ray results; prerequisite for issuance or renewal of license.—

(1) As a requirement for issuance or renewal of its

license, each licensed facility shall require that all clinical laboratory tests performed by or for the licensed facility be performed by a clinical laboratory appropriately certified by the Centers for Medicare and Medicaid Services (CMS) under the federal Clinical Laboratory Improvement Amendments (CLIA) ~~licensed under the provisions of chapter 483~~.

Section 17. Section 395.0091, Florida Statutes, is created to read:

395.0091 Alternate-site testing.—The agency, in consultation with the Board of Clinical Laboratory Personnel, shall adopt by rule the criteria for alternate-site testing to be performed under the supervision of a clinical laboratory director. The elements to be addressed in the rule include, but are not limited to: a hospital internal needs assessment; a protocol of implementation, including tests to be performed and who will perform the tests; criteria to be used in selecting the method of testing to be used for alternate-site testing; minimum training and education requirements for those who will perform alternate-site testing, such as documented training, licensure, certification, or other medical professional background not limited to laboratory professionals; documented inservice training as well as initial and ongoing competency validation; an appropriate internal and external quality control protocol; an internal mechanism for identifying and tracking alternate-site testing by the central laboratory; and recordkeeping

requirements. Alternate-site testing locations must register when the hospital applies to renew its license. For purposes of this section, the term "alternate-site testing" means any laboratory testing done under the administrative control of a hospital, but performed out of the physical or administrative confines of the central laboratory.

Section 18. Paragraph (f) of subsection (1) of section 395.0161, Florida Statutes, is amended to read:

395.0161 Licensure inspection.—

(1) In addition to the requirement of s. 408.811, the agency shall make or cause to be made such inspections and investigations as it deems necessary, including:

~~(f) Inspections of mobile surgical facilities at each time a facility establishes a new location, prior to the admission of patients. However, such inspections shall not be required when a mobile surgical facility is moved temporarily to a location where medical treatment will not be provided.~~

Section 19. Subsection (3) of section 395.0163, Florida Statutes, is amended to read:

395.0163 Construction inspections; plan submission and approval; fees.—

~~(3) In addition to the requirements of s. 408.811, the agency shall inspect a mobile surgical facility at initial licensure and at each time the facility establishes a new location, prior to admission of patients. However, such~~

~~inspections shall not be required when a mobile surgical facility is moved temporarily to a location where medical treatment will not be provided.~~

Section 20. Subsection (2), paragraph (c) of subsection (6), and subsections (16) and (17) of section 395.0197, Florida Statutes, are amended to read:

395.0197 Internal risk management program.—

(2) The internal risk management program is the responsibility of the governing board of the health care facility. Each licensed facility shall hire a risk manager~~,~~ ~~licensed under s. 395.10974,~~ who is responsible for implementation and oversight of such facility's internal risk management program and who demonstrates competence, by education or experience, in the following areas: ~~as required by this section. A risk manager must not be made responsible for more than four internal risk management programs in separate licensed facilities, unless the facilities are under one corporate ownership or the risk management programs are in rural hospitals.~~

(a) Applicable standards of health care risk management.

(b) Applicable federal, state, and local health and safety laws and rules.

(c) General risk management administration.

(d) Patient care.

(e) Medical care.

(f) Personal and social care.

(g) Accident prevention.

(h) Departmental organization and management.

(i) Community interrelationships.

(j) Medical terminology.

(6)

(c) The report submitted to the agency shall also contain the name ~~and license number~~ of the risk manager of the licensed facility, a copy of its policy and procedures which govern the measures taken by the facility and its risk manager to reduce the risk of injuries and adverse incidents, and the results of such measures. The annual report is confidential and is not available to the public pursuant to s. 119.07(1) or any other law providing access to public records. The annual report is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board. The annual report is not available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause.

(16) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any risk manager~~, licensed under s. 395.10974,~~ for the implementation and oversight of the internal risk management program in a facility licensed under this chapter or chapter 390 as required by this section, for any act or proceeding undertaken or performed within the scope of the functions of such internal risk management program if the risk manager acts without intentional fraud.

(17) A privilege against civil liability is hereby granted to any ~~licensed~~ risk manager or licensed facility with regard to information furnished pursuant to this chapter, unless the ~~licensed~~ risk manager or facility acted in bad faith or with malice in providing such information.

Section 21. Section 395.1046, Florida Statutes, is repealed.

Section 22. Subsection (2) of section 395.1055, Florida Statutes, is amended, and paragraph (i) is added to subsection (1) to read:

395.1055 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(i) All hospitals providing pediatric cardiac

catheterization, pediatric open-heart surgery, organ transplantation, neonatal intensive care services, psychiatric services, or comprehensive medical rehabilitation meet the minimum licensure requirements adopted by the agency. Such licensure requirements shall include quality of care, nurse staffing, physician staffing, physical plant, equipment, emergency transportation, and data reporting standards.

(2) Separate standards may be provided for general and specialty hospitals, ambulatory surgical centers, ~~mobile surgical facilities,~~ and statutory rural hospitals as defined in s. 395.602.

Section 23. Section 395.10971, Florida Statutes, is repealed.

Section 24. Section 395.10972, Florida Statutes, is repealed.

Section 25. Section 395.10973, Florida Statutes, is amended to read:

395.10973 Powers and duties of the agency.—It is the function of the agency to:

(1) Adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part and part II of chapter 408 conferring duties upon it.

~~(2) Develop, impose, and enforce specific standards within the scope of the general qualifications established by this part which must be met by individuals in order to receive licenses as~~

~~health care risk managers. These standards shall be designed to ensure that health care risk managers are individuals of good character and otherwise suitable and, by training or experience in the field of health care risk management, qualified in accordance with the provisions of this part to serve as health care risk managers, within statutory requirements.~~

~~(3) Develop a method for determining whether an individual meets the standards set forth in s. 395.10974.~~

~~(4) Issue licenses to qualified individuals meeting the standards set forth in s. 395.10974.~~

~~(5) Receive, investigate, and take appropriate action with respect to any charge or complaint filed with the agency to the effect that a certified health care risk manager has failed to comply with the requirements or standards adopted by rule by the agency or to comply with the provisions of this part.~~

~~(6) Establish procedures for providing periodic reports on persons certified or disciplined by the agency under this part.~~

(2) ~~(7)~~ Develop a model risk management program for health care facilities which will satisfy the requirements of s. 395.0197.

(3) ~~(8)~~ Enforce the special-occupancy provisions of the Florida Building Code which apply to hospitals, intermediate residential treatment facilities, and ambulatory surgical centers in conducting any inspection authorized by this chapter and part II of chapter 408.

Section 26. Section 395.10974, Florida Statutes, is repealed.

Section 27. Section 395.10975, Florida Statutes, is repealed.

Section 28. Subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

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

~~(a) "Emergency care hospital" means a medical facility which provides:~~

~~1. Emergency medical treatment; and~~

~~2. Inpatient care to ill or injured persons prior to their transportation to another hospital or provides inpatient medical care to persons needing care for a period of up to 96 hours. The 96-hour limitation on inpatient care does not apply to respite, skilled nursing, hospice, or other nonacute care patients.~~

~~(b) "Essential access community hospital" means any facility which:~~

~~1. Has at least 100 beds;~~

~~2. Is located more than 35 miles from any other essential access community hospital, rural referral center, or urban hospital meeting criteria for classification as a regional referral center;~~

~~3. Is part of a network that includes rural primary care hospitals;~~

~~4. Provides emergency and medical backup services to rural primary care hospitals in its rural health network;~~

~~5. Extends staff privileges to rural primary care hospital physicians in its network; and~~

~~6. Accepts patients transferred from rural primary care hospitals in its network.~~

~~(c) "Inactive rural hospital bed" means a licensed acute care hospital bed, as defined in s. 395.002(13), that is inactive in that it cannot be occupied by acute care inpatients.~~

(a)~~(d)~~ "Rural area health education center" means an area health education center (AHEC), as authorized by Pub. L. No. 94-484, which provides services in a county with a population density of up to ~~no greater than~~ 100 persons per square mile.

(b)~~(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 up to 100 persons per square mile;

2. An acute care hospital, in a county with a population density of up to 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 up to 100 persons per

square mile;

4. A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92 which has up to 175 licensed beds;

5. A hospital with a service area that has a population of up to 100 persons 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 Transparency at the agency; or

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

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, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room. 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. A hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year shall continue to be a

rural hospital from the date of designation through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room.

~~(f) "Rural primary care hospital" means any facility meeting the criteria in paragraph (e) or s. 395.605 which provides:~~

~~1. Twenty-four-hour emergency medical care;~~

~~2. Temporary inpatient care for periods of 72 hours or less to patients requiring stabilization before discharge or transfer to another hospital. The 72-hour limitation does not apply to respite, skilled nursing, hospice, or other nonacute care patients; and~~

~~3. Has no more than six licensed acute care inpatient beds.~~

(c) ~~(g)~~ "Swing-bed" means a bed which can be used interchangeably as either a hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) bed pursuant to 42 C.F.R. parts 405, 435, 440, 442, and 447.

Section 29. Section 395.603, Florida Statutes, is amended to read:

395.603 ~~Deactivation of general hospital beds;~~ Rural hospital impact statement.—

~~(1) The agency shall establish, by rule, a process by which a rural hospital, as defined in s. 395.602, that seeks licensure as a rural primary care hospital or as an emergency~~

~~care hospital, or becomes a certified rural health clinic as defined in Pub. L. No. 95-210, or becomes a primary care program such as a county health department, community health center, or other similar outpatient program that provides preventive and curative services, may deactivate general hospital beds. Rural primary care hospitals and emergency care hospitals shall maintain the number of actively licensed general hospital beds necessary for the facility to be certified for Medicare reimbursement. Hospitals that discontinue inpatient care to become rural health care clinics or primary care programs shall deactivate all licensed general hospital beds. All hospitals, clinics, and programs with inactive beds shall provide 24-hour emergency medical care by staffing an emergency room. Providers with inactive beds shall be subject to the criteria in s. 395.1041. The agency shall specify in rule requirements for making 24-hour emergency care available. Inactive general hospital beds shall be included in the acute care bed inventory, maintained by the agency for certificate-of-need purposes, for 10 years from the date of deactivation of the beds. After 10 years have elapsed, inactive beds shall be excluded from the inventory. The agency shall, at the request of the licensee, reactivate the inactive general beds upon a showing by the licensee that licensure requirements for the inactive general beds are met.~~

~~(2)~~ In formulating and implementing policies and rules

that may have significant impact on the ability of rural hospitals to continue to provide health care services in rural communities, the agency, the department, or the respective regulatory board adopting policies or rules regarding the licensure or certification of health care professionals shall provide a rural hospital impact statement. The rural hospital impact statement shall assess the proposed action in light of the following questions:

(1) ~~(a)~~ Do the health personnel affected by the proposed action currently practice in rural hospitals or are they likely to in the near future?

(2) ~~(b)~~ What are the current numbers of the affected health personnel in this state, their geographic distribution, and the number practicing in rural hospitals?

(3) ~~(c)~~ What are the functions presently performed by the affected health personnel, and are such functions presently performed in rural hospitals?

(4) ~~(d)~~ What impact will the proposed action have on the ability of rural hospitals to recruit the affected personnel to practice in their facilities?

(5) ~~(e)~~ What impact will the proposed action have on the limited financial resources of rural hospitals through increased salaries and benefits necessary to recruit or retain such health personnel?

(6) ~~(f)~~ Is there a less stringent requirement which could

apply to practice in rural hospitals?

(7) ~~(g)~~ Will this action create staffing shortages, which could result in a loss to the public of health care services in rural hospitals or result in closure of any rural hospitals?

Section 30. Section 395.604, Florida Statutes, is repealed.

Section 31. Section 395.605, Florida Statutes, is repealed.

Section 32. Paragraph (c) of subsection (1) of section 395.701, Florida Statutes, is amended to read:

395.701 Annual assessments on net operating revenues for inpatient and outpatient services to fund public medical assistance; administrative fines for failure to pay assessments when due; exemption.—

(1) For the purposes of this section, the term:

(c) "Hospital" means a health care institution as defined in s. 395.002(12), but does not include any hospital operated by a state ~~the~~ agency ~~or the Department of Corrections~~.

Section 33. Paragraph (b) of subsection (2) of section 395.7015, Florida Statutes, is amended to read:

395.7015 Annual assessment on health care entities.—

(2) There is imposed an annual assessment against certain health care entities as described in this section:

(b) For the purpose of this section, "health care entities" include the following:

1. Ambulatory surgical centers ~~and mobile surgical facilities licensed under s. 395.003. This subsection shall only apply to mobile surgical facilities operating under contracts entered into on or after July 1, 1998~~.

~~2. Clinical laboratories licensed under s. 483.091, excluding any hospital laboratory defined under s. 483.041(6), any clinical laboratory operated by the state or a political subdivision of the state, any clinical laboratory which qualifies as an exempt organization under s. 501(c)(3) of the Internal Revenue Code of 1986, as amended, and which receives 70 percent or more of its gross revenues from services to charity patients or Medicaid patients, and any blood, plasma, or tissue bank procuring, storing, or distributing blood, plasma, or tissue either for future manufacture or research or distributed on a nonprofit basis, and further excluding any clinical laboratory which is wholly owned and operated by 6 or fewer physicians who are licensed pursuant to chapter 458 or chapter 459 and who practice in the same group practice, and at which no clinical laboratory work is performed for patients referred by any health care provider who is not a member of the same group.~~

2.~~3.~~ Diagnostic-imaging centers that are freestanding outpatient facilities that provide specialized services for the identification or determination of a disease through examination and also provide sophisticated radiological services, and in which services are rendered by a physician licensed by the Board

of Medicine under s. 458.311, s. 458.313, or s. 458.317, or by an osteopathic physician licensed by the Board of Osteopathic Medicine under s. 459.0055 or s. 459.0075. For purposes of this paragraph, "sophisticated radiological services" means the following: magnetic resonance imaging; nuclear medicine; angiography; arteriography; computed tomography; positron emission tomography; digital vascular imaging; bronchography; lymphangiography; splenography; ultrasound, excluding ultrasound providers that are part of a private physician's office practice or when ultrasound is provided by two or more physicians licensed under chapter 458 or chapter 459 who are members of the same professional association and who practice in the same medical specialties; and such other sophisticated radiological services, excluding mammography, as adopted in rule by the board.

Section 34. Subsection (1) of section 400.0625, Florida Statutes, is amended to read:

400.0625 Minimum standards for clinical laboratory test results and diagnostic X-ray results.—

(1) Each nursing home, as a requirement for issuance or renewal of its license, shall require that all clinical laboratory tests performed for the nursing home be performed by a clinical laboratory licensed under the provisions of chapter 483, except for such self-testing procedures as are approved by the agency by rule. ~~Results of clinical laboratory tests~~

~~performed prior to admission which meet the minimum standards provided in s. 483.181(3) shall be accepted in lieu of routine examinations required upon admission and clinical laboratory tests which may be ordered by a physician for residents of the nursing home.~~

Section 35. Subsection (1) and paragraphs (b), (e), and (f) of subsection (4) of section 400.464, Florida Statutes, are amended, and subsection (6) is added to that section to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.—

(1) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this part and part II of chapter 408 and entities licensed or registered by or applying for such licensure or registration from the Agency for Health Care Administration pursuant to this part. A license issued by the agency is required in order to operate a home health agency in this state. A license issued after June 30, 2017, must specify the home health services the organization is authorized to perform and indicate whether such specified services are considered skilled care. The provision or advertising of services which require licensure pursuant to this part without such services being specified on the face of the license issued after June 30, 2017, constitutes unlicensed activity as prohibited under s. 408.812.

(4)

(b) The operation or maintenance of an unlicensed home health agency or the performance of any home health services in violation of this part is declared a nuisance, inimical to the public health, welfare, and safety. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the home health agency or the provision of home health services in violation of this part or part II of chapter 408, until compliance with this part or the rules adopted under this part has been demonstrated to the satisfaction of the agency.

(e) Any person who owns, operates, or maintains an unlicensed home health agency and who, ~~within 10 working days~~ after receiving notification from the agency, fails to cease operation and apply for a license under this part commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continued operation is a separate offense.

(f) Any home health agency that fails to cease operation after agency notification may be fined in accordance with s. 408.812 ~~$500 for each day of noncompliance~~.

(6) Any person, entity, or organization providing home health services that is exempt from licensure under subsection (5), may voluntarily apply for a certificate of exemption from licensure under its exempt status with the agency on a form that

sets forth its name or names and addresses, a statement of the reasons why it is exempt from licensure as a home health agency, and other information deemed necessary by the agency. A certificate of exemption is valid for a period of not more than 2 years and is not transferable. The agency may charge an applicant for a certificate of exemption in an amount equal to $100 or the actual cost of processing the certificate.

Section 36. Subsections (7), (8), and (9) of section 400.471, Florida Statutes, are renumbered as subsections (6), (7), and (8), respectively, and subsection (2), present subsection (6), and paragraph (g) of present subsection (10) are amended to read:

400.471 Application for license; fee.—

(2) In addition to the requirements of part II of chapter 408, the initial applicant, the applicant for a change of ownership, and the applicant for the addition of skilled care services, must file with the application satisfactory proof that the home health agency is in compliance with this part and applicable rules, including:

(a) A listing of services to be provided, either directly by the applicant or through contractual arrangements with existing providers.

(b) The number and discipline of professional staff to be employed.

~~(c) Completion of questions concerning volume data on the~~

~~renewal application as determined by rule.~~

(c) ~~(d)~~ A business plan, signed by the applicant, which details the home health agency's methods to obtain patients and its plan to recruit and maintain staff.

(d) ~~(e)~~ Evidence of contingency funding as required under s. 408.8065 ~~equal to 1 month's average operating expenses during the first year of operation~~.

(e) ~~(f)~~ A balance sheet, income and expense statement, and statement of cash flows for the first 2 years of operation which provide evidence of having sufficient assets, credit, and projected revenues to cover liabilities and expenses. The applicant has demonstrated financial ability to operate if the applicant's assets, credit, and projected revenues meet or exceed projected liabilities and expenses. An applicant may not project an operating margin of 15 percent or greater for any month in the first year of operation. All documents required under this paragraph must be prepared in accordance with generally accepted accounting principles and compiled and signed by a certified public accountant.

(f) ~~(g)~~ All other ownership interests in health care entities for each controlling interest, as defined in part II of chapter 408.

(g) ~~(h)~~ In the case of an application for initial licensure, an application for a change of ownership, or an application for the addition of skilled care services,

documentation of accreditation, or an application for accreditation, from an accrediting organization that is recognized by the agency as having standards comparable to those required by this part and part II of chapter 408. A home health agency that ~~is not Medicare or Medicaid certified and~~ does not provide skilled care is exempt from this paragraph. Notwithstanding s. 408.806, an initial applicant ~~that has applied for accreditation~~ must provide proof of accreditation that is not conditional or provisional and a survey demonstrating compliance with the requirements of this part, part II of chapter 408, and applicable rules from an accrediting organization that is recognized by the agency as having standards comparable to those required by this part and part II of chapter 408 within 120 days after the date of the agency's receipt of the application for licensure ~~or the application shall be withdrawn from further consideration~~. Such accreditation must be continuously maintained by the home health agency to maintain licensure. The agency shall accept, in lieu of its own periodic licensure survey, the submission of the survey of an accrediting organization that is recognized by the agency if the accreditation of the licensed home health agency is not provisional and if the licensed home health agency authorizes releases of, and the agency receives the report of, the accrediting organization.

~~(6) The agency may not issue a license designated as~~

~~certified to a home health agency that fails to satisfy the requirements of a Medicare certification survey from the agency.~~

(9)~~(10)~~ The agency may not issue a renewal license for a home health agency in any county having at least one licensed home health agency and that has more than one home health agency per 5,000 persons, as indicated by the most recent population estimates published by the Legislature's Office of Economic and Demographic Research, if the applicant or any controlling interest has been administratively sanctioned by the agency during the 2 years prior to the submission of the licensure renewal application for one or more of the following acts:

(g) Demonstrating a pattern of failing to provide a service specified in the home health agency's written agreement with a patient or the patient's legal representative, or the plan of care for that patient, except ~~unless a reduction in service is mandated by Medicare, Medicaid, or a state program or~~ as provided in s. 400.492(3). A pattern may be demonstrated by a showing of at least three incidents, regardless of the patient or service, in which the home health agency did not provide a service specified in a written agreement or plan of care during a 3-month period;

Section 37. Subsection (5) of section 400.474, Florida Statutes, is amended to read:

400.474 Administrative penalties.—

(5) The agency shall impose a fine of $5,000 against a

home health agency that demonstrates a pattern of failing to provide a service specified in the home health agency's written agreement with a patient or the patient's legal representative, or the plan of care for that patient, except ~~unless a reduction in service is mandated by Medicare, Medicaid, or a state program or~~ as provided in s. 400.492(3). A pattern may be demonstrated by a showing of at least three incidences, regardless of the patient or service, where the home health agency did not provide a service specified in a written agreement or plan of care during a 3-month period. The agency shall impose the fine for each occurrence. The agency may also impose additional administrative fines under s. 400.484 for the direct or indirect harm to a patient, or deny, revoke, or suspend the license of the home health agency for a pattern of failing to provide a service specified in the home health agency's written agreement with a patient or the plan of care for that patient.

Section 38. Paragraph (c) of subsection (2) of section 400.476, Florida Statutes, is amended to read:

400.476 Staffing requirements; notifications; limitations on staffing services.—

(2) DIRECTOR OF NURSING.—

(c) A home health agency that provides skilled nursing care must ~~is not Medicare or Medicaid certified and does not provide skilled care or provides only physical, occupational, or speech therapy is not required to~~ have a director of nursing ~~and~~

~~is exempt from paragraph (b)~~.

Section 39. Subsection (2) of section 400.484, Florida Statutes, is amended to read:

400.484 Right of inspection; violations ~~deficiencies~~; fines.—

(2) The agency shall impose fines for various classes of violations ~~deficiencies~~ in accordance with the following schedule:

(a) Class I violations are defined in s. 408.813 ~~A class I deficiency is any act, omission, or practice that results in a patient's death, disablement, or permanent injury, or places a patient at imminent risk of death, disablement, or permanent injury~~. Upon finding a class I violation ~~deficiency~~, the agency shall impose an administrative fine in the amount of $15,000 for each occurrence and each day that the violation ~~deficiency~~ exists.

(b) Class II violations are defined in s. 408.813 ~~A class II deficiency is any act, omission, or practice that has a direct adverse effect on the health, safety, or security of a patient~~. Upon finding a class II violation ~~deficiency~~, the agency shall impose an administrative fine in the amount of $5,000 for each occurrence and each day that the violation ~~deficiency~~ exists.

(c) Class III violations are defined in s. 408.813 ~~A class III deficiency is any act, omission, or practice that has an~~

~~indirect, adverse effect on the health, safety, or security of a patient~~. Upon finding an uncorrected or repeated class III violation ~~deficiency~~, the agency shall impose an administrative fine not to exceed $1,000 for each occurrence and each day that the uncorrected or repeated violation ~~deficiency~~ exists.

(d) Class IV violations are defined in s. 408.813 ~~A class IV deficiency is any act, omission, or practice related to required reports, forms, or documents which does not have the potential of negatively affecting patients~~. These violations are of a type that the agency determines do not threaten the health, safety, or security of patients. Upon finding an uncorrected or repeated class IV violation ~~deficiency~~, the agency shall impose an administrative fine not to exceed $500 for each occurrence and each day that the uncorrected or repeated violation ~~deficiency~~ exists.

Section 40. Subsection (4) of section 400.497, Florida Statutes, is amended to read:

400.497 Rules establishing minimum standards.—The agency shall adopt, publish, and enforce rules to implement part II of chapter 408 and this part, including, as applicable, ss. 400.506 and 400.509, which must provide reasonable and fair minimum standards relating to:

(4) Licensure and certificate of exemption application and renewal.

Section 41. Subsection (5), paragraphs (d) and (e) of

subsection (6), paragraph (a) of subsection (15), and subsections (19) and (20) of section 400.506, Florida Statutes, are amended to read:

400.506 Licensure of nurse registries; requirements; penalties.—

(5)(a) In addition to the requirements of s. 408.812, any person who owns, operates, or maintains an unlicensed nurse registry and who, ~~within 10 working days~~ after receiving notification from the agency, fails to cease operation and apply for a license under this part commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continued operation is a separate offense.

(b) If a nurse registry fails to cease operation after agency notification, the agency may impose a fine in accordance with s. 408.812 ~~of $500 for each day of noncompliance~~.

(6)

(d) A registered nurse, licensed practical nurse, certified nursing assistant, companion or homemaker, or home health aide referred for contract under this chapter by a nurse registry is deemed an independent contractor and not an employee of the nurse registry under any chapter, regardless of the obligations imposed on a nurse registry under this chapter or chapter 408.

(e) Upon referral of a registered nurse, licensed practical nurse, certified nursing assistant, companion or

homemaker, or home health aide for contract in a private residence or facility, the nurse registry shall advise the patient, the patient's family, or any other person acting on behalf of the patient, at the time of the contract for services, that the caregiver referred by the nurse registry is an independent contractor and that the ~~it is not the obligation of a~~ nurse registry is not permitted to monitor, supervise, manage, or train a caregiver referred for contract under this chapter.

(15)(a) The agency may deny, suspend, or revoke the license of a nurse registry and shall impose a fine of $5,000 against a nurse registry that:

1. Provides services to residents in an assisted living facility for which the nurse registry does not receive fair market value remuneration.

2. Provides staffing to an assisted living facility for which the nurse registry does not receive fair market value remuneration.

3. Fails to provide the agency, upon request, with copies of all contracts with assisted living facilities which were executed within the last 5 years.

~~4. Gives remuneration to a case manager, discharge planner, facility-based staff member, or third-party vendor who is involved in the discharge planning process of a facility licensed under chapter 395 or this chapter and from whom the nurse registry receives referrals. A nurse registry is exempt~~

~~from this subparagraph if it does not bill the Florida Medicaid program or the Medicare program or share a controlling interest with any entity licensed, registered, or certified under part II of chapter 408 that bills the Florida Medicaid program or the Medicare program.~~

~~5. Gives remuneration to a physician, a member of the physician's office staff, or an immediate family member of the physician, and the nurse registry received a patient referral in the last 12 months from that physician or the physician's office staff. A nurse registry is exempt from this subparagraph if it does not bill the Florida Medicaid program or the Medicare program or share a controlling interest with any entity licensed, registered, or certified under part II of chapter 408 that bills the Florida Medicaid program or the Medicare program.~~

(19) ~~It is not the obligation of~~ A nurse registry is not permitted to monitor, supervise, manage, or train a registered nurse, licensed practical nurse, certified nursing assistant, companion or homemaker, or home health aide referred for contract under this chapter. In the event of a violation of this chapter or a violation of any other law of this state by a referred registered nurse, licensed practical nurse, certified nursing assistant, companion or homemaker, or home health aide, or a deficiency in credentials which comes to the attention of the nurse registry, the nurse registry shall advise the patient to terminate the referred person's contract, providing the

reason for the suggested termination; cease referring the person to other patients or facilities; and, if practice violations are involved, notify the licensing board. This section does not affect or negate any other obligations imposed on a nurse registry under chapter 408.

(20) Records required to be filed under this chapter with the nurse registry as a repository of records must be kept in accordance with rules adopted by the agency. The nurse registry is not permitted ~~has no obligation~~ to review or act upon such records except as specified in subsection (19).

Section 42. Subsection (1) of section 400.606, Florida Statutes, is amended to read:

400.606 License; application; renewal; conditional license or permit; certificate of need.—

(1) In addition to the requirements of part II of chapter 408, the initial application and change of ownership application must be accompanied by a plan for the delivery of home, residential, and homelike inpatient hospice services to terminally ill persons and their families. Such plan must contain, but need not be limited to:

(a) The estimated average number of terminally ill persons to be served monthly.

(b) The geographic area in which hospice services will be available.

(c) A listing of services which are or will be provided,

either directly by the applicant or through contractual arrangements with existing providers.

(d) Provisions for the implementation of hospice home care within 3 months after licensure.

(e) Provisions for the implementation of hospice homelike inpatient care within 12 months after licensure.

(f) The number and disciplines of professional staff to be employed.

(g) The name and qualifications of any existing or potential contractee.

(h) A plan for attracting and training volunteers.

~~If the applicant is an existing licensed health care provider, the application must be accompanied by a copy of the most recent profit-loss statement and, if applicable, the most recent licensure inspection report.~~

Section 43. Subsection (6) of section 400.925, Florida Statutes, is amended to read:

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

(6) "Home medical equipment" includes any product as defined by the Federal Drug Administration's Drugs, Devices and Cosmetics Act, any products reimbursed under the Medicare Part B Durable Medical Equipment benefits, or any products reimbursed under the Florida Medicaid durable medical equipment program. Home medical equipment includes:

(a) Oxygen and related respiratory equipment; ~~manual, motorized, or customized wheelchairs and related seating and positioning, but does not include prosthetics or orthotics or any splints, braces, or aids custom fabricated by a licensed health care practitioner;~~

(b) Motorized scooters;

(c) Personal transfer systems; ~~and~~

(d) Specialty beds, for use by a person with a medical need; and

(e) Manual, motorized, or customized wheelchairs and related seating and positioning, but does not include prosthetics or orthotics or any splints, braces, or aids custom fabricated by a licensed health care practitioner.

Section 44. Subsection (4) of section 400.931, Florida Statutes, is amended to read:

400.931 Application for license; fee.—

(4) When a change of the general manager of a home medical equipment provider occurs, the licensee must notify the agency of the change within the timeframes established in part II of chapter 408 and applicable rules ~~45 days~~.

Section 45. Subsection (2) of section 400.933, Florida Statutes, is amended to read:

400.933 Licensure inspections and investigations.—

(2) The agency shall accept, in lieu of its own periodic inspections for licensure, submission of the following:

(a) The survey or inspection of an accrediting organization, provided the accreditation of the licensed home medical equipment provider is not provisional and provided the licensed home medical equipment provider authorizes release of, and the agency receives the report of, the accrediting organization; or

(b) A copy of a valid medical oxygen retail establishment permit issued by the Department of Business and Professional Regulation ~~Health~~, pursuant to chapter 499.

Section 46. Subsection (2) of section 400.980, Florida Statutes, is amended to read:

400.980 Health care services pools.—

(2) The requirements of part II of chapter 408 apply to the provision of services that require licensure or registration pursuant to this part and part II of chapter 408 and to entities registered by or applying for such registration from the agency pursuant to this part. Registration or a license issued by the agency is required for the operation of a health care services pool in this state. In accordance with s. 408.805, an applicant or licensee shall pay a fee for each license application submitted using this part, part II of chapter 408, and applicable rules. The agency shall adopt rules and provide forms required for such registration and shall impose a registration fee in an amount sufficient to cover the cost of administering this part and part II of chapter 408. In addition to the

requirements in part II of chapter 408, the registrant must provide the agency with any change of information contained on the original registration application within the timeframes established in this part, part II of chapter 408, and applicable rules ~~14 days prior to the change~~.

Section 47. Paragraphs (a) through (d) of subsection (4) of section 400.9905, Florida Statutes, are amended to read:

400.9905 Definitions.—

(4) "Clinic" means an entity where health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. As used in this part, the term does not include and the licensure requirements of this part do not apply to:

(a) Entities licensed or registered by the state under chapter 395; entities licensed or registered by the state and providing only health care services within the scope of services authorized under their respective licenses under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, ~~part I of chapter 483,~~ chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services or

other health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 395; entities that own, directly or indirectly, entities licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, ~~part I of chapter 483,~~ chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(c) Entities that are owned, directly or indirectly, by an entity licensed or registered by the state pursuant to chapter 395; entities that are owned, directly or indirectly, by an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, ~~part I of chapter 483,~~ chapter 484, or chapter 651; end-

stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital under chapter 395.

(d) Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state pursuant to chapter 395; entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, ~~part I of chapter 483,~~ chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

Notwithstanding this subsection, an entity shall be deemed a clinic and must be licensed under this part in order to receive reimbursement under the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7405, unless exempted under s. 627.736(5)(h).

Section 48. Paragraph (a) of subsection (2) of section 408.033, Florida Statutes, is amended to read:

408.033 Local and state health planning.—

(2) FUNDING.—

(a) The Legislature intends that the cost of local health councils be borne by assessments on selected health care facilities subject to facility licensure by the Agency for Health Care Administration, including abortion clinics, assisted living facilities, ambulatory surgical centers, birthing centers, ~~clinical laboratories except community nonprofit blood banks and clinical laboratories operated by practitioners for exclusive use regulated under s. 483.035,~~ home health agencies, hospices, hospitals, intermediate care facilities for the developmentally disabled, nursing homes, health care clinics, and multiphasic testing centers and by assessments on organizations subject to certification by the agency pursuant to chapter 641, part III, including health maintenance organizations and prepaid health clinics. Fees assessed may be collected prospectively at the time of licensure renewal and prorated for the licensure period.

Section 49. Paragraph (e) of subsection (3) of section 408.036, Florida Statutes, is amended to read:

408.036 Projects subject to review; exemptions.—

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

~~(c) For mobile surgical facilities and related health care services provided under contract with the Department of Corrections or a private correctional facility operating pursuant to chapter 957.~~

Section 50. Subsection (4) of section 408.061, Florida Statutes, is amended to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.—

(4) Within 120 days after the end of its fiscal year, each health care facility, excluding continuing care facilities, hospitals operated by state agencies, and nursing homes as defined in s. 408.07(13) and (36) ~~408.07(14) and (37)~~, shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the provider. However, hospitals' actual financial experience shall be their audited actual experience. Every nursing home shall submit to the agency, in a format designated by the agency, a statistical profile of the nursing home residents. The agency, in conjunction with the Department of Elderly Affairs and the Department of Health, shall review these statistical profiles and develop

recommendations for the types of residents who might more appropriately be placed in their homes or other noninstitutional settings.

Section 51. Subsection (11) of section 408.07, Florida Statutes, is amended to read:

408.07 Definitions.—As used in this chapter, with the exception of ss. 408.031-408.045, the term:

~~(11) "Clinical laboratory" means a facility licensed under s. 483.091, excluding: any hospital laboratory defined under s. 483.041(6); any clinical laboratory operated by the state or a political subdivision of the state; any blood or tissue bank where the majority of revenues are received from the sale of blood or tissue and where blood, plasma, or tissue is procured from volunteer donors and donated, processed, stored, or distributed on a nonprofit basis; and any clinical laboratory which is wholly owned and operated by physicians who are licensed pursuant to chapter 458 or chapter 459 and who practice in the same group practice, and at which no clinical laboratory work is performed for patients referred by any health care provider who is not a member of that same group practice.~~

Section 52. Subsection (4) of section 408.20, Florida Statutes, is amended to read:

408.20 Assessments; Health Care Trust Fund.—

(4) Hospitals operated by state agencies ~~the Department of Children and Families, the Department of Health, or the~~

~~Department of Corrections~~ are exempt from the assessments required under this section.

Section 53. Section 408.7056, Florida Statutes, is repealed.

Section 54. Subsections (10), (11), and (27) of section 408.802, Florida Statutes, are amended to read:

408.802 Applicability.—The provisions of this part apply to the provision of services that require licensure as defined in this part and to the following entities licensed, registered, or certified by the agency, as described in chapters 112, 383, 390, 394, 395, 400, 429, 440, 483, and 765:

~~(10) Mobile surgical facilities, as provided under part I of chapter 395.~~

~~(11) Health care risk managers, as provided under part I of chapter 395.~~

~~(27) Clinical laboratories, as provided under part I of chapter 483.~~

Section 55. Subsections (12) and (13) of section 408.803, Florida Statutes, are renumbered as subsections (13) and (14), respectively, and a new subsection (12) is added to that section to read:

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

(12) "Relative" means an individual who is the father, mother, stepfather, stepmother, son, daughter, brother, sister, grandmother, grandfather, great-grandmother, great-grandfather,

grandson, granddaughter, uncle, aunt, first cousin, nephew, niece, husband, wife, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepson, stepdaughter, stepbrother, stepsister, half-brother, or half-sister of a patient or client.

Section 56. Paragraph (a) of subsection (1) and paragraph (c) of subsection (7) of section 408.806, Florida Statutes, are amended, and subsection (9) is added to that section, to read:

408.806 License application process.—

(1) An application for licensure must be made to the agency on forms furnished by the agency, submitted under oath or attestation, and accompanied by the appropriate fee in order to be accepted and considered timely. The application must contain information required by authorizing statutes and applicable rules and must include:

(a) The name, address, and social security number, or individual taxpayer identification number if a social security number cannot legally be obtained, of:

1. The applicant;

2. The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider;

3. The financial officer or similarly titled person who is responsible for the financial operation of the licensee or provider; and

4. Each controlling interest if the applicant or

controlling interest is an individual.

The licensee shall ensure that no person has any ownership interest in the licensee, directly or indirectly, regardless of ownership structure, who is ineligible pursuant to s. 408.809(4). The licensee shall ensure that no person holds or has held any ownership interest, directly or indirectly, regardless of ownership structure, in a provider that has had a license or change of ownership application denied, revoked, or excluded pursuant to s. 408.815.

(7)

(c) If an inspection is required by the authorizing statute for a license application other than an initial application, the inspection must be unannounced. This paragraph does not apply to inspections required pursuant to ss. 383.324, 395.0161(4) and~~,~~ 429.67(6)~~, and 483.061(2)~~.

(9) A licensee that holds a license for multiple providers licensed by the agency may request all related license expiration dates be aligned. The agency may issue a license for an abbreviated licensure period with a prorated licensure fee.

Section 57. Subsection (8) of section 408.810, Florida Statutes, is amended, and subsection (11) is added to that section to read:

408.810 Minimum licensure requirements.—In addition to the licensure requirements specified in this part, authorizing

statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.

(8) Upon application for initial licensure or change of ownership licensure, the applicant shall furnish satisfactory proof of the applicant's financial ability to operate in accordance with the requirements of this part, authorizing statutes, and applicable rules. The agency shall establish standards for this purpose, including information concerning the applicant's controlling interests. The agency shall also establish documentation requirements, to be completed by each applicant, that show anticipated provider revenues and expenditures, the basis for financing the anticipated cash-flow requirements of the provider, and an applicant's access to contingency financing. A current certificate of authority, pursuant to chapter 651, may be provided as proof of financial ability to operate. The agency may require a licensee to provide proof of financial ability to operate at any time if there is evidence of financial instability, including, but not limited to, unpaid expenses necessary for the basic operations of the provider. An applicant applying for change of ownership licensure is exempt from furnishing proof of the applicant's financial ability to operate if the provider has been licensed for at least 5 years, and:

(a) The licensee change is a result of a corporate

reorganization under which the controlling interest is unchanged and the applicant submits organization charts that represent the current and proposed structure of the reorganized corporation; or

(b) The licensee change is due solely to the death of a controlling interest, and the surviving controlling interests continue to hold at least 51 percent of ownership after the change of ownership.

(11) The agency may adopt rules that govern the circumstances under which a controlling interest, an administrator, an employee, a contractor, or a representative thereof who is not a relative of the patient or client may act as a legal representative, agent, health care surrogate, power of attorney, or guardian of a patient or client. Such rules may include requirements related to disclosure, bonding, restrictions, and client protections.

Section 58. Section 408.812, Florida Statutes, is amended to read:

408.812 Unlicensed activity.—

(1) A person or entity may not offer or advertise services that require licensure as defined by this part, authorizing statutes, or applicable rules to the public without obtaining a valid license from the agency. A licenseholder may not advertise or hold out to the public that he or she holds a license for other than that for which he or she actually holds the license.

(2) The operation or maintenance of an unlicensed provider or the performance of any services that require licensure without proper licensure is a violation of this part and authorizing statutes. Unlicensed activity constitutes harm that materially affects the health, safety, and welfare of clients and constitutes abuse and neglect as defined in s. 415.102. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the unlicensed provider or the performance of any services in violation of this part and authorizing statutes, until compliance with this part, authorizing statutes, and agency rules has been demonstrated to the satisfaction of the agency.

(3) It is unlawful for any person or entity to own, operate, or maintain an unlicensed provider. If after receiving notification from the agency, such person or entity fails to cease operation ~~and apply for a license under this part and authorizing statutes~~, the person or entity shall be subject to penalties as prescribed by authorizing statutes and applicable rules. Each day of ~~continued~~ operation is a separate offense.

(4) Any person or entity that fails to cease operation after agency notification may be fined $1,000 for each day of noncompliance.

(5) When a controlling interest or licensee has an

interest in more than one provider and fails to license a provider rendering services that require licensure, the agency may revoke all licenses and impose actions under s. 408.814 and regardless of correction, impose a fine of $1,000 per day, unless otherwise specified by authorizing statutes, against each licensee until such time as the appropriate license is obtained or the unlicensed activity ceases ~~for the unlicensed operation~~.

(6) In addition to granting injunctive relief pursuant to subsection (2), if the agency determines that a person or entity is operating or maintaining a provider without obtaining a license and determines that a condition exists that poses a threat to the health, safety, or welfare of a client of the provider, the person or entity is subject to the same actions and fines imposed against a licensee as specified in this part, authorizing statutes, and agency rules.

(7) Any person aware of the operation of an unlicensed provider must report that provider to the agency.

Section 59. Subsections (10), (11), and (26) of section 408.820, Florida Statutes, are amended to read:

408.820 Exemptions.—Except as prescribed in authorizing statutes, the following exemptions shall apply to specified requirements of this part:

~~(10) Mobile surgical facilities, as provided under part I of chapter 395, are exempt from s. 408.810(7)-(10).~~

~~(11) Health care risk managers, as provided under part I~~

~~of chapter 395, are exempt from ss. 408.806(7), 408.810(4)-(10), and 408.811.~~

~~(26) Clinical laboratories, as provided under part I of chapter 483, are exempt from s. 408.810(5)-(10).~~

Section 60. Subsection (7) of section 409.905, Florida Statutes, is 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.

(7) INDEPENDENT LABORATORY SERVICES.—The agency shall pay for medically necessary diagnostic laboratory procedures ordered by a licensed physician or other licensed practitioner of the healing arts which are provided for a recipient in a laboratory

that meets the requirements for Medicare participation and appropriately certified by the Centers for Medicare and Medicaid Services (CMS) under the federal Clinical Laboratory Improvement Amendments (CLIA) ~~is licensed under chapter 483, if required~~.

Section 61. Subsection (6) of section 409.9116, Florida Statutes, is amended to read:

409.9116 Disproportionate share/financial assistance program for rural hospitals.—In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall administer a federally matched disproportionate share program and a state-funded financial assistance program for statutory rural hospitals. The agency shall make disproportionate share payments to statutory rural hospitals that qualify for such payments and financial assistance payments to statutory rural hospitals that do not qualify for disproportionate share payments. The disproportionate share program payments shall be limited by and conform with federal requirements. Funds shall be distributed quarterly in each fiscal year for which an appropriation is made. 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.

(6) This section applies only to hospitals that were defined as statutory rural hospitals, or their successor-in-

interest hospital, prior to January 1, 2001. Any additional hospital that is defined as a statutory rural hospital, or its successor-in-interest hospital, on or after January 1, 2001, is not eligible for programs under this section unless additional funds are appropriated each fiscal year specifically to the rural hospital disproportionate share and financial assistance programs in an amount necessary to prevent any hospital, or its successor-in-interest hospital, eligible for the programs prior to January 1, 2001, from incurring a reduction in payments because of the eligibility of an additional hospital to participate in the programs. A hospital, or its successor-in-interest hospital, which received funds pursuant to this section before January 1, 2001, and which qualifies under s. 395.602(2)(b) ~~395.602(2)(c)~~, shall be included in the programs under this section and is not required to seek additional appropriations under this subsection.

Section 62. Paragraphs (a) and (b) of subsection (1) of section 409.975, Florida Statutes, are amended to read:

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to

s. 409.967(2)(c). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(a) Plans must include all providers in the region that are classified by the agency as essential Medicaid providers, unless the agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers. Providers are essential for serving Medicaid enrollees if they offer services that are not available from any other provider within a reasonable access standard, or if they provided a substantial share of the total units of a particular service used by Medicaid patients within the region during the last 3 years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid patients. The agency may not classify physicians and other practitioners as essential providers. The agency, at a minimum, shall determine which providers in the following categories are essential Medicaid providers:

1. Federally qualified health centers.

2. Statutory teaching hospitals as defined in s. 408.07(44) ~~408.07(45)~~.

3. Hospitals that are trauma centers as defined in s. 395.4001(14).

4. Hospitals located at least 25 miles from any other

hospital with similar services.

Managed care plans that have not contracted with all essential providers in the region as of the first date of recipient enrollment, or with whom an essential provider has terminated its contract, must negotiate in good faith with such essential providers for 1 year or until an agreement is reached, whichever is first. Payments for services rendered by a nonparticipating essential provider shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. A rate schedule for all essential providers shall be attached to the contract between the agency and the plan. After 1 year, managed care plans that are unable to contract with essential providers shall notify the agency and propose an alternative arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the nonparticipating essential service provider. If the alternative arrangement is approved by the agency, payments to nonparticipating essential providers after the date of the agency's approval shall equal 90 percent of the applicable Medicaid rate. Except for payment for emergency services, if the alternative arrangement is not approved by the agency, payment to nonparticipating essential providers shall equal 110 percent

of the applicable Medicaid rate.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

2. Regional perinatal intensive care centers as defined in s. 383.16(2).

3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(27) ~~395.002(28)~~.

4. Accredited and integrated systems serving medically complex children which comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and

the plan. Except for payments for emergency services, payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

Section 63. Subsections (5) and (17) of section 429.02, Florida Statutes, are amended to read:

429.02 Definitions.—When used in this part, the term:

(5) "Assisted living facility" means any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which, ~~undertakes~~ through its ownership or management, provides ~~to provide~~ housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.

(17) "Personal services" means direct physical assistance with or supervision of the activities of daily living, ~~and~~ the self-administration of medication or ~~and~~ other similar services which the department may define by rule. "Personal services" may ~~shall~~ not be construed to mean the provision of medical, nursing, dental, or mental health services, or, with the exception of authorized adult day care services provided within a licensed assisted living facility, personal services to individuals who are not residents of the facility.

Section 64. Paragraphs (b) and (d) of subsection (2) of

section 429.04, Florida Statutes, are amended, and subsection (3) is added to that section to read:

429.04 Facilities to be licensed; exemptions.—

(2) The following are exempt from licensure under this part:

(b) Any facility or part of a facility licensed by the Agency for Persons with Disabilities under chapter 393, a mental health facility licensed under ~~or~~ chapter 394, a hospital licensed under chapter 395, a nursing home licensed under part II of chapter 400, an inpatient hospice licensed under part IV of chapter 400, a home for special services licensed under part V of chapter 400, an intermediate care facility licensed under part VIII of chapter 400, or a transitional living facility licensed under part XI of chapter 400.

(d) Any person who provides housing, meals, and one or more personal services on a 24-hour basis in the person's own home to not more than two adults who do not receive optional state supplementation. The person who provides the housing, meals, and personal services must own or rent the home and must have established the home as the person's permanent residence. Any person holding a homestead exemption at an address other than that at which the person asserts this exemption shall be presumed to not have established permanent residence under this exemption ~~reside therein~~. This exemption does not apply to a person or entity who previously held licensure issued by the

agency and such licensure was revoked or licensure renewal was denied by final order of the agency, or when the person or entity voluntarily relinquished licensure during agency enforcement proceedings.

(3) Upon agency investigation of unlicensed activity, any person or entity asserting an exemption pursuant to this section shall have the burden of providing documentation substantiating that the person or entity is entitled to the licensure exemption.

Section 65. Paragraphs (b) and (d) of subsection (1) of section 429.08, Florida Statutes, are amended and subsection (3) is added to that section to read:

429.08 Unlicensed facilities; referral of person for residency to unlicensed facility; penalties.—

(1)

(b) ~~Except as provided under paragraph (d),~~ Any person who owns, rents, or otherwise maintains a building or property that operates~~,~~ or maintains an unlicensed assisted living facility commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.

(d) In addition to the requirements of s. 408.812, any person who owns, operates, or maintains an unlicensed assisted living facility after receiving notice from the agency ~~due to a change in this part or a modification in rule within 6 months~~

~~after the effective date of such change and who, within 10 working days after receiving notification from the agency, fails to cease operation or apply for a license under this part~~ commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.

Section 66. Section 429.176, Florida Statutes, is amended to read:

429.176 Notice of change of administrator.—If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements.

Section 67. Paragraph (h) of subsection (1) of section 429.41, Florida Statutes, is amended to read:

429.41 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also ensure a safe and sanitary environment that is residential and

noninstitutional in design or nature. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. Uniform firesafety standards for assisted living facilities shall be established by the State Fire Marshal pursuant to s. 633.206. The agency, in consultation with the department, may adopt rules to administer the requirements of part II of chapter 408. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and preferences of residents, the department, in consultation with the agency, the Department of Children and Families, and the Department of Health, shall adopt rules, policies, and procedures to administer this part, which must include reasonable and fair minimum standards in relation to:

(h) The care and maintenance of residents, which must include, but is not limited to:

1. The supervision of residents;

2. The provision of personal services. With the exception of authorized adult day care services provided within a licensed assisted living facility, an assisted living facility may not provide personal services to individuals who are not residents of the facility;

3. The provision of, or arrangement for, social and leisure activities;

4. The arrangement for appointments and transportation to appropriate medical, dental, nursing, or mental health services, as needed by residents;

5. The management of medication;

6. The nutritional needs of residents;

7. Resident records; and

8. Internal risk management and quality assurance.

Section 68. Subsection (4) of section 456.001, Florida Statutes, is amended to read:

456.001 Definitions.—As used in this chapter, the term:

(4) "Health care practitioner" means any person licensed under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part II or part III ~~or part IV~~ of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491.

Section 69. Paragraph (i) of subsection (2) of section 456.057, Florida Statutes, is amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished; disclosure of information.—

(2) As used in this section, the terms "records owner," "health care practitioner," and "health care practitioner's employer" do not include any of the following persons or

entities; furthermore, the following persons or entities are not authorized to acquire or own medical records, but are authorized under the confidentiality and disclosure requirements of this section to maintain those documents required by the part or chapter under which they are licensed or regulated:

(i) Medical physicists licensed under part III ~~IV~~ of chapter 483.

Section 70. Subsection (2) of section 458.307, Florida Statutes, is amended to read:

458.307 Board of Medicine.—

(2) Twelve members of the board must be licensed physicians in good standing in this state who are residents of the state and who have been engaged in the active practice or teaching of medicine for at least 4 years immediately preceding their appointment. One of the physicians must be on the full-time faculty of a medical school in this state, and one of the physicians must be in private practice and on the full-time staff of a statutory teaching hospital in this state as defined in s. 408.07. At least one of the physicians must be a graduate of a foreign medical school. The remaining three members must be residents of the state who are not, and never have been, licensed health care practitioners. One member must be a health care risk manager ~~licensed under s. 395.10974~~. At least one member of the board must be 60 years of age or older.

Section 71. Subsection (1) of section 458.345, Florida

Statutes, is amended to read:

458.345 Registration of resident physicians, interns, and fellows; list of hospital employees; prescribing of medicinal drugs; penalty.—

(1) Any person desiring to practice as a resident physician, assistant resident physician, house physician, intern, or fellow in fellowship training which leads to subspecialty board certification in this state, or any person desiring to practice as a resident physician, assistant resident physician, house physician, intern, or fellow in fellowship training in a teaching hospital in this state as defined in s. 408.07(44) ~~408.07(45)~~ or s. 395.805(2), who does not hold a valid, active license issued under this chapter shall apply to the department to be registered and shall remit a fee not to exceed $300 as set by the board. The department shall register any applicant the board certifies has met the following requirements:

(a) Is at least 21 years of age.

(b) Has not committed any act or offense within or without the state which would constitute the basis for refusal to certify an application for licensure pursuant to s. 458.331.

(c) Is a graduate of a medical school or college as specified in s. 458.311(1)(f).

Section 72. Part I of chapter 483, Florida Statutes, consisting of sections 483.011, 483.021, 483.031, 483.035,

483.041, 483.051, 483.061, 483.091, 483.101, 483.111, 483.172, 483.181, 483.191, 483.201, 483.221, 483.23, 483.245, and 483.26, is repealed.

Section 73. Section 483.294, Florida Statutes, is amended to read:

483.294 Inspection of centers.—In accordance with s. 408.811, the agency shall~~, at least once annually,~~ inspect the premises and operations of all centers subject to licensure under this part.

Section 74. Subsection (3) of section 483.801, Florida Statutes, is amended to read:

483.801 Exemptions.—This part applies to all clinical laboratories and clinical laboratory personnel within this state, except:

(3) Persons engaged in testing performed by laboratories that are wholly owned and operated by one or more practitioners who are licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, or chapter 466 and who practice in the same group practice, and in which no clinical laboratory work is performed for patients referred by any health care provider who is not a member of the same group ~~regulated under s. 483.035(1) or exempt from regulation under s. 483.031(2)~~.

Section 75. Subsections (2), (3), and (4) of section 483.803, Florida Statutes, are amended to read:

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

~~(2) "Clinical laboratory" means a clinical laboratory as defined in s. 483.041.~~

~~(3) "Clinical laboratory examination" means a clinical laboratory examination as defined in s. 483.041.~~

(2)~~(4)~~ "Clinical laboratory personnel" includes a clinical laboratory director, supervisor, technologist, blood gas analyst, or technician who performs or is responsible for laboratory test procedures, but the term does not include trainees, persons who perform screening for blood banks or plasmapheresis centers, phlebotomists, or persons employed by a clinical laboratory to perform manual pretesting duties or clerical, personnel, or other administrative responsibilities~~,~~ ~~or persons engaged in testing performed by laboratories regulated under s. 483.035(1) or exempt from regulation under s. 483.031(2)~~.

Section 76. Section 483.813, Florida Statutes, is amended to read:

483.813 Clinical laboratory personnel license.—A person may not conduct a clinical laboratory examination or report the results of such examination unless such person is licensed under this part to perform such procedures. However, this provision does not apply to any practitioner of the healing arts authorized to practice in this state ~~or to persons engaged in testing performed by laboratories regulated under s. 483.035(1)~~

~~or exempt from regulation under s. 483.031(2)~~. The department may grant a temporary license to any candidate it deems properly qualified, for a period not to exceed 1 year.

Section 77. Paragraph (c) of subsection (7), paragraph (c) of subsection (8), and paragraph (c) of subsection (9) of section 491.003, Florida Statutes, are amended to read:

491.003 Definitions.—As used in this chapter:

(7) The "practice of clinical social work" is defined as the use of scientific and applied knowledge, theories, and methods for the purpose of describing, preventing, evaluating, and treating individual, couple, marital, family, or group behavior, based on the person-in-situation perspective of psychosocial development, normal and abnormal behavior, psychopathology, unconscious motivation, interpersonal relationships, environmental stress, differential assessment, differential planning, and data gathering. The purpose of such services is the prevention and treatment of undesired behavior and enhancement of mental health. The practice of clinical social work includes methods of a psychological nature used to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, and substance abuse. The practice of clinical social work includes, but is not limited to, psychotherapy, hypnotherapy, and sex therapy. The practice of clinical social

work also includes counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients, when using methods of a psychological nature to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, or substance abuse. The practice of clinical social work may also include clinical research into more effective psychotherapeutic modalities for the treatment and prevention of such conditions.

(c) The terms "diagnose" and "treat," as used in this chapter, when considered in isolation or in conjunction with any provision of the rules of the board, shall not be construed to permit the performance of any act which clinical social workers are not educated and trained to perform, including, but not limited to, admitting persons to hospitals for treatment of the foregoing conditions, treating persons in hospitals without medical supervision, prescribing medicinal drugs as defined in chapter 465, authorizing clinical laboratory procedures ~~pursuant to chapter 483~~, or radiological procedures, or use of electroconvulsive therapy. In addition, this definition shall not be construed to permit any person licensed, provisionally licensed, registered, or certified pursuant to this chapter to describe or label any test, report, or procedure as

"psychological," except to relate specifically to the definition of practice authorized in this subsection.

(8) The "practice of marriage and family therapy" is defined as the use of scientific and applied marriage and family theories, methods, and procedures for the purpose of describing, evaluating, and modifying marital, family, and individual behavior, within the context of marital and family systems, including the context of marital formation and dissolution, and is based on marriage and family systems theory, marriage and family development, human development, normal and abnormal behavior, psychopathology, human sexuality, psychotherapeutic and marriage and family therapy theories and techniques. The practice of marriage and family therapy includes methods of a psychological nature used to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders or dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, and substance abuse. The practice of marriage and family therapy includes, but is not limited to, marriage and family therapy, psychotherapy, including behavioral family therapy, hypnotherapy, and sex therapy. The practice of marriage and family therapy also includes counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients, when using methods of a psychological nature to evaluate, assess, diagnose,

treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, or substance abuse. The practice of marriage and family therapy may also include clinical research into more effective psychotherapeutic modalities for the treatment and prevention of such conditions.

(c) The terms "diagnose" and "treat," as used in this chapter, when considered in isolation or in conjunction with any provision of the rules of the board, shall not be construed to permit the performance of any act which marriage and family therapists are not educated and trained to perform, including, but not limited to, admitting persons to hospitals for treatment of the foregoing conditions, treating persons in hospitals without medical supervision, prescribing medicinal drugs as defined in chapter 465, authorizing clinical laboratory procedures ~~pursuant to chapter 483~~, or radiological procedures, or use of electroconvulsive therapy. In addition, this definition shall not be construed to permit any person licensed, provisionally licensed, registered, or certified pursuant to this chapter to describe or label any test, report, or procedure as "psychological," except to relate specifically to the definition of practice authorized in this subsection.

(9) The "practice of mental health counseling" is defined as the use of scientific and applied behavioral science

theories, methods, and techniques for the purpose of describing, preventing, and treating undesired behavior and enhancing mental health and human development and is based on the person-in-situation perspectives derived from research and theory in personality, family, group, and organizational dynamics and development, career planning, cultural diversity, human growth and development, human sexuality, normal and abnormal behavior, psychopathology, psychotherapy, and rehabilitation. The practice of mental health counseling includes methods of a psychological nature used to evaluate, assess, diagnose, and treat emotional and mental dysfunctions or disorders (whether cognitive, affective, or behavioral), behavioral disorders, interpersonal relationships, sexual dysfunction, alcoholism, and substance abuse. The practice of mental health counseling includes, but is not limited to, psychotherapy, hypnotherapy, and sex therapy. The practice of mental health counseling also includes counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients, when using methods of a psychological nature to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), behavioral disorders, sexual dysfunction, alcoholism, or substance abuse. The practice of mental health counseling may also include clinical research into more effective psychotherapeutic modalities for the

treatment and prevention of such conditions.

(c) The terms "diagnose" and "treat," as used in this chapter, when considered in isolation or in conjunction with any provision of the rules of the board, shall not be construed to permit the performance of any act which mental health counselors are not educated and trained to perform, including, but not limited to, admitting persons to hospitals for treatment of the foregoing conditions, treating persons in hospitals without medical supervision, prescribing medicinal drugs as defined in chapter 465, authorizing clinical laboratory procedures ~~pursuant to chapter 483~~, or radiological procedures, or use of electroconvulsive therapy. In addition, this definition shall not be construed to permit any person licensed, provisionally licensed, registered, or certified pursuant to this chapter to describe or label any test, report, or procedure as "psychological," except to relate specifically to the definition of practice authorized in this subsection.

Section 78. Paragraph (h) of subsection (4) of section 627.351, Florida Statutes, is amended to read:

627.351 Insurance risk apportionment plans.—

(4) MEDICAL MALPRACTICE RISK APPORTIONMENT.—

(h) As used in this subsection:

1. "Health care provider" means hospitals licensed under chapter 395; physicians licensed under chapter 458; osteopathic physicians licensed under chapter 459; podiatric physicians

licensed under chapter 461; dentists licensed under chapter 466; chiropractic physicians licensed under chapter 460; naturopaths licensed under chapter 462; nurses licensed under part I of chapter 464; midwives licensed under chapter 467; ~~clinical laboratories registered under chapter 483;~~ physician assistants licensed under chapter 458 or chapter 459; physical therapists and physical therapist assistants licensed under chapter 486; health maintenance organizations certificated under part I of chapter 641; ambulatory surgical centers licensed under chapter 395; other medical facilities as defined in subparagraph 2.; blood banks, plasma centers, industrial clinics, and renal dialysis facilities; or professional associations, partnerships, corporations, joint ventures, or other associations for professional activity by health care providers.

2. "Other medical facility" means a facility the primary purpose of which is to provide human medical diagnostic services or a facility providing nonsurgical human medical treatment, to which facility the patient is admitted and from which facility the patient is discharged within the same working day, and which facility is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy or an office maintained by a physician or dentist for the practice of medicine shall not be construed to be an "other medical facility."

3. "Health care facility" means any hospital licensed

under chapter 395, health maintenance organization certificated under part I of chapter 641, ambulatory surgical center licensed under chapter 395, or other medical facility as defined in subparagraph 2.

Section 79. Paragraph (h) of subsection (1) of section 627.602, Florida Statutes, is amended to read:

627.602 Scope, format of policy.—

(1) Each health insurance policy delivered or issued for delivery to any person in this state must comply with all applicable provisions of this code and all of the following requirements:

(h) Section 641.312 and the provisions of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, relating to internal grievances. This paragraph does not apply ~~to a health insurance policy that is subject to the Subscriber Assistance Program under s. 408.7056 or~~ to the types of benefits or coverages provided under s. 627.6513(1)-(14) issued in any market.

Section 80. Paragraphs (b) and (e) of subsection (1) of section 627.64194, Florida Statutes, are amended to read:

627.64194 Coverage requirements for services provided by nonparticipating providers; payment collection limitations.—

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

(b) "Facility" means a licensed facility as defined in s. 395.002(16) and an urgent care center as defined in s.

395.002(30).

(e) "Nonparticipating provider" means a provider who is not a preferred provider as defined in s. 627.6471 or a provider who is not an exclusive provider as defined in s. 627.6472. For purposes of covered emergency services under this section, a facility licensed under chapter 395 or an urgent care center defined in s. 395.002(29) ~~395.002(30)~~ is a nonparticipating provider if the facility has not contracted with an insurer to provide emergency services to its insureds at a specified rate.

Section 81. Section 627.6513, Florida Statutes, is amended to read:

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

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

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

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

(4) Workers' compensation or similar insurance.

(5) Automobile medical payment insurance.

(6) Credit-only insurance.

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

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

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

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

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

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

(13) Hospital indemnity or other fixed indemnity insurance, if offered as independent, noncoordinated benefits.

(14) Benefits provided through a Medicare supplemental health insurance policy, as defined under s. 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. chapter 55, and similar supplemental

coverage provided to coverage under a group health plan, which are offered as a separate insurance policy and as independent, noncoordinated benefits.

Section 82. Effective January 1, 2018, paragraph (j) of subsection (1) of section 641.185, Florida Statutes, is amended to read:

641.185 Health maintenance organization subscriber protections.—

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

~~(j) A health maintenance organization should receive timely and, if necessary, urgent review by an independent state external review organization for unresolved grievances and appeals pursuant to s. 408.7056.~~

Section 83. Effective January 1, 2018, section 641.312, Florida Statutes, is amended to read:

641.312 Scope.—The Office of Insurance Regulation may adopt rules to administer the provisions of the National Association of Insurance Commissioners' Uniform Health Carrier External Review Model Act, issued by the National Association of

Insurance Commissioners and dated April 2010. This section does not apply to ~~a health maintenance contract that is subject to the Subscriber Assistance Program under s. 408.7056 or to~~ the types of benefits or coverages provided under s. 627.6513(1)-(14) issued in any market.

Section 84. Effective January 1, 2018, subsection (4) of section 641.3154, Florida Statutes, is amended to read:

641.3154 Organization liability; provider billing prohibited.—

(4) A provider or any representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for payment of services for which the organization is liable, if the provider in good faith knows or should know that the organization is liable. This prohibition applies during the pendency of any claim for payment made by the provider to the organization for payment of the services and any legal proceedings or dispute resolution process to determine whether the organization is liable for the services if the provider is informed that such proceedings are taking place. It is presumed that a provider does not know and should not know that an organization is liable unless:

(a) The provider is informed by the organization that it

accepts liability;

(b) A court of competent jurisdiction determines that the organization is liable; or

~~(c) The office or agency makes a final determination that the organization is required to pay for such services subsequent to a recommendation made by the Subscriber Assistance Panel pursuant to s. 408.7056; or~~

(c)~~(d)~~ The agency issues a final order that the organization is required to pay for such services subsequent to a recommendation made by a resolution organization pursuant to s. 408.7057.

Section 85. Effective January 1, 2018, paragraph (c) of subsection (5) of section 641.51, Florida Statutes, is amended to read:

641.51 Quality assurance program; second medical opinion requirement.—

(5)

(c) For second opinions provided by contract physicians the organization is prohibited from charging a fee to the subscriber in an amount in excess of the subscriber fees established by contract for referral contract physicians. The organization shall pay the amount of all charges, which are usual, reasonable, and customary in the community, for second opinion services performed by a physician not under contract with the organization, but may require the subscriber to be

responsible for up to 40 percent of such amount. The organization may require that any tests deemed necessary by a noncontract physician shall be conducted by the organization. The organization may deny reimbursement rights granted under this section in the event the subscriber seeks in excess of three such referrals per year if such subsequent referral costs are deemed by the organization to be evidence that the subscriber has unreasonably overutilized the second opinion privilege. A subscriber thus denied reimbursement under this section shall have recourse to grievance procedures as specified in ss. ~~408.7056,~~ 641.495~~,~~ and 641.511. The organization's physician's professional judgment concerning the treatment of a subscriber derived after review of a second opinion shall be controlling as to the treatment obligations of the health maintenance organization. Treatment not authorized by the health maintenance organization shall be at the subscriber's expense.

Section 86. Effective January 1, 2018, section 641.511, Florida Statutes, is amended to read:

641.511 Subscriber grievance reporting and resolution requirements.—

(1) Every organization must have a grievance procedure available to its subscribers for the purpose of addressing complaints and grievances. ~~Every organization must notify its subscribers that a subscriber must submit a grievance within 1 year after the date of occurrence of the action that initiated~~

~~the grievance, and may submit the grievance for review to the Subscriber Assistance Program panel as provided in s. 408.7056 after receiving a final disposition of the grievance through the organization's grievance process. An organization shall maintain records of all grievances and shall report annually to the agency the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition of the grievances.~~

(2) When an organization receives an initial complaint from a subscriber, the organization must respond to the complaint within a reasonable time after its submission. At the time of receipt of the initial complaint, the organization shall inform the subscriber that the subscriber has a right to file a written grievance at any time and that assistance in preparing the written grievance shall be provided by the organization.

(3) Each organization's grievance procedure, as required under subsection (1), must include, at a minimum:

(a) An explanation of how to pursue redress of a grievance.

(b) The names of the appropriate employees or a list of grievance departments that are responsible for implementing the organization's grievance procedure. The list must include the address and the toll-free telephone number of each grievance department, the address of the agency and its toll-free telephone hotline number, and the address of the Subscriber

Assistance Program and its toll-free telephone number.

(c) The description of the process through which a subscriber may, at any time, contact the toll-free telephone hotline of the agency to inform it of the unresolved grievance.

(d) A procedure for establishing methods for classifying grievances as urgent and for establishing time limits for an expedited review within which such grievances must be resolved.

(e) A notice that a subscriber may voluntarily pursue binding arbitration in accordance with the terms of the contract if offered by the organization, after completing the organization's grievance procedure ~~and as an alternative to the Subscriber Assistance Program~~. Such notice shall include an explanation that the subscriber may incur some costs if the subscriber pursues binding arbitration, depending upon the terms of the subscriber's contract.

(f) A process whereby the grievance manager acknowledges the grievance and investigates the grievance in order to notify the subscriber of a final decision in writing.

(g) A procedure for providing individuals who are unable to submit a written grievance with access to the grievance process, which shall include assistance by the organization in preparing the grievance and communicating back to the subscriber.

(4)(a) With respect to a grievance concerning an adverse determination, an organization shall make available to the

subscriber a review of the grievance by an internal review panel; such review must be requested within 30 days after the organization's transmittal of the final determination notice of an adverse determination. A majority of the panel shall be persons who previously were not involved in the initial adverse determination. A person who previously was involved in the adverse determination may appear before the panel to present information or answer questions. The panel shall have the authority to bind the organization to the panel's decision.

(b) An organization shall ensure that a majority of the persons reviewing a grievance involving an adverse determination are providers who have appropriate expertise. An organization shall issue a copy of the written decision of the review panel to the subscriber and to the provider, if any, who submits a grievance on behalf of a subscriber. In cases where there has been a denial of coverage of service, the reviewing provider shall not be a provider previously involved with the adverse determination.

(c) An organization shall establish written procedures for a review of an adverse determination. Review procedures shall be available to the subscriber and to a provider acting on behalf of a subscriber.

~~(d) In any case when the review process does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber,~~

~~the subscriber or the provider acting on behalf of the subscriber may submit a written grievance to the Subscriber Assistance Program.~~

(5) Except as provided in subsection (6), the organization shall resolve a grievance within 60 days after receipt of the grievance, or within a maximum of 90 days if the grievance involves the collection of information outside the service area. These time limitations are tolled if the organization has notified the subscriber, in writing, that additional information is required for proper review of the grievance and that such time limitations are tolled until such information is provided. After the organization receives the requested information, the time allowed for completion of the grievance process resumes. The Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, is adopted and incorporated by reference as applicable to all organizations that administer small and large group health plans that are subject to 29 C.F.R. s. 2560.503-1. The claims procedures of the regulations of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, shall be the minimum standards for grievance processes for claims for benefits for small and large group health plans that are subject to 29 C.F.R. s. 2560.503-1.

(6)(a) An organization shall establish written procedures for the expedited review of an urgent grievance. A request for

an expedited review may be submitted orally or in writing and shall be subject to the review procedures of this section, if it meets the criteria of this section. Unless it is submitted in writing, for purposes of the grievance reporting requirements in subsection (1), the request shall be considered an appeal of a utilization review decision and not a grievance. Expedited review procedures shall be available to a subscriber and to the provider acting on behalf of a subscriber. For purposes of this subsection, "subscriber" includes the legal representative of a subscriber.

(b) Expedited reviews shall be evaluated by an appropriate clinical peer or peers. The clinical peer or peers shall not have been involved in the initial adverse determination.

(c) In an expedited review, all necessary information, including the organization's decision, shall be transmitted between the organization and the subscriber, or the provider acting on behalf of the subscriber, by telephone, facsimile, or the most expeditious method available.

(d) In an expedited review, an organization shall make a decision and notify the subscriber, or the provider acting on behalf of the subscriber, as expeditiously as the subscriber's medical condition requires, but in no event more than 72 hours after receipt of the request for review. If the expedited review is a concurrent review determination, the service shall be continued without liability to the subscriber until the

subscriber has been notified of the determination.

(e) An organization shall provide written confirmation of its decision concerning an expedited review within 2 working days after providing notification of that decision, if the initial notification was not in writing.

(f) An organization shall provide reasonable access, not to exceed 24 hours after receiving a request for an expedited review, to a clinical peer who can perform the expedited review.

~~(g) In any case when the expedited review process does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the subscriber or the provider acting on behalf of the subscriber may submit a written grievance to the Subscriber Assistance Program.~~

(g) ~~(h)~~ An organization shall not provide an expedited retrospective review of an adverse determination.

~~(7) Each organization shall send to the agency a copy of its quarterly grievance reports submitted to the office pursuant to s. 408.7056(12).~~

(7) ~~(8)~~ The agency shall investigate all reports of unresolved quality of care grievances received from~~:~~

~~(a)~~ Annual and quarterly grievance reports submitted by the organization to the office.

~~(b) Review requests of subscribers whose grievances remain unresolved after the subscriber has followed the full grievance~~

~~procedure of the organization.~~

~~(9)(a) The agency shall advise subscribers with grievances to follow their organization's formal grievance process for resolution prior to review by the Subscriber Assistance Program. The subscriber may, however, submit a copy of the grievance to the agency at any time during the process.~~

~~(b) Requiring completion of the organization's grievance process before the Subscriber Assistance Program panel's review does not preclude the agency from investigating any complaint or grievance before the organization makes its final determination.~~

~~(10) Each organization must notify the subscriber in a final decision letter that the subscriber may request review of the organization's decision concerning the grievance by the Subscriber Assistance Program, as provided in s. 408.7056, if the grievance is not resolved to the satisfaction of the subscriber. The final decision letter must inform the subscriber that the request for review must be made within 365 days after receipt of the final decision letter, must explain how to initiate such a review, and must include the addresses and toll-free telephone numbers of the agency and the Subscriber Assistance Program.~~

(8) ~~(11)~~ Each organization, as part of its contract with any provider, must require the provider to post a consumer assistance notice prominently displayed in the reception area of the provider and clearly noticeable by all patients. The

consumer assistance notice must state the addresses and toll-free telephone numbers of the Agency for Health Care Administration~~, the Subscriber Assistance Program,~~ and the Department of Financial Services. The consumer assistance notice must also clearly state that the address and toll-free telephone number of the organization's grievance department shall be provided upon request. The agency may adopt rules to implement this section.

(9)~~(12)~~ The agency may impose administrative sanction, in accordance with s. 641.52, against an organization for noncompliance with this section.

Section 87. Effective January 1, 2018, subsection (1) of section 641.515, Florida Statutes, is amended to read:

641.515 Investigation by the agency.—

(1) The agency shall investigate further any quality of care issue contained in recommendations and reports submitted pursuant to s. ~~ss. 408.7056 and~~ 641.511. The agency shall also investigate further any information that indicates that the organization does not meet accreditation standards or the standards of the review organization performing the external quality assurance assessment pursuant to reports submitted under s. 641.512. Every organization shall submit its books and records and take other appropriate action as may be necessary to facilitate an examination. The agency shall have access to the organization's medical records of individuals and records of

employed and contracted physicians, with the consent of the subscriber or by court order, as necessary to carry out the provisions of this part.

Section 88. Effective January 1, 2018, subsection (2) of section 641.55, Florida Statutes, is amended to read:

641.55 Internal risk management program.—

(2) The risk management program shall be the responsibility of the governing authority or board of the organization. Every organization which has an annual premium volume of $10 million or more and which directly provides health care in a building owned or leased by the organization shall hire a risk manager~~, certified under ss. 395.10971-395.10975,~~ who shall be responsible for implementation of the organization's risk management program required by this section. A part-time risk manager shall not be responsible for risk management programs in more than four organizations or facilities. Every organization which does not directly provide health care in a building owned or leased by the organization and every organization with an annual premium volume of less than $10 million shall designate an officer or employee of the organization to serve as the risk manager.

The gross data compiled under this section or s. 395.0197 shall be furnished by the agency upon request to organizations to be utilized for risk management purposes. The agency shall adopt

rules necessary to carry out the provisions of this section.

Section 89. Section 641.60, Florida Statutes, is repealed.

Section 90. Section 641.70, Florida Statutes, is amended to read:

641.70 Agency duties relating to ~~the Statewide Managed Care Ombudsman Committee and~~ the district managed care ombudsman committees.—

(1) The agency shall adopt rules that specify:

(a) Procedures by which ~~the statewide committee and~~ district committees receive reports of enrollee complaints from the agency.

(b) Procedures by which enrollee information shall be made available ~~to members of the statewide committee and~~ to the district committees.

(c) Procedures by which recommendations made by the committees shall be considered for incorporation into policies and procedures of the agency.

~~(d) Procedures by which statewide committee members shall be reimbursed for authorized expenditures.~~

(d)~~(e)~~ Any other procedures that are necessary to administer this section and s. ~~ss. 641.60 and~~ 641.65.

(2) The Agency for Health Care Administration shall provide a meeting place for district committees in agency offices and shall provide the necessary administrative support to assist ~~the statewide committee and~~ district committees,

within available resources.

(3) The secretary of the agency shall ensure the full cooperation and assistance of agency employees with ~~members of~~ the ~~statewide committee and~~ district committees.

Section 91. Subsection (3) of section 641.75, Florida Statutes, is amended to read:

641.75 Immunity from liability; limitation on testimony.—

(3) Members of any state or district ombudsman committee shall not be required to testify in any court with respect to matters held to be confidential except as may be necessary to enforce ss. 641.61-641.75 ~~641.60-641.75~~.

Section 92. Paragraph (b) of subsection (6) of section 766.118, Florida Statutes, is amended to read:

766.118 Determination of noneconomic damages.—

(6) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF A PRACTITIONER PROVIDING SERVICES AND CARE TO A MEDICAID RECIPIENT.—Notwithstanding subsections (2), (3), and (5), with respect to a cause of action for personal injury or wrongful death arising from medical negligence of a practitioner committed in the course of providing medical services and medical care to a Medicaid recipient, regardless of the number of such practitioner defendants providing the services and care, noneconomic damages may not exceed $300,000 per claimant, unless the claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner. A

practitioner providing medical services and medical care to a Medicaid recipient is not liable for more than $200,000 in noneconomic damages, regardless of the number of claimants, unless the claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner. The fact that a claimant proves that a practitioner acted in a wrongful manner does not preclude the application of the limitation on noneconomic damages prescribed elsewhere in this section. For purposes of this subsection:

(b) The term "practitioner," in addition to the meaning prescribed in subsection (1), includes any hospital or~~,~~ ambulatory surgical center~~, or mobile surgical facility~~ as defined and licensed under chapter 395.

Section 93. Subsection (4) of section 766.202, Florida Statutes, is amended to read:

766.202 Definitions; ss. 766.201-766.212.—As used in ss. 766.201-766.212, the term:

(4) "Health care provider" means any hospital or~~,~~ ambulatory surgical center~~, or mobile surgical facility~~ as defined and licensed under chapter 395; a birth center licensed under chapter 383; any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, part I of chapter 464, chapter 466, chapter 467, part XIV of chapter 468, or chapter 486; ~~a clinical lab licensed under chapter 483;~~ a health maintenance organization certificated

under part I of chapter 641; a blood bank; a plasma center; an industrial clinic; a renal dialysis facility; or a professional association partnership, corporation, joint venture, or other association for professional activity by health care providers.

Section 94. Subsection (1) of section 945.36, Florida Statutes, is amended to read:

945.36 ~~Exemption from health testing regulations for~~ Law enforcement personnel authorized to conduct ~~conducting~~ drug tests on inmates and releasees.—

(1) Any law enforcement officer, state or county probation officer, or employee of the Department of Corrections~~,~~ who is certified by the Department of Corrections pursuant to subsection (2) may administer~~, is exempt from part I of chapter 483, for the limited purpose of administering~~ a urine screen drug test to:

(a) Persons during incarceration;

(b) Persons released as a condition of probation for either a felony or misdemeanor;

(c) Persons released as a condition of community control;

(d) Persons released as a condition of conditional release;

(e) Persons released as a condition of parole;

(f) Persons released as a condition of provisional release;

(g) Persons released as a condition of pretrial release;

or

(h) Persons released as a condition of control release.

Section 95. Paragraph (b) of subsection (2) of section 1009.65, Florida Statutes, is amended to read:

1009.65 Medical Education Reimbursement and Loan Repayment Program.—

(2) From the funds available, the Department of Health shall make payments to selected medical professionals as follows:

(b) All payments shall be contingent on continued proof of primary care practice in an area defined in s. 395.602(2)(b) ~~395.602(2)(c)~~, or an underserved area designated by the Department of Health, provided the practitioner accepts Medicaid reimbursement if eligible for such reimbursement. Correctional facilities, state hospitals, and other state institutions that employ medical personnel shall be designated by the Department of Health as underserved locations. Locations with high incidences of infant mortality, high morbidity, or low Medicaid participation by health care professionals may be designated as underserved.

Section 96. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2017.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7075 PCB CFS 17-02 Child Welfare
SPONSOR(S): Children, Families & Seniors Subcommittee, Harrell
TIED BILLS: **IDEN./SIM. BILLS:** SB 1680

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Children, Families & Seniors Subcommittee	10 Y, 0 N	Tuszynski	Brazzell
1) Health Care Appropriations Subcommittee		Fontaine	Pridgeon
2) Health & Human Services Committee			

SUMMARY ANALYSIS

Chapter 39, F.S., creates the child welfare dependency system, administered by the Department of Children and Families' (DCF) Office of Child Welfare in partnership with local communities and the courts. DCF contracts for foster care placement and related services with lead agencies, also known as community-based care organizations (CBC).

DCF is required to administer a system of care that prevents the separation of children from their families and provides interventions to allow children to remain safely in their own homes. However, when it is determined that in-home services are not enough to allow a child to safely remain in his or her home, the child is removed from his or her home and placed with a safe and appropriate temporary out-of-home placement. DCF uses a child welfare practice model that standardized the approach to safety decision making and risk assessment to determine a child's safety.

HB 7075 requires DCF to develop, in collaboration with CBCs, service providers, and other community stakeholders, a statewide quality rating system for providers of residential group care and foster homes. The system must promote high quality in services and accommodations by creating measurable minimum quality standards that providers must meet to contract with CBCs. DCF must submit a report to the Governor, President of the Senate, and Speaker of the House on October 1, 2017, and by October 1 of each year thereafter. The initial report must include an update on implementation and a plan for oversight of the implementation of the system and beginning in October of 2019 the report must include a list of providers meeting minimum quality standards, the percentage of children placed with highly rated providers, and any negative actions taken against providers for not meeting minimum quality standards.

The bill requires DCF to not only ensure the quality of contracted services and programs offered to families in the dependency system, but also ensure an adequate array of services available to be delivered through the CBCs.

The bill allows the dependency court to order "maintain and strengthen" in the child's home as a permanency goal for children in the dependency system by adding this goal to the options a dependency court is able to order for children in the dependency system. The bill also revises the definition of "permanency goal" by removing language duplicated in substantive law.

The bill extends the jurisdiction of the dependency court over young adults with a disability until the age of 22. The bill also requires that a child's transition plan must be approved by the court before a child's 18th birthday regardless of whether the child is leaving care at 18 and requires that the transition plan must be attached to the case plan and updated before each judicial review.

The bill has an indeterminate fiscal impact, but costs may be absorbed within existing resources and mitigated by funding provided in the House proposed General Appropriations Act for FY 2017-18. See fiscal comments.

The bill provides an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Florida's Child Welfare System

Chapter 39, F.S., creates the dependency system that aims to protect children and prevent abuse, abandonment, and neglect.[1] The Department of Children and Families (DCF) Office of Child Welfare works in partnership with local communities and the courts to ensure the safety, timely permanency and well-being of children.

DCF's practice model is based on preserving and strengthening the child's family ties whenever possible, removing the child from his or her home only when his or her welfare and safety cannot be adequately safeguarded otherwise.[2] DCF contracts with community-based care lead agencies (CBC) to coordinate case management and services for families within the dependency system.

The Department of Children and Families' Practice Model

DCF's child welfare practice model (model) standardizes the approach to safety decision making and risk assessment used to determine a child's safety.[3] The model seeks to achieve the goals of safety, permanency, and child and family well-being.[4] The model emphasizes parent engagement and empowerment as well as the training and support of child welfare professionals to assess child safety.[5] Several key practices are used to achieve these goals.[6]

- Engaging the family to build rapport and trust.
- Partner with all involved stakeholders to increase support for the family.
- Plan for child safety by including the family and other partners to develop and implement short-term actions to keep the child safe in the home or, if necessary, in out-of-home care.
- Plan for changes by working with the child, family members, and other team members to identify appropriate interventions and supports necessary to achieve child safety, permanency and well-being.
- Monitor and adapt case plans to help families navigate the dependency system and link them to services aimed at helping maintain child and family well-being.

The model emphasizes a family-centered practice with the goal of keeping children in their homes whenever possible.[7]

Community-Based Care Organizations and Services

DCF contracts for case management, out-of-home care, and related services with lead agencies, also known as community-based care organizations (CBCs). The model of using CBCs to provide child welfare services is designed to increase local community ownership of service delivery and design.[8]

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[1] S. 39.001(8), F.S.
[2] S. 39.001(4), F.S.
[3] The Department of Children and Families, *2013 Year in Review*, available at: http://www.dcf.state.fl.us/admin/publications/year-in-review/2013/page19.shtml (last accessed March 6, 2017).
[4] The Department of Children and Families, *Florida's Child Welfare Practice Model*, available at: http://www.myflfamilies.com/service-programs/child-welfare/child-welfare-practice-model (last accessed March 7, 2017).
[5] Supra, at FN 3.
[6] Supra, at FN 4.
[7] The Department of Children and Families, *2012 Year in Review*, available at: http://www.dcf.state.fl.us/admin/publications/year-in-review/2012/page9.shtml (last accessed March 7, 2017).

DCF, through the CBCs, is required to administer a system of care[9] for children that is directed toward:

- Prevention of separation of children from their families;
- Intervention to allow children to remain safely in their own homes;
- Reunification of families who have had children removed from their care;
- Safety for children who are separated from their families;
- Focus on the well-being of children through emphasis on educational stability and timely health care;
- Permanency; and
- Transition to independence and self-sufficiency.

CBCs are responsible for providing foster care and related services. These services include, but are not limited to, counseling, domestic violence services, substance abuse services, family preservation, emergency shelter, and adoption.[10] The CBC must give priority to services that are evidence-based and trauma informed.[11] CBCs contract with a number of subcontractors for case management and direct care services to children and their families.[12] There are 17 CBCs statewide, which together serve the state's 20 judicial circuits.[13]

Dependency Case Process

When a child is removed from his or her home, a series of dependency court proceedings must occur to adjudicate the child dependent and place him or her in out-of-home care, as indicated by the chart below.

Proceeding	Description	Statute
Removal	The child's home is determined to be unsafe, and the child is removed	s. 39.401, F.S.
Shelter Hearing	A shelter hearing occurs within 24 hours after removal. The judge determines whether to keep the child out-of-home.	s. 39.401, F.S.
Petition for Dependency	A petition for dependency occurs within 21 days of the shelter hearing. This petition seeks to find the child dependent.	s. 39.501, F.S.
Arraignment Hearing and Shelter Review	An arraignment and shelter review occurs within 28 days of the shelter hearing. This allows the parent to admit, deny, or consent to the allegations within the petition for dependency and allows the court to review any shelter placement.	s. 39.506, F.S.
Adjudicatory Trial	An adjudicatory trial is held within 30 days of arraignment, to determine whether a child is dependent.	s. 39.507, F.S.
Disposition Hearing	Disposition occurs within 15 days of arraignment or 30 days of adjudication. The judge reviews and orders the case plan for the family and the appropriate placement of the child.	ss. 39. 506 and 39.521, F.S.
Judicial Review Hearings	The court must review the case plan and placement every 6 months, or upon motion of a party.	s. 39.701, F.S.

[8] Community-Based Care, The Department of Children and Families, accessible at http://www.myflfamilies.com/service-programs/community-based-care (last viewed February 12, 2016).
[9] S. 409.145(1), F.S.
[10] Id.
[11] S. 409.988(3), F.S.
[12] Supra. at FN 8.
[13] Community Based Care Lead Agency Map, The Department of Children and Families, available at: http://www.myflfamilies.com/service-programs/community-based-care/cbc-map (last accessed March 6, 2017).

Placements of Children in the Child Welfare System

In-Home with Services

DCF is required to administer a system of care that prevents the separation of children from their families and provides interventions to allow children to remain safely in their own homes.[14] Protective investigators and CBC case managers can refer families for in-home services to allow a child, who would otherwise be unsafe, to remain in his or her own home.

As of December 31, 2016, there were 12,477 children receiving in-home services.[15]

Out of Home Placements

When a child protective investigator determines that in-home services are not enough to allow a child to safely remain in his or her home, the investigator removes the child from his or her home and places the child with a safe and appropriate temporary placement. These temporary placements, referred to as out-of-home care, provide housing and services to children until they can return home to their family or achieve permanency with another family through adoption or guardianship.[16] CBCs must place all children in out-of-home care in the most appropriate available setting after conducting an assessment using child-specific factors.[17]

Relatives and Non-Relative Caregivers

Research indicates that children in the care of relatives and non-relatives, such as grandparents or family friends, benefit from increased placement stability and are less likely to change placements as compared to children placed in general foster care.[18] When possible, child protective investigators and lead agency case managers place the children with a relative or responsible adult that the child knows and with whom they have a relationship.[19] Relative and non-relative caregivers are not required to be licensed, but do undergo a home-study to determine if the home is appropriate to place the child.[20]

As of December 31, 2016, there were 13,056 children placed with relative and non-relative caregivers.

Licensed Out-of-Home Care

When a relative or non-relative caregiver placement is not possible, protective investigators and case managers try to place the children in family foster homes licensed by DCF.[21] A family foster home is a licensed 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.[22] Foster homes are inspected and licensed,[23] and foster parents go through a rigorous interview process before being approved.[24]

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[14] Supra, at FN 9.
[15] Department of Children and Families, DCF Quick Facts, Child Welfare, available at: http://www.dcf.state.fl.us/general-information/quick-facts/cw/ (last accessed March 8, 2017).
[16] Office of Program Policy and Government Accountability, Research Memorandum, Florida's Residential Group Care Program for Children in the Child Welfare System (December 22, 2014) (on file with the Children, Families, and Seniors Subcommittee).
[17] Child-specific factors include age, sex, sibling status, physical, educational, emotional, and developmental needs, maltreatment, community ties, and school placement. (Rule 65C-28.004, F.A.C.)
[18] David Rubin and Downes, K., et al., The Impact of Kinship Care on Behavioral Well-being for Children in Out-of-Home Care (June 2, 2008), available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2654276/ (last accessed March 8, 2017).
[19] Office of Program Policy and Government Accountability, Research Memorandum, Florida's Residential Group Care Program for Children in the Child Welfare System (December 22, 2014) (on file with the Children, Families, and Seniors Subcommittee).
[20] S. 39.521(2)(r), F.S.
[21] Id.
[22] S. 409.175, F.S.
[23] Id.
[24] Florida Department of Children and Families, *Fostering Definitions*, available at: http://www.myflfamilies.com/service-programs/foster-care/definitions (last accessed March 7, 2017).

Some children have extraordinary needs, such as multiple placement disruptions, mental or behavioral health problems, juvenile justice involvement, or disabilities, which may lead case managers to place them in residential group care (RGC). The primary purpose of RGC is to provide a setting that addresses the unique needs of children and youth who require more intensive services than a family setting can provide.[25] RGC placements are licensed by DCF as residential child-caring agencies[26] that provide staffed 24-hour care for children in facilities maintained for that purpose, regardless of whether operated for profit or whether a fee is charged.[27] These include maternity homes, runaway shelters, group homes, and emergency shelters.[28] The two primary models of group care are the shift model, with staff working in shifts providing 24-hour supervision, and the family model, which has a house parent or parents that live with and are responsible for 24-hour care of children in the group home.[29]

By law, CBCs must assess any child that meets the following criteria for placement in RGC:

- The child is 11 or older;
- The child has been in licensed family foster care for six months or longer and removed from family foster care more than once; and
- The child has serious behavioral problems or has been determined to be without the options of either family reunification or adoption. [30]

In addition, the CBC must consider psychological evaluations, information provided by professionals with knowledge of the child, and the desires of the child concerning placement.[31] Children who do not meet the specified criteria may still be placed in RGC if it is determined that such placement is the most appropriate for the child.[32]

RGC placement can also serve as a treatment component of the children's mental and behavioral health care. [33] Children in RGC with behavioral health needs receive mental health, substance abuse, and support services that are provided through Medicaid-funded Behavioral Health Overlay Services.[34] Residential group homes also directly employ or contract with therapists and counselors to provide services within the group home setting.[35]

As of December 31, 2016, there were 12,478 children in licensed out-of-home care, including in foster homes and RGC.[36]

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[25] Supra, at FN 19.
[26] Supra, at FN 19.
[27] S. 409.175, F.S.
[28] Id.
[29] Supra, at FN 19.
[30] S. 39.523(1), F.S.
[31] Id.
[32] S. 39.523(4), F.S.
[33] Richard Barth, *Institutions vs. Foster Homes: The Empirical Base for the Second Century of Debate*. Chapel Hill, NC: University of North Carolina, School of Social Work, Jordan Institute for Families (June 17, 2002), available at: http://www.researchgate.net/publication/237273744_vs._Foster_Homes_The_Empirical_Base_for_a_Century_of_Action.
[34] Office of Program Policy and Government Accountability, Research Memorandum, Florida's Child Welfare System: Out-of Home Care (November. 12, 2015) (on file with the Children, Families, and Seniors Subcommittee).
[35] Id.
[36] Supra, at FN 15.

Licensure

DCF licenses most out-of-home placements, including family foster homes, residential child-caring agencies (residential group care), and child-placing agencies.[37] The following placements do not require licensure:[38]

- Relative caregivers;
- Non-relative caregivers;
- An adoptive home which has been approved by the department or by a licensed child-placing agency for children placed for adoption; and
- Persons or neighbors who care for children in their homes for less than 90 days.

Licensure involves meeting rules and regulations pertaining to: [39]

- The good moral character of personnel and foster parents based on background screening, education, training, and experience requirements;
- Operation, conduct, and maintenance;
- The provision of food, clothing, educational opportunities, services, equipment, and individual supplies to assure the healthy physical, emotional, and mental development of the children served;
- The appropriateness, safety, cleanliness, and general adequacy of the premises, including fire prevention and health standards, to provide for the physical comfort, care, and well-being of the children served;
- The ratio of staff to children required to provide adequate care and supervision of the children served; and
- In the case of foster homes, the maximum number of children in the home.

These licensure standards are the minimum requirements that must be met to care for children within the child welfare system. DCF must issue a license for those homes and agencies that meet the minimum licensure standards.[40] However, the issuance of a license does not require a CBC to place a child with any home or agency.[41]

Extended Foster Care

In 2014, the Legislature provided foster youth the option to extend foster care.[42] Previously, youth did not have the option to remain in foster care after their 18th birthday. Now, through extended foster care, they have the option to remain in care until they turn 21 or 22 if the young adult has a disability. [43] Young adults are also eligible to receive financial assistance as they continue pursuing academic and career goals if enrolled in an eligible post-secondary institution.[44] In extended foster care, young adults continue to receive case management services and other supports to provide them with a sound platform for success as independent adults.

[37] S. 409.175, F.S.
[38] Id.
[39] S. 409.175, F.S.
[40] S. 409.175(6)(h), F.S.
[41] S. 409.175(6)(i), F.S.
[42] S. 39.6251, F.S.
[43] The Department of Children and Families, *Extended Foster Care – My Future My Choice*, available at: http://www.myflfamilies.com/service-programs/independent-living/extended-foster-care (last accessed March 7, 2017).
[44] Id.

Transition Plans

During the 6 month period immediately after a dependent child reaches 17 years of age, DCF and the CBCs, in collaboration with the child, his or her caregiver, and any other person the child would like to include must develop a transition plan.[45] These transition plans must address services, housing, health insurance, education, workforce support and employment services, and the maintenance of mentoring relationships and other personal supports.[46] The plan is designed to help transition a child in the dependency system to adulthood. A child's transition plan must be approved by the court "if a child is planning to leave care upon reaching 18 years of age . . . before the child leaves care."[47]

Residential Group Care Quality Standards

Florida Institute for Child Welfare

The Florida Institute for Child Welfare (FICW) published a technical report titled "Improving the Quality of Residential Group Care: A Review of Current Trends, Empirical Evidence, and Recommendations" in July of 2015. This report looked at the current trends and evidence related to residential group care, finding that:

> "Although the appropriate use of RGC has been a subject of longstanding debate, most child welfare experts, including practitioners, researchers, and advocacy groups, acknowledge that for some youth involved in the child welfare system, high quality group care is an essential and even lifesaving intervention."[48]

Based on reviews of current trends and issues, findings from research, and reviews of recommendations proposed by child welfare experts and advocacy groups, the FICW made the following seven recommendations.[49]

1. Develop and implement a basic set of common quality standards for RGC.
2. Increase evaluation efforts to identify and support evidence-based RGC services.
3. Support RGC providers in strengthening efforts to engage families.
4. Explore innovative approaches, including those that are trauma-informed and relationship-based.
5. Increase efforts to identify and implement culturally competent practices that are supported by research.
6. Continue to build upon efforts to strengthen the child welfare workforce.
7. Explore flexible funding strategies that can help facilitate higher quality services and innovative uses of RGC that are consistent with systems of care principles.

The recommendations made by the FICW focus mainly on quality and implementing strategies to facilitate high quality services within RGC.

Group Care Quality Standards Workgroup

Also in 2015, DCF and the Florida Coalition for Children established the Group Care Quality Standards Workgroup (workgroup), with representation from group care providers, CBCs, and DCF. The workgroup reviewed standards-related literature to determine consensus and ensure a high quality of

[45] S. 39.6035(1), F.S.
[46] Id.
[47] S. 39.6035(4), F.S.
[48] Boel-Studt, S. M. (2015). *Improving the Quality of Residential Group Care: A Review of Current Trends, Empirical Evidence, and Recommendations* (Florida Institute for Child Welfare).
[49] Id.

group care standards.[50] The workgroup identified eight specific categories for quality standards with 251 distinct quality standards for residential group care.[51]

The workgroup and FICW started the Quality Standards for Group Care Initiative, which consists of 6 project phases:[52]

1. Development of core quality standards
2. Development of a quality assessment tool
3. Pilot test of the quality assessment tool
4. Field test of the quality assessment tool
5. Implementation of the quality assessment tool
6. Validation of the quality assessment tool.

In September 2015, DCF reviewed and approved the core quality standards, completing Phase 1.[53] The FICW developed a quality assessment tool shortly thereafter, completing phase 2.[54]

On October 31, 2016, a rating scale pilot (phase 3) was implemented in DCF's Central service region with 11 group homes.[55] Once the field test is completed in July 2017, the data will be analyzed and the quality assessment tool will be finalized. Statewide implementation (phase 5) is scheduled for September of 2017 with validation (phase 6) scheduled 1 and 2 years after that.[56]

Effect of Proposed Language

HB 7075 extends the jurisdiction of the dependency court over young adults with a disability until the age of 22. The bill language updates the section of law detailing who the court has jurisdiction over to align with the extended foster care statute.[57] The bill requires that a regardless of whether a child is choosing to leave care at age 18, the child's transition plan must be approved by the court before a child's 18th birthday. The bill also requires that the transition plan must be attached to the case plan and updated before each judicial review. This change in transition plan procedure will ensure that a young adult's transition plan detailing his or her transition out of the dependency system will be completed before his or her 18th birthday, regardless of the decision to leave care or stay in extended foster care. This will provide the court and other parties more time for input and planning.

The bill allows the dependency court to order "maintain and strengthen" a placement in the child's home as a permanency goal for children in the dependency system. This terminology is regularly used as a case plan goal but is not included in statute among the permanency goals the dependency court may order. This change aligns statute with current practice and DCF's practice model. The bill also revises the definition of "permanency goal" to remove provisions already duplicated in substantive law detailing what permanency goals the dependency court may order.

The bill requires DCF to ensure quality of contracted services and programs as well as ensure an adequate array of services available to be delivered through the CBCs. Statute currently vests responsibility in DCF for the quality of contracted services and their delivery in accordance with federal

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[50] Group Care Quality Standards Workgroup, *Quality Standards for Group Care*, Florida Department of Children and Families and the Florida Coalition of Children (2015) (on file with Children, Families, and Seniors subcommittee staff).
[51] Id.
[52] Boel-Studt, S., et al., (2016). *Group Care Quality Standards Assessment: Pilot Test Orientation* [PowerPoint slides], (on file with Children, Families, & Seniors Subcommittee staff).
[53] Florida Institute of Child Welfare, Quality Standards for Residential Group Care, A Pilot Test and Initial Validation of a Quality Rating Scale for Florida's Residential Group Homes, available at: http://ficw.fsu.edu/technical-assistance-training/quality-standards-residential-group-care (last accessed March 11, 2017).
[54] Id.
[55] Id.
[56] Supra, FN 52.
[57] S. 39.6251(5)(a), F.S.

and state law. The new language expands that responsibility to not only ensure the quality of services but to also require an adequate array of services to be made available for children and families within the dependency system.

The bill requires DCF to develop, in collaboration with CBCs, service providers, and other community stakeholders, a statewide quality rating system for providers of residential group care and foster homes. The system must promote high quality in services and accommodations by creating measurable minimum quality standards that providers must meet to contract with CBCs. DCF must submit a report to the Governor, President of the Senate, and Speaker of the House on October 1, 2017, and by October 1 of each year thereafter. The initial report must include an update on implementation and a plan for oversight of the implementation of the system and beginning in October of 2019 the report must include a list of providers meeting minimum quality standards, the percentage of children placed with highly rated providers, and any negative actions taken against providers for not meeting minimum quality standards.

The bill provides for an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 39.01, F.S., relating to definitions.
Section 2: Amends s. 39.013, F.S., relating to procedures and jurisdiction; right to counsel.
Section 3: Amends s. 39.6035, F.S., relating to transition plan.
Section 4: Amends s. 39.621, F.S., relating to permanency determination by the court.
Section 5: Amends s. 409.996, F.S., relating to duties of the Department of Children and Families.
Section 6: Provides for an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill has an indeterminate fiscal impact on state government. See fiscal comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill has an indeterminate fiscal impact on the private sector. See fiscal comments.

D. FISCAL COMMENTS:

The bill appears to have an indeterminate fiscal impact upon DCF and CBCs. The House proposed General Appropriations Act (GAA) for FY 2017-18 includes additional funding specifically to CBCs that may mitigate the impact of the bill's requirements.

The bill requires DCF, the CBCs, and other stakeholders to develop a statewide quality rating system for providers of residential group care and foster homes. The House proposed GAA includes $15.7 million for CBC core service functions, which could be applied towards this effort. The workload to the department may be absorbed within existing resources since DCF is currently piloting a residential group care rating system with the Florida Institute for Child Welfare Services.

The bill extends the court's jurisdiction over those dependent children with a disability to age 22 and requires court review of all children's transition plans prior to his or her 18th birthday. Currently, a transition plan must be completed during the 180 day period after the child reaches age 17. Since a judicial review of the child's case is required every six months, and court jurisdiction is currently to age 21, these requirements should have a minimal fiscal impact on the court system.

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:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to child welfare; amending s. 39.01, F.S.; redefining the term "permanency goal"; amending s. 39.013, F.S.; extending court jurisdiction to age 22 for young adults with disabilities in foster care; amending s. 39.6035, F.S.; requiring a transition plan to be approved before a child reaches 18 years of age; amending s. 39.621, F.S.; specifying the circumstances under which the permanency goal of maintaining and strengthening the placement with a parent may be used; amending s. 409.996, F.S.; requiring the Department of Children and Families, in collaboration with certain entities, to develop a statewide quality rating system for residential group care providers and foster homes; requiring the system to be implemented by a specified date; providing requirements for the system; requiring the department to submit a report to the Governor and the Legislature by a specified date and annually thereafter; providing requirements for the report; providing an effective date.

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

Section 1. Subsection (52) of section 39.01, Florida Statutes, is amended to read:

39.01 Definitions.—When used in this chapter, unless the context otherwise requires:

(52) "Permanency goal" means the living arrangement identified for the child to return to or identified as the permanent living arrangement of the child. ~~Permanency goals applicable under this chapter, listed in order of preference, are:~~

~~(a) Reunification;~~

~~(b) Adoption when a petition for termination of parental rights has been or will be filed;~~

~~(c) Permanent guardianship of a dependent child under s. 39.6221;~~

~~(d) Permanent placement with a fit and willing relative under s. 39.6231; or~~

~~(e) Placement in another planned permanent living arrangement under s. 39.6241.~~

The permanency goal is also the case plan goal. If concurrent case planning is being used, reunification may be pursued at the same time that another permanency goal is pursued.

Section 2. Subsection (2) of section 39.013, Florida Statutes, is amended to read:

39.013 Procedures and jurisdiction; right to counsel.—

(2) The circuit court has exclusive original jurisdiction of all proceedings under this chapter, of a child voluntarily

placed with a licensed child-caring agency, a licensed child-placing agency, or the department, and of the adoption of children whose parental rights have been terminated under this chapter. Jurisdiction attaches when the initial shelter petition, dependency petition, or termination of parental rights petition, or a petition for an injunction to prevent child abuse issued pursuant to s. 39.504, is filed or when a child is taken into the custody of the department. The circuit court may assume jurisdiction over any such proceeding regardless of whether the child was in the physical custody of both parents, was in the sole legal or physical custody of only one parent, caregiver, or some other person, or was not in the physical or legal custody of any person when the event or condition occurred that brought the child to the attention of the court. When the court obtains jurisdiction of any child who has been found to be dependent, the court shall retain jurisdiction, unless relinquished by its order, until the child reaches 21 years of age, or 22 years of age if the child has a disability, with the following exceptions:

(a) If a young adult chooses to leave foster care upon reaching 18 years of age.

(b) If a young adult does not meet the eligibility requirements to remain in foster care under s. 39.6251 or chooses to leave care under that section.

(c) If a young adult petitions the court at any time

before his or her 19th birthday requesting the court's continued jurisdiction, the juvenile court may retain jurisdiction under this chapter for a period not to exceed 1 year following the young adult's 18th birthday for the purpose of determining whether appropriate services that were required to be provided to the young adult before reaching 18 years of age have been provided.

(d) If a petition for special immigrant juvenile status and an application for adjustment of status have been filed on behalf of a foster child and the petition and application have not been granted by the time the child reaches 18 years of age, the court may retain jurisdiction over the dependency case solely for the purpose of allowing the continued consideration of the petition and application by federal authorities. Review hearings for the child shall be set solely for the purpose of determining the status of the petition and application. The court's jurisdiction terminates upon the final decision of the federal authorities. Retention of jurisdiction in this instance does not affect the services available to a young adult under s. 409.1451. The court may not retain jurisdiction of the case after the immigrant child's 22nd birthday.

Section 3. Subsection (4) of section 39.6035, Florida Statutes, is amended to read:

39.6035 Transition plan.—

(4) ~~If a child is planning to leave care upon reaching 18~~

~~years of age,~~ The transition plan must be approved by the court before the child's 18th birthday and must be attached to the case plan and updated before each judicial review ~~child leaves care and the court terminates jurisdiction~~.

Section 4. Present subsections (2) through (11) of section 39.621, Florida Statutes, are redesignated as subsections (3) through (12), respectively, and a new subsection (2) is added to that section, to read:

39.621 Permanency determination by the court.—

(2) The permanency goal of maintaining and strengthening the placement with a parent may be used in all of the following circumstances:

(a) If a child has not been removed from a parent, even if adjudication of dependency is withheld, the court may leave the child in the current placement with maintaining and strengthening the placement as a permanency option.

(b) If a child has been removed from a parent and is placed with the parent from whom the child was not removed, the court may leave the child in the placement with the parent from whom the child was not removed with maintaining and strengthening the placement as a permanency option.

(c) If a child has been removed from a parent and is subsequently reunified with that parent, the court may leave the child with that parent with maintaining and strengthening the placement as a permanency option.

Section 5. Section 409.996, Florida Statutes, is amended to read:

409.996 Duties of the Department of Children and Families.—The department shall contract for the delivery, administration, or management of care for children in the child protection and child welfare system. In doing so, the department retains responsibility to ensure ~~for~~ the quality of contracted services and programs and ~~shall ensure~~ that an adequate array of services is available to be ~~are~~ delivered in accordance with applicable federal and state statutes and regulations.

(1) The department shall enter into contracts with lead agencies for the performance of the duties by the lead agencies pursuant to s. 409.988. At a minimum, the contracts must:

(a) Provide for the services needed to accomplish the duties established in s. 409.988 and provide information to the department which is necessary to meet the requirements for a quality assurance program pursuant to subsection (18) and the child welfare results-oriented accountability system pursuant to s. 409.997.

(b) Provide for graduated penalties for failure to comply with contract terms. Such penalties may include financial penalties, enhanced monitoring and reporting, corrective action plans, and early termination of contracts or other appropriate action to ensure contract compliance. The financial penalties shall require a lead agency to reallocate funds from

administrative costs to direct care for children.

(c) Ensure that the lead agency shall furnish current and accurate information on its activities in all cases in client case records in the state's statewide automated child welfare information system.

(d) Specify the procedures to be used by the parties to resolve differences in interpreting the contract or to resolve disputes as to the adequacy of the parties' compliance with their respective obligations under the contract.

(2) The department must adopt written policies and procedures for monitoring the contract for delivery of services by lead agencies which must be posted on the department's website. These policies and procedures must, at a minimum, address the evaluation of fiscal accountability and program operations, including provider achievement of performance standards, provider monitoring of subcontractors, and timely followup of corrective actions for significant monitoring findings related to providers and subcontractors. These policies and procedures must also include provisions for reducing the duplication of the department's program monitoring activities both internally and with other agencies, to the extent possible. The department's written procedures must ensure that the written findings, conclusions, and recommendations from monitoring the contract for services of lead agencies are communicated to the director of the provider agency and the community alliance as

expeditiously as possible.

(3) The department shall receive federal and state funds as appropriated for the operation of the child welfare system, transmit these funds to the lead agencies as agreed to in the contract, and provide information on its website of the distribution of the federal funds. The department retains responsibility for the appropriate spending of these funds. The department shall monitor lead agencies to assess compliance with the financial guidelines established pursuant to s. 409.992 and other applicable state and federal laws.

(4) The department shall provide technical assistance and consultation to lead agencies in the provision of care to children in the child protection and child welfare system.

(5) The department retains the responsibility for the review, approval or denial, and issuances of all foster home licenses.

(6) The department shall process all applications submitted by lead agencies for the Interstate Compact on the Placement of Children and the Interstate Compact on Adoption and Medical Assistance.

(7) The department shall assist lead agencies with access to and coordination with other service programs within the department.

(8) The department shall determine Medicaid eligibility for all referred children and shall coordinate services with the

Agency for Health Care Administration.

(9) The department shall develop, in cooperation with the lead agencies, a third-party credentialing entity approved pursuant to s. 402.40(3), and the Florida Institute for Child Welfare established pursuant to s. 1004.615, a standardized competency-based curriculum for certification training for child protection staff.

(10) The department shall maintain the statewide adoptions website and provide information and training to the lead agencies relating to the website.

(11) The department shall provide training and assistance to lead agencies regarding the responsibility of lead agencies relating to children receiving supplemental security income, social security, railroad retirement, or veterans' benefits.

(12) With the assistance of a lead agency, the department shall develop and implement statewide and local interagency agreements needed to coordinate services for children and parents involved in the child welfare system who are also involved with the Agency for Persons with Disabilities, the Department of Juvenile Justice, the Department of Education, the Department of Health, and other governmental organizations that share responsibilities for children or parents in the child welfare system.

(13) With the assistance of a lead agency, the department shall develop and implement a working agreement between the lead

agency and the substance abuse and mental health managing entity to integrate services and supports for children and parents serviced in the child welfare system.

(14) The department shall work with the Agency for Health Care Administration to provide each Medicaid-eligible child with early and periodic screening, diagnosis, and treatment, including 72-hour screening, periodic child health checkups, and prescribed followup for ordered services, including, but not limited to, medical, dental, and vision care.

(15) The department shall assist lead agencies in developing an array of services in compliance with the Title IV-E waiver and shall monitor the provision of such services.

(16) The department shall provide a mechanism to allow lead agencies to request a waiver of department policies and procedures that create inefficiencies or inhibit the performance of the lead agency's duties.

(17) The department shall directly or through contract provide attorneys to prepare and present cases in dependency court and shall ensure that the court is provided with adequate information for informed decisionmaking in dependency cases, including a face sheet for each case which lists the names and contact information for any child protective investigator, child protective investigation supervisor, case manager, and case manager supervisor, and the regional department official responsible for the lead agency contract. The department shall

provide to the court the case information and recommendations provided by the lead agency or subcontractor. For the Sixth Judicial Circuit, the department shall contract with the state attorney for the provision of these services.

(18) The department, in consultation with lead agencies, shall establish a quality assurance program for contracted services to dependent children. The quality assurance program shall be based on standards established by federal and state law and national accrediting organizations.

(a) The department must evaluate each lead agency under contract at least annually. These evaluations shall cover the programmatic, operational, and fiscal operations of the lead agency and must be consistent with the child welfare results-oriented accountability system required by s. 409.997. The department must consult with dependency judges in the circuit or circuits served by the lead agency on the performance of the lead agency.

(b) The department and each lead agency shall monitor out-of-home placements, including the extent to which sibling groups are placed together or provisions to provide visitation and other contacts if siblings are separated. The data shall identify reasons for sibling separation. Information related to sibling placement shall be incorporated into the results-oriented accountability system required pursuant to s. 409.997 and into the evaluation of the outcome specified in s.

409.986(2)(e). The information related to sibling placement shall also be made available to the institute established pursuant s. 1004.615 for use in assessing the performance of child welfare services in relation to the outcome specified in s. 409.986(2)(e).

(c) The department shall, to the extent possible, use independent financial audits provided by the lead agency to eliminate or reduce the ongoing contract and administrative reviews conducted by the department. If the department determines that such independent financial audits are inadequate, other audits, as necessary, may be conducted by the department. This paragraph does not abrogate the requirements of s. 215.97.

(d) The department may suggest additional items to be included in such independent financial audits to meet the department's needs.

(e) The department may outsource programmatic, administrative, or fiscal monitoring oversight of lead agencies.

(f) A lead agency must assure that all subcontractors are subject to the same quality assurance activities as the lead agency.

(19) The department and its attorneys have the responsibility to ensure that the court is fully informed about issues before it, to make recommendations to the court, and to present competent evidence, including testimony by the

department's employees, contractors, and subcontractors, as well as other individuals, to support all recommendations made to the court. The department's attorneys shall coordinate lead agency or subcontractor staff to ensure that dependency cases are presented appropriately to the court, giving consideration to the information developed by the case manager and direction to the case manager if more information is needed.

(20) The department, in consultation with lead agencies, shall develop a dispute resolution process so that disagreements between legal staff, investigators, and case management staff can be resolved in the best interest of the child in question before court appearances regarding that child.

(21) The department shall periodically, and before procuring a lead agency, solicit comments and recommendations from the community alliance established in s. 20.19(5), any other community groups, or public hearings. The recommendations must include, but are not limited to:

(a) The current and past performance of a lead agency.

(b) The relationship between a lead agency and its community partners.

(c) Any local conditions or service needs in child protection and child welfare.

(22) The department shall develop, in collaboration with lead agencies, service providers, current and former foster children, and other community stakeholders, a statewide quality

rating system for residential group care providers and foster homes. This system must promote high quality in services and accommodations by creating measurable minimum quality standards that providers must meet to contract with the lead agencies and that foster homes must meet to receive placements. Domains addressed by a quality rating system for residential group care providers may include, but need not be limited to, admissions, service planning and treatment planning, living environment, and program and service requirements. The quality rating system must be implemented by July 1, 2019.

(a) The rating system must include:

1. Delineated levels of quality that are clearly and concisely defined, the domains measured, and criteria which must be met to be placed in each level. The quality rating system must differentiate between shift and family-style models while encouraging a high level of quality in both;

2. Contractual incentives for achieving and maintaining high levels of quality; and

3. A well-defined process for notice, inspection, remediation, appeal, and enforcement.

(b) The department shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1 of each year, with the first report due October 1, 2017. The report must, at a minimum, include an update on the development of a statewide quality rating system

for residential group care providers and foster homes and a plan for department oversight of the implementation of the statewide quality rating system for residential group care providers and foster homes by the community-based care lead agencies. Beginning in 2019 and in subsequent years, the report must also contain a list of residential group care providers meeting minimum quality standards and their quality ratings; the percentage of children placed in residential group care with highly rated providers; any negative action taken against contracted providers for not meeting minimum quality standards; the percentages of highly rated foster homes by lead agency; and the percentage of children placed in highly rated foster homes.

Section 6. This act shall take effect July 1, 2017.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCA 17-01 Medicaid Services
SPONSOR(S): Health Care Appropriations Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

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

SUMMARY ANALYSIS

The bill conforms statutes to the funding decisions related to the Medicaid Program included in the House proposed General Appropriations Act (GAA) for Fiscal Year 2017-2018. The bill:

- Amends the definition of a "rural hospital" to eliminate sole community hospitals with up to 175 beds;
- Consolidates the Project AIDS Care waiver, Adult Cystic Fibrosis waiver, and Traumatic Brain Injury and Spinal Cord Injury waiver within the Medicaid Long Term Care waiver, effective January 1, 2018;
- Removes obsolete language related to ambulatory surgical center reimbursements due to the implementation of a prospective payment system;
- Removes Hospital Outpatient services reimbursements from the statutory rate freeze due to the implementation of a prospective payment system;
- Requires local governments that submit Intergovernmental Transfers to AHCA to submit the total amount of the funds as agreed upon in the executed letter of agreement, no later than October 31 of the year the funds are pledged unless an alternative plan is specifically approved by AHCA;
- Revises "Medicaid Payments" within the Statewide Medicaid Residency Program to include Hospital Outpatient Medicaid rates due to the implementation of a prospective payment system;
- Revises the years of audited data used in determining Disproportionate Share Hospital payments;
- Provides conforming cross-references.

The bill provides for an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a federal and state partnership established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Department of Health (DOH), the Agency for Persons with Disabilities, and the Department of Elderly Affairs (DOEA).

The Florida Medicaid program covers approximately 4 million low-income individuals, including approximately 2.3 million, or 58.7%, of the children in Florida.[1] Medicaid is the second largest single program in the state, behind public education, representing 31 percent of the total FY 2016-2017 budget. Medicaid expenditures represent over 19 percent of the total state funds appropriated in FY 2016-2017.

Medicaid Waivers

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Also, Section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

States may also ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. For example, Florida has a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.[2] In addition to the Section 1115 waiver for the MMA program, Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-term Care (LTC) program.[3]

Approximately 82% of the Medicaid population in Florida is enrolled in the MMA and LTC programs.[4]

Florida's Medicaid Managed Care Long-term Care Program

The LTC program provides long-term care services to eligible Medicaid beneficiaries. Individuals must enroll in the LTC program if they are age 65 or older and eligible for Medicaid, age 18 or older and eligible for Medicaid by reason of a disability, or determined by the Comprehensive Assessment and Review of Long-term Care Services (CARES) unit[5] at DOEA to need nursing facility level of care and also meets one or more established criteria, such as receiving TANF or enrolled in hospice care.[6]

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[1] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, February 2017, available at http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last accessed March 17, 2017).
[2] S. 409.964, F.S.
[3] Id.
[4] Supra, FN 1.
[5] CARES is a federally mandated pre-admission screening program to assess each individual who requests Medicaid reimbursement for nursing facility placement, or who seeks to receive home and community-based services through other Medicaid waivers.
[6] Agency for Health Care Administration, Statewide Medicaid Managed Care, *Long-term Care Program Snapshot*, December 6, 2016, available at https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot.pdf (last accessed February 27, 2017).

The LTC program also allows individuals who are eligible for various other Home and Community-based Services (HCBS) waivers[7] to enroll. Such waivers include:

- Developmental Disabilities Waiver (iBudget);
- Traumatic Brain and Spinal Cord Injury Waiver;
- Project AIDS Care Waiver; and
- Adult Cystic Fibrosis Waiver.[8]

LTC plan providers also cover some expanded benefits, such as dental, emergency financial assistance, non-medical transportation, over-the-counter medications/supplies, and vision services.[9]

Traumatic Brain and Spinal Cord Injury Waiver

The Traumatic Brain and Spinal Cord Injury (TB/SCI) waiver is an HCBS waiver operated by DOH that provides services for individuals with traumatic brain injuries and spinal cord injuries.[10] For purposes of the waiver, "traumatic brain injury" is an injury that produces an altered state of consciousness or anatomic, motor, sensory, or cognitive/behavioral deficits and "spinal cord injury" is an injury that has significant involvement of two of the following: motor deficit, sensory deficit, or bowel and bladder dysfunction.[11] To be eligible, individuals must be 18 years of age or older, be Medicaid eligible, have one of the conditions previously described, and meet nursing home level of care as determined by CARES.[12]

The TB/SCI waiver includes services such as assistive technologies, attendant care, adult companion, counseling, personal care, and support coordination. Currently, the TB/SCI waiver has approximately 350 individuals enrolled with 350 on the waitlist.[13]

Adult Cystic Fibrosis Waiver

The Adult Cystic Fibrosis (ACF) waiver is an HCBS waiver operated by DOH that provides services for individuals with a diagnosis of cystic fibrosis; a chronic, progressive, and terminal genetic disorder that affects a person's lungs and digestive system.[14] To be eligible, individuals must be 18 years of age or older, be Medicaid eligible, have a diagnosis of cystic fibrosis, and meet nursing home level of care as determined by CARES.[15]

The ACF waiver includes services such as case management, counseling, personal care, prescription drugs, respite care, and respiratory therapy. Currently, the ACF waiver has approximately 140 individuals enrolled with none on the waitlist.[16]

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[7] Infra, FN 10; Medicaid HCBS waivers are authorized by Section 2176 of the Omnibus Budget Reconciliation Act of 1981 and incorporated into Title XIX of the Social Security Act as Section 1915(c). States can use this authority to offer a broad array of services not otherwise available through Medicaid that are intended to prevent or delay institutional placement. Florida's HCBS waivers vary on a number of dimensions. Some waivers are limited to persons with specific diseases or physical conditions (such as cystic fibrosis); others serve broader groups (such as persons who are elderly and/or have disabilities). Waivers also differ with respect to the number and types of services provided, payment method, and whether waiver services are available statewide or limited to a few counties.
[8] Supra, FN 6.
[9] Id.
[10] Office of Program Policy Analysis and Government Accountability, *Profile of Florida's Medicaid Home and Community-Based Services Waivers*, Report No. 13-07, March 2013, available at http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1307rpt.pdf (last accessed February 27, 2017).
[11] Id.
[12] Id.
[13] Agency for Health Care Administration, Agency Analysis of 2017 House Bill 619, p. 3 (Feb. 6, 2017).
[14] Supra, FN 10.
[15] Id.
[16] Supra, FN 13

Project AIDS Care Waiver

The Project AIDS Care (PAC) waiver is an HCBS waiver operated by AHCA that provides services for individuals with a diagnosis of acquired immune deficiency syndrome (AIDS). To be eligible, individuals must be Medicaid eligible, have a diagnosis of AIDS, have an AIDS-related opportunistic infection, be at risk for hospitalization, meet income eligibility requirements of the Social Security Administration for SSI,[17] and not be enrolled in the MMA or LTC programs.[18] To meet SSI income requirements, an individual must not earn more than $2,205 per month, or 300% of the Federal Benefits Rate (FBR).[19]

The PAC waiver includes services such as case management, home-delivered meals, personal care, restorative massage, specialized medical equipment, and skilled nursing. Currently, the PAC waiver has approximately 7,800 individuals enrolled with none on the waitlist.

Sole Community Hospitals

The federal Medicare program classifies a hospital as a "sole community hospital" based on criteria specified in title 42, s. 412.92, of the Code of Federal Regulations, including whether the hospital is situated in a federally-designated rural area, the hospital's capacity, and the hospital's distance from other hospitals. A sole community hospital is given special treatment and is eligible for payment adjustments from the Medicare program due to the federal government's consideration of the hospital's accessibility to residents of rural areas who have limited options for hospital services.

In 2016, the Legislature amended the definition of a rural hospital to include hospitals classified as sole community hospitals having up to 175 licensed beds, beginning in the 2016-2017 fiscal year.[20] Chapter 2016-66, Laws of Florida provided non-recurring funding for the increased cost associated with amending the definition to include hospitals classified as sole community hospitals.

Outpatient Reimbursement

Florida Medicaid currently reimburses hospital outpatient services using hospital specific cost-based rates which pay a flat rate referred to as a "per diem" to each payable revenue code submitted on an outpatient claim. The hospital outpatient rates are based on unaudited, historical cost reports submitted prior to services being rendered. The reimbursement rates are adjusted post-payment for some facilities each year based on audited cost reports. The cost report audit and rate adjustment processes can take several years for full reconciliation and finalization of payment.

During the 2015 Legislative Session, the Legislature authorized the study and design of an Outpatient Prospective Payment System (OPPS) for Florida Medicaid[21]. The Legislature required that the Agency for Health Care Administration develop a plan to convert Medicaid payments for outpatient services, including hospital outpatient services and ambulatory surgery centers, to a prospective payment system and identify steps necessary for the transition to be completed in a budget neutral manner.

During the 2016 Legislative Session, the Legislature amended s. 409.905, F.S., replacing AHCA's existing per diem and retroactive adjustment fee methodology for Medicaid outpatient care, with a prospective payment system. Under the new system, AHCA will calculate reimbursement rates annually for Hospital Outpatient Services. Additionally, s. 409.908(5), F.S., was amended to reflect the

[17] SSI is the Supplemental Security Income program, a federal income supplement program designed to help aged, blind, and disabled people with little to no income by providing cash to meet basic needs such as food, clothing and shelter; *See* Social Security Administration, Supplemental Security Income Home Page – 2016 Edition, *What is Supplemental Security Income?*, available at https://www.ssa.gov/ssi/ (last accessed February 27, 2017).
[18] Supra, FN 10.
[19] Current FBR is $735 per month; Department of Children and Families, *SSI-Related Programs – Financial Eligibility Standards*, available at http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/a_09.pdf (last accessed February 26, 2017).
[20] Chapter 2016-65, Laws of Florida
[21] Chapter 2015-232, Laws of Florida

transition to prospective payment system for ambulatory surgical centers. The new rates are required to go into effect on July 1, 2017, and on July 1 every year thereafter. The new methodology must function like an outpatient prospective payment system by categorizing the amount and type of services used in outpatient visits, and group together procedures that share similar characteristics and costs.

Intergovernmental Transfers

Certain programs, including but not limited to the Statewide Medicaid Residency Program, the Graduate Medical Education Startup Bonus Program, the Disproportionate Share Hospital (DSH), and certain hospital reimbursement exemptions 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 may be used to augment hospital payments in other ways, specifically through direct payment programs authorized by the federal Centers for Medicare and Medicaid Services (CMS) through waivers or state plan amendments. Examples include the Upper Payment Limit (UPL) and Low Income Pool (LIP) programs. 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, 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. Current law requires local governments who will be submitting IGTs to submit to AHCA the final executed letter of agreement containing the total amount of the IGTs authorized by the entity, no later than October 1 of each year. Currently, there is no date requirement for the local governments to transfer the actual IGTs to AHCA.

Statewide Medicaid Residency Program

In 2013, the Legislature created the Statewide Medicaid Residency Program (SMRP) to fund graduate medical education (GME).[22] GME is the education and training of physicians following graduation from a medical school in which 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. These residency programs vary in length from three to seven years. Previously, graduate medical education was reimbursed through hospital inpatient and outpatient reimbursements.

The SMRP defines "Medicaid payment" as payments made to reimburse a hospital for direct inpatient services, as determined by AHCA. Consequently, AHCA must calculate an allocation fraction in accordance with statutory formula on or before September 15 of each year. A hospital's annual allocation equals the funds appropriated for the SMRP in the GAA multiplied by its allocation fraction. Regardless of the formula, a hospital's annual allocation may not exceed two-times the average per resident amount for all hospitals. Any funds beyond this amount must be redistributed to participating hospitals whose annual allocation does not exceed this limit. AHCA must distribute each participating hospital's annual allocation in four installments on the final business day of each quarter of the state fiscal year.[23]

Disproportionate Share Hospital Program

The Medicaid Disproportionate Share Hospital (DSH) Program funding distributions are provided to hospitals that provide a disproportionate share of the Medicaid or charity care services to uninsured individuals. Each year, the Legislature delineates how the funds will be distributed to each eligible facility either through statutory formulas or other direction in the implementing bill or proviso.

[22] Chapter 2013-48, Laws of Florida
[23] S. 409.909, F.S.

Effect of Proposed Bill

Medicaid Waivers

The bill requires PAC, ACF, and TB/SCI waiver beneficiaries to transition to the LTC program by January 1, 2018. Once all eligible Medicaid beneficiaries have transitioned, AHCA must seek federal approval to terminate the waivers. Waiver consolidation removes administrative burdens on AHCA and DOH by transferring Medicaid beneficiaries from these HCBS waivers into the LTC program. Similar services, and in some cases expanded services, are available to the waiver beneficiaries in the LTC program as are currently available through the waivers.

Project AIDS Care Waiver Consolidation

The bill would transfer approximately 7,800 individuals from the PAC waiver to the LTC program.

The bill amends eligibility requirements, subject to federal approval, for individuals who would otherwise be eligible for the PAC waiver but do not meet the eligibility requirements for the LTC program. The bill makes those individuals with a diagnosis of AIDS, an AIDS-related opportunistic infection, at risk of hospitalization as determined by AHCA, and income at or below 300% of the FBR eligible for Medicaid. This change in the eligibility requirement would allow an individual otherwise eligible for the PAC waiver, who does not meet the nursing home level of care requirement for the LTC program, to be eligible for the MMA program.

The LTC program offers similar services to those offered under the PAC waiver. Some services will not be available, such as massage therapy, but other services available under the LTC program will replace those services.[24]

Adult Cystic Fibrosis Waiver Consolidation

The bill would transfer approximately 140 individuals from the ACF waiver to the LTC program.

The bill amends CARES screening requirements to include "hospital level of care" for individuals diagnosed with cystic fibrosis. Currently, to meet LTC eligibility requirements, CARES must determine an individual requires "nursing facility care." This change will allow those individuals diagnosed with cystic fibrosis who do not meet the nursing facility level of care requirement to be eligible for the LTC program.

The LTC program offers similar services to those offered under the ACF waiver, but certain services are not available, such as nutritional supplements and the amount of sterile saline needed by individuals with ACF. AHCA will require LTC program plans to cover over-the-counter benefits to fill the gap in available services.[25]

Traumatic Brain Injury and Spinal Cord Injury Waiver

The bill transfers approximately 350 individuals from the TB/SCI waiver to the LTC program, and 350 individuals from the TB/SCI waiver waitlist to the LTC program waitlist. It is likely those individuals transferred onto the LTC waitlist will transition into the LTC program faster than they would have moved into the TB/SCI waiver due to their high level of acuity and the large number of people enrolled per year from the waitlist into the LTC program.

[24] Supra, FN 13 at pg. 4.
[25] Supra, FN 13 at pg. 5.

The LTC program offers services similar to those available through the TB/SCI waiver and expanded benefits will be available to individuals who transfer.

The bill also deletes s. 409.906(13)(b), F.S., a section of law that allows AHCA to consolidate certain waiver programs that will become obsolete upon passage of the bill.

Sole Community Hospitals

The bill amends s. 395.602, F.S., to revise the definition of "rural hospital" by deleting the provision allowing a hospital to qualify as a rural hospital by being classified as a sole community hospital having up to 175 licensed beds since the increased costs associated with this change was funding with non-recurring appropriations.

Outpatient Reimbursement

During the 2016 Legislative Session, the Legislature required that the Agency for Health Care Administration implement prospective payments for outpatient services, including hospital outpatient services and ambulatory surgery centers.[26] The bill deletes obsolete language in s. 409.908(5), F.S., due to the statutorily required implementation of a prospective payment system effective July 1, 2017. The new rates go into effect on July 1, 2017, and on July 1 every year thereafter. Additionally, the bill eliminates hospital outpatient services from the statutory rate freeze that ensures no increase in statewide expenditures resulting from a change in unit costs effective July 1, 2011.

Intergovernmental Transfers

The bill amends s. 409.908, F.S., to require the local governments to submit to AHCA the total amount of the IGTs as agreed upon in the executed letter of agreement, no later than October 31 of the year the IGTs are pledged unless an alternative plan is specifically approved by AHCA.

Statewide Medicaid Residency Program

This legislation amends s. 409.909, F.S., to modify the definition of "Medicaid payments" under the SMRP to include outpatient services. This change is necessitated by the statutory transition to a prospective outpatient payment system. This is similar to the transition that occurred when Florida moved to inpatient Diagnosis Related Groups.

Disproportionate Share Hospital Program

The bill amends s. 409.911, F.S., to update existing law to provide payments for the 2017-2018 fiscal year related to hospitals in the Disproportionate Share Hospital (DSH) Programs and Medicaid DSH based upon the average of the 2009, 2010, and 2011 audited disproportionate share data to determine each hospital's Medicaid days and charity care.

The bill provides for an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.602, F.S., relating to rural hospitals.
Section 2: Amends s. 409.904, F.S., relating to optional payments to eligible persons.
Section 3: Amends s. 409.906, F.S., relating to optional Medicaid services.
Section 4: Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.
Section 5: Amends s. 409.909, F.S., relating to Statewide Medicaid Residency Program.

[26] Chapter 2016-65, Laws of Florida

Section 6: Amends s. 409.911, F.S., relating to Disproportionate Share Program
Section 7: Amends s. 409.979, F.S., relating to eligibility.
Section 8: Amends s. 391.055, F.S., conforming cross-references.
Section 9: Amends s. 393.0661, F.S., conforming cross-references.
Section 10: Amends s. 409.968, F.S., conforming cross-references.
Section 11: Amends s. 427.0135, F.S., conforming cross-references.
Section 12: Amends s. 1011.70, F.S., conforming cross-references.
Section 13: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   $476,864,450 in federal Medicaid funds will be generated through the implementation of the Hospital Outpatient Prospective Payment System, the GME program, and the DSH programs:

   - Hospital Outpatient Services = $146,635,622
   - Graduate Medical Education = $110,916,000
   - Disproportionate Share Hospital Program = $219,313,128

2. Expenditures:

   The bill will require a transfer of General Revenue funds from DOH to AHCA relating to the TB/SCI waiver in the amount of $1,976,544. The bill will require a transfer of General Revenue funds from DOH to AHCA related to the ACF waiver in the amount of $474,206.

   The bill will require AHCA to internally transfer General Revenue of $1,668,324 between budget categories to transfer the PAC waiver to the LTC program.

   The bill does not increase the Medicaid outpatient reimbursements as the transition from a cost-based reimbursement system to a prospective payment system is required to be budget neutral.

   The bill will require AHCA to make payments to eligible DSH providers, based on the statutory formulas, a total amount of $309,917,284 ($6.5 million General Revenue).

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   In order to earn matching federal dollars for IGT funded programs, local governments and other local political subdivisions would be required to provide $249,828,895 in contributions, no later than October 31, 2017.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

D. FISCAL COMMENTS:

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

2. Other:

B. RULE-MAKING AUTHORITY:

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to Medicaid services; amending s. 395.602, F.S.; revising the definition of the term "rural hospital" to delete sole community hospitals; amending s. 409.904, F.S.; providing that certain persons with AIDS are eligible for optional payments for medical assistance and related services; amending s. 409.906, F.S.; deleting a provision relating to consolidation of waiver services to conform to changes made by the act; amending s. 409.908, F.S.; deleting a provision relating to reimbursement rate parameters for certain Medicaid providers; authorizing the agency to receive funds from certain governmental entities for specified purposes; providing requirements for letters of agreement executed by a local governmental entity; amending s. 409.909, F.S.; revising the definition of the term "Medicaid payments" to include the outpatient enhanced ambulatory payment group for purposes of the Statewide Medicaid Residency Program; amending s. 409.911, F.S.; updating references to data used for calculating disproportionate share program payments to certain hospitals for the 2017-2018 fiscal year; amending s. 409.979, F.S.; revising eligibility criteria for certain long-term care services; providing for certain home and community-based service

waiver participants to transition into the long-term care managed care program; requiring the agency to seek federal approval to terminate certain waiver programs; amending ss. 391.055, 393.0661, 409.968, 427.0135, and 1011.70, F.S.; conforming cross-references; providing an effective date.

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

Section 1. 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, the term:

(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 up to 100 persons per square mile;

2. An acute care hospital, in a county with a population density of up to 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 up to 100 persons per

square mile;

~~4. A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92 which has up to 175 licensed beds;~~

4.~~5.~~ A hospital with a service area that has a population of up to 100 persons 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 Transparency at the agency; or

5.~~6.~~ A hospital designated as a critical access hospital, as defined in s. 408.07.

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, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room. 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. A hospital that was licensed as a rural hospital during

the 2010-2011 or 2011-2012 fiscal year shall continue to be a rural hospital from the date of designation through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room.

Section 2. Subsection (11) is added to section 409.904, Florida Statutes, to read:

409.904 Optional payments for eligible persons.—The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(11) Subject to federal waiver approval, a person with acquired immune deficiency syndrome (AIDS) who has an AIDS-related opportunistic infection and is at risk of hospitalization as determined by the agency or its designee, and whose income is at or below 300 percent of the federal benefit rate (FBR).

Section 3. Paragraph (b) of subsection (13) of section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security

Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited 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, 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 or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(13) HOME AND COMMUNITY-BASED SERVICES.—

~~(b) The agency may consolidate types of services offered in the Aged and Disabled Waiver, the Channeling Waiver, the Project AIDS Care Waiver, and the Traumatic Brain and Spinal Cord Injury Waiver programs in order to group similar services under a single service, or continue a service upon evidence of~~

~~the need for including a particular service type in a particular waiver. The agency is authorized to seek a Medicaid state plan amendment or federal waiver approval to implement this policy.~~

Section 4. Subsections (6) through (26) of section 409.908, Florida Statutes, are renumbered as subsections (5) through (25), respectively, present subsections (5) and (24) are amended, and a new subsection (26) is added to that section, 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.

~~(5) An ambulatory surgical center shall be reimbursed the lesser of the amount billed by the provider or the Medicare-established allowable amount for the facility.~~

(23) ~~(24)~~ (a) The agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs effective July 1, 2011. Reimbursement rates shall be as provided in the General Appropriations Act.

(b) Base rate reimbursement for inpatient services under a diagnosis-related group payment methodology shall be provided in the General Appropriations Act.

(c) Base rate reimbursement for outpatient services under an enhanced ambulatory payment group methodology shall be provided in the General Appropriations Act.

(d) ~~(c)~~ This subsection applies to the following provider types:

~~1. Inpatient hospitals.~~

~~2. Outpatient hospitals.~~

1. ~~3.~~ Nursing homes.

2. ~~4.~~ County health departments.

~~5. Prepaid health plans.~~

(e) ~~(d)~~ The agency shall apply the effect of this subsection to the reimbursement rates for nursing home diversion programs.

(26) The agency may 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. Funds received for this purpose shall be separately accounted for and may 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 and in the manner authorized under the General Appropriations Act and pursuant to an agreement between the agency and the local governmental entity. In order for the agency to certify such local governmental funds, a local governmental entity must submit a final, executed letter of agreement to the agency, which must be received by October 1 of each fiscal year and provide the total

amount of local governmental funds authorized by the entity for that fiscal year under the General Appropriations Act. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form must identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. Local governmental funds outlined in the letters of agreement must be received by the agency no later than October 31 of each fiscal year in which such funds are pledged, unless an alternative plan is specifically approved by the agency.

Section 5. Paragraph (b) of subsection (2) of section 409.909, Florida Statutes, is amended to read:

409.909 Statewide Medicaid Residency Program.—

(2) On or before September 15 of each year, the agency shall calculate an allocation fraction to be used for distributing funds to participating hospitals. On or before the final business day of each quarter of a state fiscal year, the agency shall distribute to each participating hospital one-fourth of that hospital's annual allocation calculated under subsection (4). The allocation fraction for each participating hospital is based on the hospital's number of full-time equivalent residents and the amount of its Medicaid payments. As used in this section, the term:

(b) "Medicaid payments" means the estimated total payments

for reimbursing a hospital for direct inpatient services for the fiscal year in which the allocation fraction is calculated based on the hospital inpatient appropriation and the parameters for the inpatient diagnosis-related group base rate and the parameters for the outpatient enhanced ambulatory payment group rate, including applicable intergovernmental transfers, specified in the General Appropriations Act, as determined by the agency. Effective July 1, 2017, the term "Medicaid payments" means the estimated total payments for reimbursing a hospital for direct inpatient and outpatient services for the fiscal year in which the allocation fraction is calculated based on the hospital inpatient appropriation and outpatient appropriation and the parameters for the inpatient diagnosis-related group base rate and the parameters for the outpatient enhanced ambulatory payment group rate, including applicable intergovernmental transfers, specified in the General Appropriations Act, as determined by the agency.

Section 6. Paragraph (a) of subsection (2) of section 409.911, Florida Statutes, is 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 2009, 2010, and 2011 ~~2007, 2008, and 2009~~ audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2017-2018 ~~2015-2016~~ state fiscal year.

Section 7. Subsections (1) and (2) of section 409.979, Florida Statutes, are amended to read:

409.979 Eligibility.—

(1) PREREQUISITE CRITERIA FOR ELIGIBILITY.—Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) preadmission screening program to require:

1. Nursing facility care as defined in s. 409.985(3); or

2. For individuals diagnosed as having cystic fibrosis, hospital level of care.

(2) ENROLLMENT OFFERS.—Subject to the availability of funds, the Department of Elderly Affairs shall make offers for enrollment to eligible individuals based on a wait-list prioritization. Before making enrollment offers, the agency and the Department of Elderly Affairs shall determine that sufficient funds exist to support additional enrollment into plans.

(a) A Medicaid recipient enrolled in one of the following home and community-based services Medicaid waiver programs who meets all of the eligibility criteria established in subsection (1) is eligible to participate in the long-term care managed care program and shall be transitioned into the long-term care managed care program by January 1, 2018:

1. Traumatic Brain and Spinal Cord Injury Waiver.

2. Adult Cystic Fibrosis Waiver.

3. Project AIDS Care Waiver.

(b) The agency shall seek federal approval to terminate the Traumatic Brain and Spinal Cord Injury Waiver, the Adult Cystic Fibrosis Waiver, and the Project AIDS Care Waiver once all eligible Medicaid recipients have transitioned into the long-term care managed care program.

Section 8. Subsection (3) of section 391.055, Florida

Statutes, is amended to read:

391.055 Service delivery systems.—

(3) The Children's Medical Services network may contract with school districts participating in the certified school match program pursuant to ss. 409.908(21) ~~409.908(22)~~ and 1011.70 for the provision of school-based services, as provided for in s. 409.9071, for Medicaid-eligible children who are enrolled in the Children's Medical Services network.

Section 9. Subsection (7) of section 393.0661, Florida Statutes, is amended to read:

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

(7) The agency shall collect premiums or cost sharing pursuant to s. 409.906(13)(c) ~~409.906(13)(d)~~.

Section 10. Paragraph (a) of subsection (4) of section 409.968, Florida Statutes, is amended to read:

409.968 Managed care plan payments.—

(4)(a) Subject to a specific appropriation and federal approval under s. 409.906(13)(d) ~~409.906(13)(e)~~, the agency

shall establish a payment methodology to fund managed care plans for flexible services for persons with severe mental illness and substance use disorders, including, but not limited to, temporary housing assistance. A managed care plan eligible for these payments must do all of the following:

1. Participate as a specialty plan for severe mental illness or substance use disorders or participate in counties designated by the General Appropriations Act;

2. Include providers of behavioral health services pursuant to chapters 394 and 397 in the managed care plan's provider network; and

3. Document a capability to provide housing assistance through agreements with housing providers, relationships with local housing coalitions, and other appropriate arrangements.

Section 11. Subsection (3) of section 427.0135, Florida Statutes, is amended to read:

427.0135 Purchasing agencies; duties and responsibilities.—Each purchasing agency, in carrying out the policies and procedures of the commission, shall:

(3) Not procure transportation disadvantaged services without initially negotiating with the commission, as provided in s. 287.057(3)(e)12., or unless otherwise authorized by statute. If the purchasing agency, after consultation with the commission, determines that it cannot reach mutually acceptable contract terms with the commission, the purchasing agency may

contract for the same transportation services provided in a more cost-effective manner and of comparable or higher quality and standards. The Medicaid agency shall implement this subsection in a manner consistent with s. 409.908(18) ~~409.908(19)~~ and as otherwise limited or directed by the General Appropriations Act.

Section 12. Subsections (1) and (5) of section 1011.70, Florida Statutes, are amended to read:

1011.70 Medicaid certified school funding maximization.—

(1) Each school district, subject to the provisions of ss. 409.9071 and 409.908(21) ~~409.908(22)~~ and this section, is authorized to certify funds provided for a category of required Medicaid services termed "school-based services," which are reimbursable under the federal Medicaid program. Such services shall include, but not be limited to, physical, occupational, and speech therapy services, behavioral health services, mental health services, transportation services, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) administrative outreach for the purpose of determining eligibility for exceptional student education, and any other such services, for the purpose of receiving federal Medicaid financial participation. Certified school funding shall not be available for the following services:

(a) Family planning.

(b) Immunizations.

(c) Prenatal care.

(5) Lab schools, as authorized under s. 1002.32, shall be authorized to participate in the Medicaid certified school match program on the same basis as school districts subject to the provisions of subsections (1)-(4) and ss. 409.9071 and 409.908(21) ~~409.908(22)~~.

Section 13. This act shall take effect July 1, 2017.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCA 17-02 Prescription Drug Monitoring Program
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		Mielke	Pridgeon

SUMMARY ANALYSIS

The bill conforms statutes to the funding decisions related to the Prescription Drug Monitoring Program included in the House proposed General Appropriations Act (GAA) for Fiscal Year 2017-2018.

Prescription Drug Monitoring Programs (PDMPs) are state-run electronic databases used to track the prescribing and dispensing of certain controlled prescription drugs to patients. PDMPs are designed to monitor this information for suspected abuse or diversion of controlled prescription drugs and provide prescribers and pharmacists with critical information regarding a patient's controlled substance prescription history. As of December 19, 2014, 49 states either had an operational PDMP database or had adopted legislation authorizing the creation of one.

In 2009, the Legislature created the Prescription Drug Monitoring Program (PDMP) within the Department of Health (DOH). The PDMP employs a database to monitor the prescribing and dispensing of certain controlled substances. Dispensers of controlled substances listed in Schedule II, III, or IV must report certain information to the PDMP database, including the name of the prescriber, the date the prescription is filled and dispensed, and the name, address, and date of birth of the person to whom the controlled substance is dispensed.

Current law requires that all costs incurred by the DOH in administering the PDMP shall be funded through federal grants or private funding applied for or received by the state. However, the 2015-2016 and 2016-2017 GAA implementing legislation authorized the use of state funds for administering the PDMP. The 2015-2016 GAA appropriated $500,000 in recurring General Revenue to the DOH to implement the PDMP.

The bill permanently authorizes the DOH to use state funds to administer the PDMP to reflect the proposed House budget recommendations for the 2017-2018 Fiscal Year.

The act shall take effect July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Prescription Drug Monitoring Program

Prescription Drug Monitoring Programs (PDMPs) are state-run electronic databases used to track the prescribing and dispensing of certain controlled prescription drugs to patients.[1] PDMPs are designed to monitor this information for suspected abuse or diversion of controlled prescription drugs and provide prescribers and pharmacists with critical information regarding a patient's controlled substance prescription history.[2] As of December 19, 2014, 49 states either had an operational PDMP database or had adopted legislation authorizing the creation of one.[3]

Chapter 2009-197, Laws of Florida, established Florida's PDMP within the Department of Health (DOH), and is codified in s. 893.055, F.S. The PDMP uses an electronic database system to monitor the prescribing and dispensing of certain controlled substances.[4] The PDMP database became operational in September of 2011, when it began receiving prescription data from pharmacies and dispensing practitioners.[5]

Florida's PDMP database is known as Electronic-Florida Online Reporting of Controlled Substances Evaluation (E-FORCSE).[6]

Funding the Prescription Drug Monitoring Program

Section 893.055(10), F.S. requires that all costs incurred by the DOH in administering the PDMP shall be funded through federal grants or private funding applied for or received by the state.

Section 893.055(11), F.S. provides the DOH may establish a direct-support organization to provide assistance, funding, and promotional support for the activities authorized for the PDMP. Thus, in 2010, the Florida PDMP Foundation (Foundation) was established.

Through June 2016, the Foundation had assets of over $1.5 million in private and corporate contributions. Of these funds, $1.4 million are currently being invested in Wells Fargo Bank purchased certificates of deposit and bank money market accounts to provide future funding when needed to continue E-FORCSE operations. These funds would be used in the event General Revenue funds currently supporting the program are discontinued. As of December 1, 2016, the Foundation has provided $1,010,513 to fund E-FORCSE.[7]

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[1] Centers for Disease Control and Prevention, *Prescription Drug Monitoring Programs, available at* http://www.cdc.gov/drugoverdose/pdmp/ (last visited March 5, 2017).

[2] *Id.*

[3] Brandeis University, Institute of Behavioral Health, and the U.S. Department of Justice, Bureau for Justice Assistance, PDMP Center of Excellence, *Status of Prescription Drug Monitoring Programs (PDMPs), available at* http://www.pdmpassist.org/pdf/PDMPProgramStatus2014.pdf (last visited March 5, 2017). Missouri is the only state without a PDMP. Legislation was filed in December 2016 to establish a program. *See http://www.senate.mo.gov/17info/BTS_Web/Bill.aspx?SessionType=R&BillID=57095432* (last visited March 5, 2017).

[4] Section 893.055(2)(a), F.S.

[5] Florida Department of Health, Electronic-Florida Online Reporting of Controlled Substances Evaluation (E-FORCSE), 2015-2016 Prescription Drug Monitoring Program Annual Report, (December 1, 2016), *available at* http://www.floridahealth.gov/statistics-and-data/e-forcse/_documents/2016PDMPAnnualReport.pdf (last visited March 5, 2017).

[6] Florida Department of Health, E-FORCSE Home Page, *available at http://www.floridahealth.gov/statistics-and-data/e-forcse/* (last visited March 5, 2017).

[7] Florida PDMP Foundation, Annual Report to the Department of Health 2016, *available at http://www.flpdmpfoundation.com/wp-content/uploads/2016/08/PDMPF_Annual_Report_2016.pdf* (last visited March 9, 2017).

Additionally, the DOH has received federal funding through six grants totaling $2,443,471. Other current grant projects include:

- Harold Rogers Data Driven Multi-Disciplinary Approach to Reducing Prescription Drug Abuse Grant 2013-PM-BX-00100 - $399,950. Project period ends March 31, 2017.
- Harold Rogers PDMP Enhancement Grant 2015-PM-BX-0009 - $499,991. Project ends September 30, 2017.
- Department of Children and Families Partnerships for Success (PFS) Grant - $86,625. Project ends September 30, 2017.
- University of Florida Harold Rogers Prescription Drug Monitoring Program: Data-Driven Responses to Prescription Drug Abuse Grant 2016-PM-BX-K005 – $17,500. Project ends September 30, 2019.[8]

In order to provide sufficient resources, the 2015-2016 General Appropriations Act appropriated $500,000 in recurring General Revenue to the DOH to implement the PDMP.[9]

Chapter 2015-222, Laws of Florida, the budget implementing bill, authorized the use of state funds appropriated in the 2015-2016 General Appropriations Act to administer the PDMP. Section 893.055(17), F.S., expired on July 1, 2016. Likewise, Chapter 2016-62, Laws of Florida, authorized the use of state funds appropriated in the 2016-2017 General Appropriations Act to administer the PDMP. Section 893.055(17), F.S., has an expiration date of July 1, 2017.

Since its inception in 2010, the PDMP has spent $3,615,939 for infrastructure, enhancements, personnel, and facility expenses.[10]

Effect of Proposed Changes

The bill amends s. 893.055, F.S., to permanently authorize the DOH to use state funds to administer the PDMP. The bill removes language providing that implementation of the program is contingent upon receipt of nonstate funding.

The bill has an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 893.055(10), F.S., relating to the prescription drug monitoring program.

Section 2: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The proposed 2017-2018 General Appropriations Act provides $500,000 in recurring General Revenue funds to DOH for operation of the Prescription Drug Monitoring Program.

[8] *Id.* at 5.
[9] Ch. 2015-232, Laws of Florida. See Specific Appropriation 503.
[10] *Id.* at 5.

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

A bill to be entitled

An act relating to the prescription drug monitoring program; amending s. 893.055, F.S.; authorizing the use of state funds for administration of the program; deleting a requirement that implementation of the program is contingent on nonstate funding; providing an effective date.

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

Section 1. Subsection (10) of section 893.055, Florida Statutes, is amended to read:

893.055 Prescription drug monitoring program.—

(10) All costs incurred by the department in administering the prescription drug monitoring program shall be funded through federal grants, ~~or~~ private funding applied for or received by the state, or state funds appropriated in the General Appropriations Act. The department may not commit funds for the monitoring program without ensuring funding is available. ~~The prescription drug monitoring program and the implementation thereof are contingent upon receipt of the nonstate funding.~~ The department and state government shall cooperate with the direct-support organization established pursuant to subsection (11) in seeking federal grant funds, other nonstate grant funds, gifts, donations, or other private moneys for the department if the

costs of doing so are not considered material. Nonmaterial costs for this purpose include, but are not limited to, the costs of mailing and personnel assigned to research or apply for a grant. Notwithstanding the exemptions to competitive-solicitation requirements under s. 287.057(3)(e), the department shall comply with the competitive-solicitation requirements under s. 287.057 for the procurement of any goods or services required by this section. Funds provided, directly or indirectly, by prescription drug manufacturers may not be used to implement the program.

Section 2. This act shall take effect July 1, 2017.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCA 17-03 Department of Veterans' Affairs
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		Mielke	Pridgeon

SUMMARY ANALYSIS

The bill conforms statutes to the funding decisions related to the Department of Veterans Affairs included in the House proposed General Appropriations Act (GAA) for Fiscal Year 2017-2018.

The State Homes for Veterans Trust Fund was created in s. 20.375(4), F.S., as a depository for specialty license plate revenues and can only be used for the purpose of constructing, operating, and maintaining domiciliary and nursing homes for veterans and for continuing promotion and marketing of veteran related specialty license plates. The Operations and Maintenance Trust Fund was created in s. 20.375(3), F.S., as a depository for the funds received from the United States Department of Veterans Affairs for the care of domiciliary and nursing home residents and can only be used for the purpose of operating and maintaining homes.

The bill terminates the State Homes for Veterans Trust Fund, transfers any balances in and revenues of the State Homes for Veterans Trust Fund to the Operations and Maintenance Trust Fund within the Department of Veterans' Affairs, and expands the use of the funds in the Operations and Maintenance Trust Fund to include supporting program operations that benefit veterans or the operations, maintenance, or construction of a nursing home.

The bill redirects the revenues received from the Florida Salutes Veterans, Untied State Marine Corps, Military Services, Support Our Troops, U.S. Paratroopers, and various other Armed Forces related specialty plates from the State Homes for Veterans Trust Fund to the Operations and Maintenance Trust Fund within the Department of Veterans' Affairs.

The bill redirects the voluntary contributions received from motor vehicle registration or renewals and applications for an original, renewal, or replacement of a driver license or identification from the State Homes for Veterans Trust Fund to the Operations and Maintenance Trust Fund within the Department of Veterans' Affairs.

A personal needs allowance is the amount of income a resident may retain for personal expenditures not covered by the nursing home such as toiletries and haircuts. Section 296.37, F.S., requires every resident of a state veteran domiciliary or nursing home who receives a pension, compensation, or gratuity from the United States Government or income from any other source of more than $35 per month to contribute to his or her maintenance and support while residing in a home. For the past three fiscal years the General Appropriations Act implementing legislation raised the personal needs allowance to $105 per month. This prior legislation expires July 1, 2017.

The bill permanently changes the personal needs allowance from $35 to $70 per month to reflect the proposed House budget recommendations for Medicaid for the 2017-2018 Fiscal Year.

The act shall take effect July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

The State Homes for Veterans Trust Fund was created as a depository for specialty license plate revenues and can only be used for the purpose of constructing, operating, and maintaining domiciliary and nursing homes for veterans and for continuing promotion and marketing of veteran related specialty license plates.[1]

The Operations and Maintenance Trust Fund was created as a depository for the funds received from the United States Department of Veterans Affairs for the care of domiciliary and nursing home residents and can only be used for the purpose of operating and maintaining homes.[2]

Specialty License Plates

Any voluntary contributions that are collected from motor vehicle registrations or renewals[3] and any voluntary contributions for state homes for veterans that are collected from an application for an original, renewal, or replacement driver license or identification card are deposited in the State Homes for Veterans Trust Fund.[4]

A portion of the fees received from issuance of the Florida Salutes Veterans License Plate, United States Marine Corps License Plate, Military Services License Plate, and Support Our Troops License Plate are deposited in the State Homes for Veterans Trust Fund and used for constructing, operating, and maintaining domiciliaries and nursing homes for veterans.[5] A portion of the revenue generated from a license plate issued pursuant to s. 320.089(1)(b), F.S., is deposited in the State Homes for Veterans Trust Fund.[6] Revenues generated from the U.S. Paratroopers License Plate are deposited in the State Homes for Veterans Trust Fund.[7]

Personal Needs Allowance

Once an individual requiring an institutional level of care has established Medicaid eligibility, some of his or her income is used to pay for Medicaid services. For individuals residing in an institution, most of their incomes are applied to the cost of that care, with the exception of a small personal needs allowance used to pay for personal needs that are not covered by Medicaid. A personal needs allowance is the amount of income a resident may retain for personal expenditures not covered by Medicaid such as clothing, toiletries and haircuts. Every resident of a state veterans home who receives a pension, compensation, or gratuity from the United States Government or income from any other source of more than $35 per month is required to contribute to his or her maintenance and support while residing in a home, pursuant to a schedule of payment determined by the home administrator and department director.[8] The total amount of such contributions shall not exceed the actual cost of operating and maintaining the home.[9]

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[1] S. 20.375(4), 320.08058, 320.0891(6).
[2] S. 20.375(3), 296.11(1).
[3] 320.02(15)(f).
[4] 322.08.
[5] 320.08058(4)(b)2., (28)(b)2.a., (38)(b), (63)(b)2.
[6] 320.089(1)(b). Such plates include Veterans of the United States Armed Forces, members of the Florida National Guard, and survivors of Pearl Harbor, among many others.
[7] 320.0891(6).
[8] 296.37(1).
[9] 296.37(1).

In 2015 the median personal needs allowance amount for an individual residing in an institution was $50 per month. Four states (AL, IL, NC, and SC) set their personal needs allowance at the federal minimum of $30 per month. Florida's personal needs allowance at $105 is the highest personal needs allowance for all 50 states and Washington D.C.[10]

Chapter 2014-53, Laws of Florida, amended s. 296.37, F.S., to increase the personal needs allowance to $105 per month. Subsequent implementing legislation for the General Appropriations Act has maintained the personal needs allowance for residents at $105 per month.[11] This provision is set to expire July 1, 2017.

Effect of Proposed Changes

The bill terminates the State Homes for Veterans Trust Fund and transfers remaining balances and all revenues to the Operations and Maintenance Trust Fund within the Department of Veterans' Affairs. The bill directs the Department of Veterans' Affairs to pay any outstanding debts or obligations of the trust fund.

The bill amends the allowable uses of funds within the Operations and Maintenance Trust Fund to include supporting program operations that benefit veterans or the operations, maintenance, or construction of a nursing home.

The bill amends the voluntary contributions that are collected from motor vehicle registrations or renewals and any voluntary contributions for state homes for veterans that are collected from an application for an original, renewal, or replacement driver license or identification card to be deposited in the Operations and Maintenance Trust Fund within the Department of Veterans' Affairs.

The bill amends the Florida Salutes Veterans License Plate, United States Marine Corps License Plate, Military Services License Plate, Support Our Troops License Plate, and U.S. Paratroopers License Plate sections of statute to redirect the revenues received to the Operations and Maintenance Trust Fund within the Department of Veterans' Affairs. The bill amends the specialty license plates issued pursuant to s. 320.089(1)(b), F.S., to redirect the revenues received to the Operations and Maintenance Trust Fund within the Department of Veterans' Affairs.

The bill permanently sets the personal needs allowance at $70 per month to reflect the proposed House budget recommendations for the Medicaid program for the 2017-2018 Fiscal Year.

The bill provides an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1. Terminates the State Homes for Veterans Trust Fund; provides for the disposition of balances in, revenues of, and all outstanding appropriations of the trust fund; prescribes procedures for the termination of the trust fund.
Section 2. Amends s. 20.375, F.S., relating to the Operations and Maintenance Trust Fund; specifies the use for the money deposited in the Operations and Maintenance Trust Fund; deletes language relating to the State Homes for Veterans Trust Fund.
Section 3. Amends s. 296.11, F.S., relating to the Operations and Maintenance Trust Fund; specifies the use for the money deposited in the Operations and Maintenance Trust Fund.
Section 4. Amends s. 296.37, F.S., relating to the personal needs allowance.
Section 5. Amends s. 296.38, F.S., relating to the Operations an d Maintenance Trust Fund; specifies the purpose of the money deposited in the Operations and Maintenance Trust Fund.

[10] Kaiser Family Foundation - Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015* (March 2016), accessible at http://files.kff.org/attachment/report-medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-in-2015 (last accessed March 24, 2017).
[11] Ch. 2015-222 and Ch. 2016-62, Laws of Florida.

Section 6. Amends s. 320.02, F.S., relating to the Operations and Maintenance Trust Fund; removing reference to the State Homes for Veterans Trust Fund.
Section 7. Amends s. 320.08058, F.S., relating to the Operations and Maintenance Trust Fund; removing reference to the State Homes for Veterans Trust Fund.
Section 8. Amends s. 320.089, F.S., relating to the Operations and Maintenance Trust Fund; removing reference to the State Homes for Veterans Trust Fund.
Section 9. Amends s. 320.0891, F.S., relating to the Operations and Maintenance Trust Fund; removing reference to the State Homes for Veterans Trust Fund.
Section 10. Amends s. 322.08, F.S., relating to the Operations and Maintenance Trust Fund; removing reference to the State Homes for Veterans Trust Fund.
Section 11. Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   This bill requires all remaining balances in, and all revenues of the State Homes for Veterans Trust Fund to be transferred to the Operations and Maintenance Trust Fund within the Department of Veterans' Affairs.

2. Expenditures:

   The 2017-2018 House proposed General Appropriations Act reflects a total reduction of $23,629,620 ($10,663,281 in General Revenue and $12,966,339 Federal Trust Funds) related to reducing the personal needs allowance from $105 monthly to $70 monthly. The reduction directly impacts the Agency for Health Care Administration (AHCA) through nursing home and institutional care facilities for the developmentally disabled reimbursements, the Agency for Persons with Disabilities (APD) for residents served through state institutions, and the Department of Children and Families (DCF) for residents served through state mental health hospitals. The reduction has an indirect impact to the Department of Veterans' Affairs.

   The AHCA provides reimbursements to state veterans' nursing homes for individuals who are Medicaid eligible for nursing home care in the same manner as private nursing home providers are reimbursed by AHCA. When the personal needs allowance is reduced, AHCA's reimbursement to the nursing homes is also reduced as the beneficiaries share of cost increases. The total reduction to AHCA's budget by reducing the personal needs allowance from $105 to $70 monthly is $20,858,411 with $7,961,470 being the general revenue impact. The impact to reimbursements to the state Veterans' Nursing Homes is included in this amount.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Residents in a nursing home will now retain $70 per month as a personal needs allowance rather than $105 per month.

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

A bill to be entitled

An act relating to the Department of Veterans' Affairs; terminating the State Homes for Veterans Trust Fund within the department; providing for the disposition of balances in, revenues of, and outstanding appropriations of the trust fund; prescribing termination procedures; amending s. 20.375, F.S.; revising provisions for use and administration of funds in the department's Operations and Maintenance Trust Fund; conforming provisions to changes made by the act; amending s. 296.11, F.S.; revising purposes for the expenditure of moneys in the trust fund; amending s. 296.37, F.S.; revising income requirements for certain contributions by residents of a veterans' nursing home; amending ss. 296.38, 320.02, 320.08058, 320.089, 320.0891, and 322.08, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. (1) The State Homes for Veterans Trust Fund within the Department of Veterans' Affairs, FLAIR number 20-2-692, is terminated.

(2) All current balances remaining in, and all revenues

of, the trust fund shall be transferred to the Operations and Maintenance Trust Fund within the Department of Veterans' Affairs.

(3) The Department of Veterans' Affairs shall pay any outstanding debts or obligations of the terminated fund as soon as practicable, and the Chief Financial Officer shall close out and remove the terminated fund from various state accounting systems using generally accepted accounting principles concerning warrants outstanding, assets, and liabilities.

Section 2. Paragraph (a) of subsection (3) and subsection (4) of section 20.375, Florida Statutes, are amended to read:

20.375 Department of Veterans' Affairs; trust funds.—The following trust funds shall be administered by the Department of Veterans' Affairs:

(3) Operations and Maintenance Trust Fund.

(a) Funds to be credited to and uses of the trust fund shall be administered in accordance with ~~the provisions of~~ ss. 215.32, 296.11, ~~and~~ 296.38, 320.08058, 320.089, and 320.0891.

~~(4) State Homes for Veterans Trust Fund.~~

~~(a) Funds to be credited to and uses of the trust fund shall be administered in accordance with the provisions of ss. 320.08058 and 320.0891.~~

~~(b) Notwithstanding the provisions of s. 216.301 and pursuant to s. 216.351, any balance in the trust fund at the end of any fiscal year shall remain in the trust fund at the end of~~

~~the year and shall be available for carrying out the purposes of the trust fund.~~

Section 3. Subsection (1) of section 296.11, Florida Statutes, is amended to read:

296.11 Funds of home and disposition of moneys.—

(1) The home shall deposit all moneys ~~which~~ it receives for care of residents from the United States Department of Veterans Affairs and residents into the Operations and Maintenance Trust Fund. All such moneys must be expended for the purpose of supporting program operations that benefit veterans or the operation, maintenance, or construction of a ~~operating and maintaining the~~ home, subject to the requirements of chapter 216.

Section 4. Subsection (1) of section 296.37, Florida Statutes, is amended to read:

296.37 Residents; contribution to support.—

(1) Every resident of the home who receives a pension, compensation, or gratuity from the United States Government, or income from any other source of more than $70 ~~$35~~ per month, shall contribute to his or her maintenance and support while a resident of the home in accordance with a schedule of payment determined by the administrator and approved by the director. The total amount of such contributions shall be to the fullest extent possible~~,~~ but~~, in no case,~~ shall not exceed the actual cost of operating and maintaining the home.

Section 5. Subsection (1) of section 296.38, Florida Statutes, is amended to read:

296.38 Funds of home and disposition of moneys.—

(1) The home shall deposit all moneys ~~which~~ it receives for care of residents from the United States Department of Veterans Affairs and residents into the Operations and Maintenance Trust Fund. All such moneys shall be expended for the purpose of supporting program operations that benefit veterans or the operation, maintenance, or construction of a ~~operating and maintaining the~~ home, subject to the requirements of chapter 216.

Section 6. Paragraph (f) of subsection (15) of section 320.02, Florida Statutes, is amended to read:

320.02 Registration required; application for registration; forms.—

(15)

(f) Notwithstanding s. 320.023, the application form for motor vehicle registration and renewal of registration must include language permitting a voluntary contribution of $1 per applicant to the state homes for veterans, to be distributed on a quarterly basis by the department to the Operations and Maintenance ~~State Homes for Veterans~~ Trust Fund within~~, which is administered by~~ the Department of Veterans' Affairs.

For the purpose of applying the service charge provided in s.

215.20, contributions received under this subsection are not income of a revenue nature.

Section 7. Paragraph (b) of subsection (4), paragraph (b) of subsection (28), paragraph (b) of subsection (38), and paragraph (b) of subsection (63) of section 320.08058, Florida Statutes, are amended to read:

320.08058 Specialty license plates.—

(4) FLORIDA SALUTES VETERANS LICENSE PLATES.—

(b) The Florida Salutes Veterans license plate annual use fee shall be distributed as follows:

1. Ten percent shall be distributed to a direct-support organization created under s. 292.055 for a period not to exceed 48 months after the date the direct-support organization is incorporated.

2. Any remaining fees must be deposited in the Operations and Maintenance ~~State Homes for Veterans~~ Trust Fund within~~, which is created in the State Treasury. All such moneys are to be administered by~~ the Department of Veterans' Affairs and must be used to support program operations that benefit veterans or the operation, maintenance, or construction of ~~solely for the purpose of constructing, operating, and maintaining~~ domiciliary and nursing homes for veterans and for continuing promotion and marketing of the license plate, subject to the requirements of chapter 216.

(28) UNITED STATES MARINE CORPS LICENSE PLATES.—

(b) The department shall distribute the United States Marine Corps license plate annual use fees as provided in this paragraph.

1. The first $50,000 collected annually shall be distributed to the Marine Corps Scholarship Foundation, Inc.

2. Any remaining fees collected annually shall be distributed as follows:

a. Thirty-five percent shall be deposited in the Operations and Maintenance ~~State Homes for Veterans~~ Trust Fund within the Department of Veterans' Affairs and must be used to support program operations that benefit veterans or the operation, maintenance, or construction of ~~solely for the purpose of constructing, operating, and maintaining~~ domiciliary and nursing homes for veterans, subject to the requirements of chapter 216.

b. Sixty-five percent shall be distributed to the Marine Corps Scholarship Foundation, Inc., which shall use all fees distributed by the department to fund scholarships and assist Marine Corps Junior ROTC and Young Marine programs of this state. The foundation shall develop a plan to distribute the funds to recipients nominated by residents of the state to receive scholarships, and to the Marine Corps Junior ROTC and Young Marine programs in the state.

(38) MILITARY SERVICES LICENSE PLATES.—

(b) The department shall retain all revenues from the sale

of such plates until all startup costs for developing and issuing the plates have been recovered. Thereafter, the annual use fee shall be deposited into the Operations and Maintenance ~~State Homes for Veterans~~ Trust Fund within the Department of Veterans' Affairs and must be used to support program operations that benefit veterans or the operation, maintenance, or construction of ~~solely to construct, operate, and maintain~~ domiciliary and nursing homes for veterans, subject to the requirements of chapter 216.

(63) SUPPORT OUR TROOPS LICENSE PLATES.—

(b) The annual use fees from the plate shall be distributed to Support Our Troops, Inc., to be used for the benefit of Florida troops and their families in accordance with its articles of incorporation. Support Our Troops, Inc., shall receive the first $60,000 of the use fees to offset startup costs for developing and establishing the plate. Thereafter, the department shall distribute the annual use fees as follows:

1. Twenty-five percent shall be distributed to Support Our Troops, Inc., to offset marketing, administration, and promotion costs.

2. Of the remaining 75 percent, 65 percent shall be distributed to Support Our Troops, Inc., and 35 percent shall be distributed to the Operations and Maintenance ~~State Homes for Veterans~~ Trust Fund within the Department of Veterans' Affairs ~~State Homes~~.

Section 8. Paragraph (b) of subsection (1) of section 320.089, Florida Statutes, is amended to read:

320.089 Veterans of the United States Armed Forces; members of National Guard; survivors of Pearl Harbor; Purple Heart medal recipients; active or retired United States Armed Forces reservists; Combat Infantry Badge, Combat Medical Badge, or Combat Action Badge recipients; Combat Action Ribbon recipients; Air Force Combat Action Medal recipients; Distinguished Flying Cross recipients; former prisoners of war; Korean War Veterans; Vietnam War Veterans; Operation Desert Shield Veterans; Operation Desert Storm Veterans; Operation Enduring Freedom Veterans; Operation Iraqi Freedom Veterans; Women Veterans; World War II Veterans; and Navy Submariners; special license plates; fee.—

(1)

(b) Notwithstanding any other provision of law to the contrary, beginning with fiscal year 2002-2003 and annually thereafter, the first $100,000 in general revenue generated from the sale of license plates issued under this section shall be deposited into the Grants and Donations Trust Fund, as described in s. 296.38(2), to be used for the purposes established by law for that trust fund. Any additional general revenue generated from the sale of such plates shall be deposited into the Operations and Maintenance ~~State Homes for Veterans~~ Trust Fund within the Department of Veterans' Affairs and used to support

program operations that benefit veterans or the operation, maintenance, or construction of ~~solely to construct, operate, and maintain~~ domiciliary and nursing homes for veterans, subject to the requirements of chapter 216.

Section 9. Subsection (6) of section 320.0891, Florida Statutes, is amended to read:

320.0891 U.S. Paratroopers license plate.—

(6) The department shall retain all annual use fee revenues from the sale of the U.S. Paratroopers license plates until all startup costs for developing and issuing the plates are recovered, not to exceed $60,000. Thereafter, the annual use fee revenues shall be distributed to the Operations and Maintenance ~~State Homes for Veterans~~ Trust Fund within the Department of Veterans' Affairs.

Section 10. Paragraph (n) of subsection (8) of section 322.08, Florida Statutes, is amended to read:

322.08 Application for license; requirements for license and identification card forms.—

(8) The application form for an original, renewal, or replacement driver license or identification card must include language permitting the following:

(n) Notwithstanding s. 322.081, a voluntary contribution of $1 per applicant to the state homes for veterans, to be distributed on a quarterly basis by the department to the Operations and Maintenance ~~State Homes for Veterans~~ Trust Fund

within~~, which is administered by~~ the Department of Veterans' Affairs.

A statement providing an explanation of the purpose of the trust funds shall also be included. For the purpose of applying the service charge provided under s. 215.20, contributions received under paragraphs (b)-(t) are not income of a revenue nature.

Section 11. This act shall take effect July 1, 2017.