Health Care Appropriations Subcommittee

Monday, January 29, 2024
3:00 PM - 6:00 PM
Morris Hall (17 HOB)

MEETING PACKET

Paul Renner
Speaker

Sam Garrison
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Care Appropriations Subcommittee

Start Date and Time: Monday, January 29, 2024 03:00 pm

End Date and Time: Monday, January 29, 2024 06:00 pm

Location: Morris Hall (17 HOB)

Duration: 3.00 hrs

Consideration of the following bill(s):

CS/HB 43 Medicaid Behavioral Health Provider Performance by Select Committee on Health Innovation, Silvers
HB 415 Pregnancy and Parenting Resources Website by Jacques
CS/HB 1271 Individuals with Disabilities by Children, Families & Seniors Subcommittee, Buchanan, Fine
HB 1441 Department of Health by Anderson
HB 1561 Office Surgeries by Busatta Cabrera
HB 1609 Pregnancy Support Services by Stevenson

To submit an electronic appearance form, and for information about attending or testifying at a committee meeting, please see the "Visiting the House" tab at www.myfloridahouse.gov.

NOTICE FINALIZED on 01/25/2024 4:03PM by EHP

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 43 Medicaid Behavioral Health Provider Performance
SPONSOR(S): Select Committee on Health Innovation, Silvers and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation	15 Y, 0 N, As CS	Lloyd	Calamas
2) Health Care Appropriations Subcommittee		Smith	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Florida has experienced a significant increase in psychiatric crisis hospitalizations of children and teens in recent years, and an increase in those children being repeatedly hospitalized in the same year. The Florida Medicaid program has a significant role in behavioral health care because it insures a disproportionate share of the children repeatedly hospitalized for behavioral health problems.

Medicaid managed care plans must meet standards set by the Agency for Health Care Administration (AHCA) for provider network adequacy; that is, for a sufficient number, type, and location of health care providers to meet the needs of a plan's enrollees. However, AHCA does not establish network adequacy standard for inpatient psychiatric care. Current law requires AHCA to test managed care plan networks for network adequacy, but does not specify how AHCA must do so. While current law requires AHCA to ensure access, current network standards and testing methods do not adequately ensure access to care.

CS/HB 43 establishes a more specific framework for Medicaid managed care network adequacy for behavioral health care services. The bill modifies the quality selection criteria for provider networks to ensure that Medicaid enrollee access to behavioral health care providers is included in future procurement processes.

For ongoing managed care plan performance, the bill requires AHCA to establish network adequacy standards for each type of behavioral health provider, including facilities, and to establish maximum wait times for appointments or admissions by each provider type. These network standards must exceed federal minimum standards. The bill also requires AHCA to be more rigorous in testing plan provider networks, by requiring AHCA to contract with an independent vendor to do this work, and to publish quarterly and annual reports on the results of network testing by plan and region.

The bill also requires AHCA to establish and enforce plan-specific, year-over-year, clinical performance goals in behavioral health. AHCA must use each plan's federal behavioral health Healthcare Effectiveness Data and Information Set (HEDIS) score in the first full year of the contract as the baseline for improvement. Similarly, the bill requires AHCA to establish behavioral health-specific metrics for plans to qualify for an achieved savings rebate.

Finally, the bill requires AHCA to report to the Legislature annually, beginning October 1, 2024, on Medicaid-enrolled children who are high-utilizers of crisis stabilization services and on plan network testing and performance data based on the measures established by AHCA under the bill. This expands and recodifies a similar report previously required by law, which ended in 2022.

AHCA must amend managed care plan contracts by January 1, 2025, to implement the bill's requirements.

The bill has an indeterminate, likely insignificant negative fiscal impact on AHCA, and no impact on local government.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments 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.

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[1] Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program.[2] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.[3]

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 (HHS) 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." Section 1115 of the Social Security Act allows states to implement demonstrations of innovative service delivery systems that improve care, increase efficiency, and reduce costs. These laws allow HHS to waive federal requirements to expand populations or services, or to try new ways of service delivery.

Florida operates under 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.[4] 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.[5]

The Florida Medicaid program covers almost 5 million low-income individuals, including approximately 2.3 million children, or almost half of the children in Florida.[6]

Medicaid Behavioral Health Services

Medicaid provides coverage for behavioral health services, including both services in the community and inpatient hospitalization. Community services include crisis stabilization, transitional day services, therapeutic behavioral on-site services, psychosocial rehabilitation, medication and medication management, behavioral health overlay services, and community supports for independent living, among other services.

[1] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[2] S. 409.905, F.S.
[3] S. 409.906, F.S.
[4] S. 409.964, F.S.
[5] *Id*.
[6] Agency for Health Care Administration, *Medicaid Eligibles Report (December 31, 2023)* available at https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-data-analytics/medicaid-eligibles-reports (last viewed January 25, 2024).

For a child to obtain covered behavioral health services, a practitioner must formally assess the child's mental health status, substance use concerns, functional capacity, strengths, and service needs, to develop a plan of care.[7]

Federal law requires state Medicaid programs to provide all medically necessary services needed by a child, under the "Early and Periodic Screening, Diagnosis and Treatment" standard established by the federal Social Security Act.[8] This applies even to services not formally covered, and to services needed beyond the scope or duration of coverage.[9]

Behavioral Health Crisis Stabilization

Crisis Stabilization Units (CSUs) are specialized public receiving facilities that receive state funding to provide services to individuals showing acute mental health disorders. CSUs screen, assess, and admit for stabilization individuals who voluntarily present themselves to the unit, as well as individuals who are brought to the unit on an involuntary basis.[10] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[11]

The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs.

Crisis stabilization services are covered by commercial health insurance, by Medicaid, and by the behavioral health safety net program for people without other coverage administered by the Department of Children and Families (DCF)[12].

Child Baker Act Data

Recent years have seen a significant increase in the number of people requiring mental health crisis stabilization – particularly children and teenagers – as indicated by the table below. The table shows indicates the significant annual increase in involuntary examination of minors between 2001 and 2017, which rose from 14,997 in 2001 to 36,078 in 2017. The rate of child examinations also rose at a much higher rate than that in the general population: a 140% increase in that time period.

[7] Agency for Health Care Administration, Community Behavioral Health Services Coverage and Limitations Handbook, March 2014, p. 2-3.
[8] Title 42 U.S.C. 1396(d).
[9] See, e.g., Agency for Health Care Administration, Behavioral Health Therapy Services Coverage Policy, Nov. 2019, p. 3.
[10] S. 394.875(1)(a), F.S. Involuntary admissions are governed by the Florida "Baker Act". For involuntary patients the receiving facility must examine the patient within 72 hours of arrival. During that 72 hours, an involuntary patient must be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility to determine if the criteria for involuntary services are met. If the patient is a minor, the examination must be initiated within 12 hours. By the end of that 72-hour examination period, one of the following must happen:

- The patient must be released;
- The patient must be released for voluntary outpatient treatment;
- The patient must consent to voluntary inpatient admission; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.

[11] *Id*.
[12] See, ch. 394 and ch. 397, F.S. DCF administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.

Fiscal Year	All Ages			Minors (< 18)		
	Involuntary Exams	% Increase to FY17/18	Rate Per 100,000	Involuntary Exams	% Increase to FY17/18	Rate Per 100,000
2017-2018	205,781	N/A	1,005	36,078	N/A	1,186
2016-2017	199,944	2.92%	992	32,763	10.12%	1,092
2015-2016	194,354	5.88%	981	32,475	11.09%	1,097
2014-2015	187,999	9.46%	964	32,650	10.50%	1,102
2013-2014	177,006	16.26%	919	30,355	18.85%	1,030
2012-2013	163,850	25.59%	859	26,808	34.58%	914
2011-2012	154,655	33.06%	818	24,836	45.26%	848
2010-2011	145,290	41.63%	773	21,752	65.86%	743
2009-2010	141,284	45.65%	754	21,128	70.76%	702
2008-2009	133,644	53.98%	711	20,258	78.09%	664
2007-2008	127,983	60.79%	685	19,705	83.09%	643
2006-2007	120,082	71.37%	661	19,238	87.54%	652
2005-2006	118,722	73.33%	668	19,019	89.69%	651
2004-2005	114,700	79.41%	660	19,065	89.24%	664
2003-2004	107,705	91.06%	634	18,286	97.30%	648
2002-2003	103,079	99.63%	620	16,845	114.18%	606
2001-2002	95,574	115.31%	586	14,997	140.57%	547

2017 DCF Task Force

In 2017, the Legislature created a task force within DCF[13] to address the issue of involuntary examination of minors age 17 years or younger, specifically by:[14]

- Analyzing data on the initiation of involuntary examinations of minors;
- Researching the root causes of and trends in such involuntary examinations;
- Identifying and evaluating options for expediting the examination process; and
- Identifying recommendations for encouraging alternatives to or eliminating inappropriate initiations of such examinations.

The task force found that specific causes of increases in involuntary examinations of children are unknown. Possible factors cited in the task force report include an increase in mental health concerns, social stressors, and a lack of availability of mental health services.[15]

As a follow up to the 2017 task force report, in 2019, the Legislature instructed DCF to prepare a report on the initiation of involuntary examinations of minors age 17 years and younger and submit it by November 1 of each odd numbered year.[16]

2019-2021 DCF Reporting

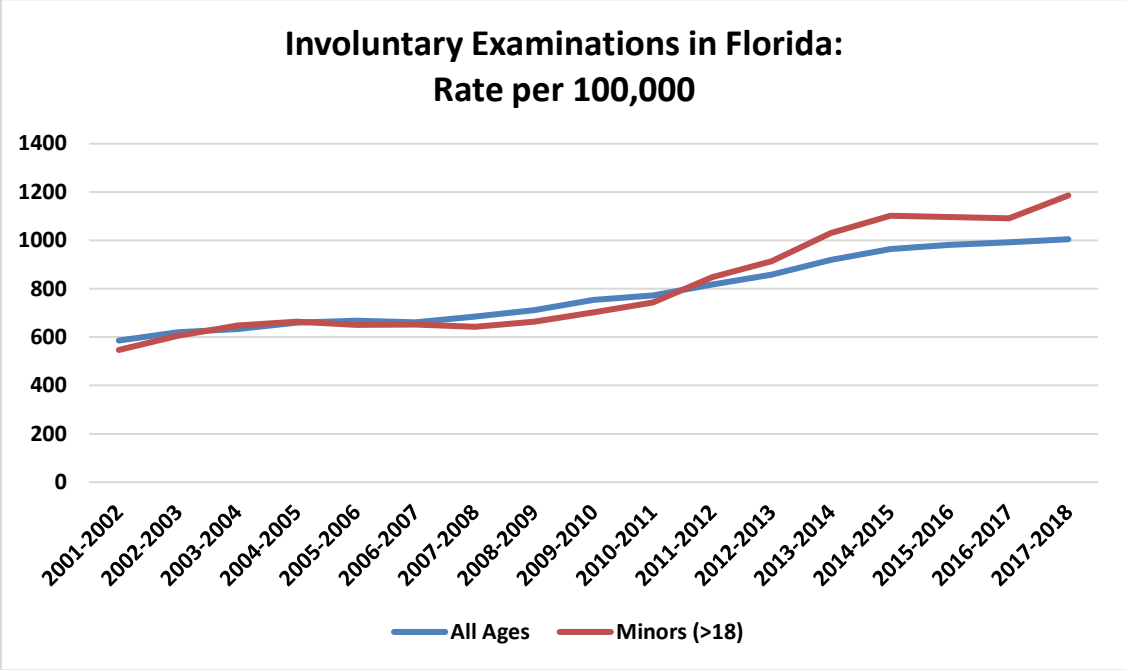
The 2019 report, revealed that some crisis stabilization units are not meeting the needs of children and adolescents with significant behavioral health needs, contributing to multiple exams.

[13] Ch. 2017-151, Laws of Florida.
[14] Florida Department of Children and Families, *Task Force Report on Involuntary Examination of Minors,* (Nov. 2017), https://www.myflfamilies.com/service-programs/samh/publications/docs/S17-005766-TASK%20FORCE%20ON%20INVOLUNTARY%20EXAMINATION%20OF%20MINORS.pdf (last viewed January 25, 2024).
[15] *Id*.
[16] Ch. 2019-134, Laws of Florida.

The 2019 report found there were 205,781 involuntary examinations in FY 2017-2018, 36,078 of which were of minors.[17] From FY 2013-2014 to FY 2017-2018, statewide involuntary examinations increased 18.85% for children. Children had a larger increase in examinations compared to young adults ages 18-24 (14.04%) and adults (12.49%). Additionally, 22.61% of minors had multiple involuntary examinations in FY 2017-2018: up to 19 involuntary examinations in a single year. DCF identified 21 minors who had more than ten involuntary examinations in FY 2017-2018, with a combined total of 285 examinations. DCF's review of medical records found:

- Most initiations were a result of minors harming themselves and were predominately initiated by law enforcement (88%);
- Many minors were involved in the child welfare system and most experienced significant family dysfunction;
- Most experienced multiple traumas such as abuse, bullying, exposure to violence, parental incarceration, and parental substance abuse and mental health issues;
- Most had behavioral disorders of childhood, such as ADHD or Oppositional Defiant Disorder, followed by mood disorders, followed by anxiety disorders;
- Most involuntary examinations were initiated at home or at a behavioral health provider; and
- Discharge planning and care coordination by the receiving facilities was not adequate enough to meet the child's needs.

The 2019 report documented the significant increase in the rate of involuntary examinations of children, from a rate (per 100,000 population) of 547 in 2001 to a rate of 1,186 in 2018.



The 2021 report made similar findings, and updated the data.[18]

[17] Florida Department of Children and Families, *Report on Involuntary Examination of Minors, 2019,* (Nov. 2019), p. 25, https://www.usf.edu/cbcs/baker-act/documents/dcfoddyearreport2019.pdf (last visited January 25, 2024).
[18] Florida Department of Children and Families, *Report on Involuntary Examination of Minors, November 2021,* Report on Involuntary Examination of Minors 2021.pdf (myflfamilies.com) (last viewed January 25, 2024).

Table 1: Minors with Repeated Involuntary Exams				
# of Involuntary Exams	Count of People	% of People	Count of Exams	% Exams
1	18,378	76.03%	18,378	51.06%
2	3,393	14.04%	6,786	18.85%
3	1,143	4.73%	3,429	9.53%
4	498	2.06%	1,992	5.53%
5	271	1.12%	1,355	3.76%
6-10	409	1.69%	2,943	8.18%
11+	**79**	**0.33%**	**1,113**	**3.09%**
Counts of exams for children with 11 or more involuntary exams during the year are grouped together to redact for cell sizes lower than 10.				

The 2021 report noted that the vast majority of children with multiple crisis examinations in a year have Medicaid coverage, which should have provided greater access to community care that would help the children avoid the need for crisis care.[19]

Child Baker Act High Utilizer Project

Following up on this work, the Legislature in 2020 required DCF and AHCA to identify children and adolescents who are the highest users of crisis stabilization and inpatient psychiatric hospitalization services, collaboratively act to meet the behavioral health needs of those children, and submit a joint quarterly report during Fiscal Years 2020-2021 and 2021-2022 to the Legislature.[20] A "high utilizer" was defined by the Department and the Agency as children or adolescents under 18 years of age with three or more admissions into a crisis stabilization unit or an inpatient psychiatric hospital within 180 days.[21]

This reporting documented the fact that the vast majority of high utilizer children are covered by Medicaid, rather than by the Department safety net program, as indicated by the table below.[22]

Children Identified as High Utilizers Jan 2022 – Jun 2022		
SOURCE	COUNT	% of TOTAL
Medicaid	550	99%
DCF only (non-Medicaid)	7	1%
TOTAL	**557**	100%

This reporting broke out the repeat child hospitalizations by Medicaid managed care plan, as indicated in the table below. Note that the plans highlighted in yellow are specialty plans, and have disproportionate numbers of children in their enrollment cohort with serious trauma (as with the Sunshine Child Welfare plan) or with serious mental illness (as with the Molina and Sunshine SMI plans). Higher rates of crisis treatment would be expected in those plans.[23]

[19] *Id.* at 11.
[20] S. 394.493(4), F.S.; Ch. 2020-107, L.O.F.
[21] Department of Children and Families and Agency for Health Care Administration, *Standards of Care in Facilities Providing Crisis Stabilization Services for Children and Adolescents, Findings and Recommendations (November 15, 2020)* available at Standards of Care in Facilities Providing Crisis Stabilization Services for Children and Adolescents (myflfamilies.com) (last viewed January 25, 2024).
[22] Department of Children and Families and Agency for Health Care Administration, Presentation to the House Subcommittee on Children, Families and Seniors, Feb. 8, 2023.
[23] *Id.*

Children < 19 Yrs. Identified as High Utilizers of CSU/ Inpatient Behavioral Health Services by Health Plan		
MMA Health Plan as of June 2022	Count of Children	High Utilizers Per 1,000 Enrollees
Aetna	2	0.02
Amerihealth	5	0.06
CCP	4	0.10
CMS Plan	49	0.57
FFS Provider	4	0.05
Humana	36	0.09
Molina	5	0.07
Molina - Serious Mental Illness*	15	3.42
Simply	34	0.08
Sunshine	142	0.14
Sunshine - Child Welfare*	129	3.33
Sunshine - Serious Mental Illness*	99	3.62
United	25	0.13
Vivida	1	0.06
Grand Total	550	0.21

AHCA reported on efforts made by the plans to improve care, including requiring managed care plans to assign the children a case manager and reaching out to parents to offer more services. According to AHCA, more than one-third of the parents contacted could not be reached or did not respond. In some instances, parents declined case management or specific service offer.[24] This may point to a need to address whole-family problems in order to assist the child.

Medicaid Provider Networks

Current law requires AHCA to establish network adequacy requirements for the managed care plans to meet when contracting with providers. Specifically, AHCA must establish standards for how many providers, the type of providers, and the regional distribution of providers are necessary for each plan to ensure access to care for the Medicaid recipients in their enrollment cohort. Each plan must establish a database of contracted providers and information about them, and publish the database online that allows Medicaid enrollees to compare provider availability to the network adequacy standards.[25]

Prior to 2020, Florida law did not expressly require the Medicaid program to test the provider networks, to confirm accuracy and compliance with the network standards.

Provider Network Testing

In 2020, the legislature required the Medicaid program to conduct (or contract for) systematic and continuous testing of the provider network databases to confirm accuracy. In addition, the legislature required more intensive network adequacy testing for the network of behavioral health providers. Section 409.967(2)(c), F.S., requires AHCA to systematically and continuously test the behavioral health network to confirm:

1. That Medicaid behavioral health providers are accepting Medicaid patients; and
2. That Medicaid enrollees have access to behavioral health services.

[24] *Id*.
[25] S. 490.967(2)(c)1., F.S.

AHCA implemented this requirement by conducting this testing in-house, as a desk review of the provider databases, or by requiring the plans to test themselves. In addition, AHCA performs periodic "secret shopper" testing by calling the provider offices and confirming[26]:

- Whether the provider's phone number and address listed in the database are correct;
- Whether the provider is available to see patients at the location listed;
- Whether the provider's staff is aware that the provider is in the plan's network; and
- Whether the provider is accepting new patients.

AHCA tests the network of behavioral health care *practitioners*; it does not test the network of inpatient or residential providers. AHCA does not establish network adequacy requirements for inpatient pediatric psychiatric beds or facilities, or assess the supply and demand for such services to determine whether there are access gaps.

This testing succeeds in identifying errors in the database and provider office confusion about participation in the plan. For example, one test of Humana practitioners in 2021 identified several providers with incorrect contact information, or which were no longer providing care at a listed location, or were no longer accepting Humana patients, or could not be reached at all.[27] A similar 2021 exercise across all plans for behavioral health practitioners identified several over 30 similar problems: provider not found, provider not at the listed location, provider does not accept new patients, and address and phone number problems.[28]

AHCA does not test how long it would take for a Medicaid enrollee to get an appointment with the practitioner, or use other methods of measuring the level of access to care. AHCA does not compile or publish reports on in its current testing results, or on trends.

Federal Network Adequacy Standards

Federal Medicaid rules require state Medicaid programs that use managed care models to develop specific quantitative standards for network adequacy, and monitor plan compliance with those standards. The federal Centers for Medicare and Medicaid Services (CMS) does not establish the specific standards for network adequacy; rather, it allows each state to develop its own guidelines and methods of measurement. However, the standards must ensure that beneficiaries have access to care,[29] and the plans must document to the state their ability to serve the anticipated enrollment before the contract begins and on an annual basis.[30]

The federal regulation does establish maximum wait times for routine appointments for primary care, obstetrics and gynecology, and outpatient mental health and substance use disorder care. Additionally, plan monitoring must include annual enrollee experience surveys for each Medicaid managed care plan, independent contractor calls to providers to verify access to appointments, and improvement plans when networks do not meet required levels.[31]

Medicaid Achieved Savings Rebates

Current law requires Medicaid managed care plans to revert any achieved savings to the state, over a certain level. However, current law establishes an achieved savings rebate whereby a plan may retain a limited amount of savings for meeting certain quality performance measures established by AHCA. Specifically, plans may retain an additional one percent of revenue if they exceed any AHCA-defined

[26] Agency for Health Care Administration, Agency Prescribed Secret Shopper Template, on file with staff of the House Subcommittee on Healthcare Regulation.
[27] Agency for Health Care Administration, Agency Prescribed Secret Shopper July 2021, on file with staff of the House Subcommittee on Healthcare Regulation.
[28] Agency for Health Care Administration, Agency Prescribed Secret Shopper, Q3 2021 Behavioral Health LDs, on file with staff of the House Subcommittee on Healthcare Regulation
[29] 42 CFR 438.68.
[30] 42 CFR 438.66.
[31] 42 CFR Part 438.

quality measure related to preventing or managing complex, chronic conditions that are associated with an elevated likelihood of requiring high-cost medical treatments.[32]

AHCA's current quality metrics for obtaining an achieved savings rebate do not specifically address behavioral health outcomes.

Effect of the Bill

CS/HB 43 enhances the statutory and contractual requirements for Medicaid managed care plans related to behavioral health care quality performance and provider network adequacy.

Medicaid Behavioral Health Provider Networks

The bill requires AHCA to establish network standards for each type of behavioral health provider serving Medicaid enrollees, including but not limiting to community-based residential providers, by October 1, 2024. Currently, AHCA does not establish adequacy standards for residential providers, pointing to a gap which the bill addresses. At a minimum, the standards must ensure timely access to care and exceed any federal requirements for behavioral health networks. For each behavioral health care provider type, AHCA must establish standards for:

- Patient to provider ratios.
- Maximum waiting times for appointments and admissions.
- Availability of innovative health care service delivery methods, such as telehealth, mobile response services, and certified community behavioral health clinics.

AHCA must amend current plan contracts by January 1, 2025, to reflect these changes.

In addition, the bill requires AHCA to contract with an independent vendor to perform systematic and continuous testing of the managed care plan network rather than only reviewing plans through desk audits, concurring with the plan attestations of provider and facility network sufficiency or accepting information as submitted through provider directories. The bill requires the vendor to produce, and AHCA to publish online, quarterly and annual reports on network performance, beginning April 1, 2025 and July 1, 2026, respectively. All reporting must be by plan and by region.

Medicaid Behavioral Health Performance Measures

The bill requires AHCA to establish specific, outcome-based, performance measures for Medicaid managed care plans.

AHCA must identify the individual HEDIS score earned by each Medicaid managed care plan during its first full contract year for each measure in the Core Set of Child and Adult Behavioral Health Indicators and notify each plan of that score. These first year HEDIS scores will serve as the plan's performance baseline. AHCA must then establish annual, plan-specific, regional performance goals, working collaboratively with the managed care plans. The performance goals must include, but are not limited to, reductions in the use of crisis stabilization services by children and adolescents, and include plan-specific targets for year-over-year improvements in outcomes for that population. In setting those performance goals, AHCA must consider each plan's population, enrollment, patient mix and clinical risk, and other factors established by AHCA.

Under the bill, managed care plans that do not meet the performance measures established by AHCA will be subject to quality improvement plans, automatic assignment suspension, and administrative and contractual sanctions determined by AHCA.

CS/HB 43 also amends the achieved savings rebate in current law to add a performance category for plans to obtain a savings rebate. AHCA must establish metrics for plans to meet in behavioral health performance, including:

[32] S. 409.967(3), F.S.

- A reduction in the incidence of crisis stabilization services for children and adolescents.
- Improvements in follow up visit rates for children and adolescents after a behavioral health related hospitalization.
- Reduction in behavioral health care related emergency room visits for children or adults.

Medicaid Behavioral Health Performance Data Reporting

The bill requires AHCA to annually report to the legislature data on children and adolescents identified as high utilizers of crisis stabilization services, the bill requires AHCA to report to the legislature annually on those numbers, and to establish specific performance goals which establish plan-specific, year-over-year improvement targets to reduce repeated use of such services and to create better outcomes for children and adolescents.

The report must also include an analysis of managed care plan contract mechanisms for enforcing or incentivizing compliance with the requirements of the bill, and data on the use of those or other mechanisms by the agency, and any other actions taken by the agency to improve behavioral health outcomes for children in Medicaid.

This provision extends and expands the high-utilizer reporting established by the legislature in 2020, which ended in 2022. The first annual report is due October 1, 2024.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.966, F.S., related to eligible plans; selection.
Section 2: Amends s. 409.967, F.S, related to managed care plan accountability.
Section 3: Creates an unnumbered section of law, related to Medicaid contract amendments.
Section 4: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill would have an indeterminate, but likely insignificant negative fiscal impact to AHCA, to contract for network adequacy testing.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Medicaid managed care plans may reallocate their Medicaid capitated payments or establish other initiatives to improve performance in behavioral health. Plans that improve performance will experience cost-avoidance savings due to fewer repeat hospitalizations of children.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to affect county or municipal governments

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rule-making authority to implement the provisions of the bill

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 22, 2024, the Select Committee on Health Innovation adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Provides greater specificity for the bill's requirement for AHCA to establish network adequacy standards for behavioral health care providers by requiring AHCA to address provider/patient ratios, maximum wait times, and availability of innovated service delivery systems.
- Requires AHCA to contract with an independent vendor to validate managed health care plan compliance with AHCA network adequacy and access standards, and publish quarterly and annual reports on findings from the independent vendor beginning April 1, 2025 and July 1, 2026, respectively.
- Requires AHCA to establish quality measure baseline scores for each managed care plan, and set annual clinical performance goals cooperatively with each managed care plan.
- Requires the performance goals to be plan-specific, show year-over-year improvements, and provides mechanisms for administrative and contractual sanctions when not achieved.
- Retains the bill's requirement for AHCA to amend managed care contracts prior to January 1, 2025 to comply with the bill.
- Retains the bill's requirement for AHCA to submit an annual report on Medicaid-enrolled children who are high utilizers of crisis stabilization.

The analysis is drafted to the committee substitute as passed by the Select Committee on Health Innovation.

A bill to be entitled

An act relating to Medicaid behavioral health provider performance; amending s. 409.966, F.S.; revising the Agency for Health Care Administration's quality selection criteria for Medicaid program provider service networks to include behavioral health providers; amending s. 409.967, F.S.; requiring the agency to establish provider network standards for behavioral health providers in the Medicaid program; revising network testing requirements; providing reporting requirements; requiring the agency to identify specified managed care plans' scores, to establish such scores as baseline indicators for the plans, and to notify the plans of their baselines for such scores; requiring the agency to establish outcome performance goals related to behavioral health care; providing that plans that do not meet specified outcome performance goals may be subject to certain sanctions; requiring the agency to submit an annual report to the Legislature; providing requirements for such reports; revising requirements for quality measures for managed care plans; requiring managed care plan contract amendments before a specified date; providing an effective date.

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

Section 1. Paragraph (a) of subsection (3) of section 409.966, Florida Statutes, is amended to read:

409.966 Eligible plans; selection.—

(3) QUALITY SELECTION CRITERIA.—

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

1. Accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body.

2. Experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations.

3. Availability and accessibility of primary care, behavioral health care, and specialty physicians in the provider network.

4. Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services.

5. Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.

6. Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

7. Evidence that an eligible plan has obtained signed contracts or written agreements or has made substantial progress in establishing relationships with providers before the plan submits a response.

8. Comments submitted in writing by any enrolled Medicaid provider relating to a specifically identified plan participating in the procurement in the same region as the submitting provider.

9. Documentation of policies and procedures for preventing fraud and abuse.

10. The business relationship an eligible plan has with any other eligible plan that responds to the invitation to negotiate.

Section 2. Paragraphs (c) and (f) of subsection (2) and paragraph (g) of subsection (3) of section 409.967, Florida Statutes, are amended, and paragraph (p) is added to subsection (2) of that section, to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) Access.—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying

the number of enrollees assigned to each primary care provider.

2. By October 1, 2024, the agency shall specifically and expressly establish network standards for each type of behavioral health provider, including, but not limited to, community-based residential providers. The standards must ensure timely access to care and exceed any federal behavioral health network requirements. At a minimum, the agency shall, for each provider type, establish standards for:

a. Patient-to-provider ratios.

b. Maximum waiting times for appointments and admissions.

c. Availability of innovative health care service delivery methods, such as telehealth, mobile response services, and certified community behavioral health clinics.

3. The agency shall ~~conduct, or~~ contract with an independent vendor for~~,~~ systematic and continuous testing of the plan provider networks ~~network databases maintained by each plan~~ to confirm accuracy, confirm that ~~behavioral health~~ providers are accepting enrollees, and confirm that enrollees have timely access to ~~behavioral health~~ services. The vendor shall, at a minimum, also test the performance of behavioral health providers under the standards established by the agency under subparagraph 2. The vendor shall produce, and the agency shall publish, online quarterly and annual reports on plan provider network performance related to behavioral health, by plan and region, beginning April 1, 2025, and July 1, 2026, respectively.

4.~~2.~~ Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

5.~~3.~~ Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

6.~~4.~~ Managed care plans serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of

information to be made available and the deadlines for submission of the data. The scope of information available to the department shall be the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and followup on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

(f) Continuous improvement.—The agency shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract.

1. Each managed care plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system must include incentives and disincentives for network providers.

2. Each managed care plan must collect and report the Healthcare Effectiveness Data and Information Set (HEDIS) measures, the federal Core Set of Children's Health Care Quality Measures, and the federal Core Set of Adult Health Care Quality Measures, as specified by the agency. Each plan must collect and report the Adult Core Set behavioral health measures beginning with data reports for the 2025 calendar year. Each plan must

stratify reported measures by age, sex, race, ethnicity, primary language, and whether the enrollee received a Social Security Administration determination of disability for purposes of Supplemental Security Income beginning with data reports for the 2026 calendar year. A plan's performance on these measures must be published on the plan's website in a manner that allows recipients to reliably compare the performance of plans. The agency shall use the measures as a tool to monitor plan performance.

a. The agency shall identify each individual HEDIS score earned by each managed care plan during the first full contract year for each measure in the Core Set of Children's and Adult behavioral health measures, and establish those scores as baseline indicators for each plan. The agency shall notify annually each plan of the plan's baseline for each HEDIS score. The agency, in consultation with each plan, shall establish regional clinical outcome performance goals for each contract year for each plan. In establishing the performance goals, the agency must take into account the plan's HEDIS baseline, population, enrollment, patient mix, clinical risk, and other factors established by the agency.

b. The agency shall establish specific outcome performance goals to reduce the incidence of crisis stabilization services for children and adolescents who are high users of such services. Performance goals must, at a minimum, establish plan-

specific, year-over-year improvement targets to reduce repeated use and ensure better behavioral health outcomes for children and adolescents.

c. A managed care plan that does not meet the behavioral health outcome performance goals established by the agency under this paragraph may be subject to quality improvement projects, automatic assignment suspension, and administrative and contractual sanctions as determined by the agency.

3. Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body, or have initiated the accreditation process, within 1 year after the contract is executed. For any plan not accredited within 18 months after executing the contract, the agency shall suspend automatic assignment under ss. 409.977 and 409.984.

(p) Annual report.—Beginning on October 1, 2024, and annually thereafter, the agency shall submit to the Legislature an annual report on Medicaid-enrolled children and adolescents who are the highest users of crisis stabilization services. The report must include demographic and geographic information; plan-specific performance data based on the performance measures in paragraph (f); plan-specific provider network testing data generated pursuant to paragraph (c), including, but not limited to, an assessment of access timeliness; and trends on reported data points beginning from the 2021-2022 fiscal year. The report

must include an analysis of relevant managed care plan contract terms and the contract enforcement mechanisms available to the agency to ensure compliance. The report must include data on enforcement or incentive actions taken by the agency to ensure compliance with network standards and progress in performance improvement, including, but not limited to, the use of the achieved savings rebate program as provided under subsection (3). The report must include a listing of other actions taken by the agency to better serve such children and adolescents.

(3) ACHIEVED SAVINGS REBATE.—

(g) A plan that exceeds agency-defined quality measures in the reporting period may retain an additional 1 percent of revenue. For the purpose of this paragraph, the quality measures must include:

1. Plan performance in ~~for~~ preventing or managing complex, chronic conditions that are associated with an elevated likelihood of requiring high-cost medical treatments.

2. Plan performance in behavioral health, including reduction in the incidence of crisis stabilization services for children and adolescents, improvement in follow-up visit rates after behavioral health-related hospitalization for children and adolescents, and reduction in behavioral health-related emergency room visits for children or adults.

Section 3. The Agency for Health Care Administration shall amend existing contracts with managed care plans to execute the

requirements of this act. Such contract amendments must be effective before January 1, 2025.

Section 4. This act shall take effect July 1, 2024.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 415 Pregnancy and Parenting Resources Website
SPONSOR(S): Jacques and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 436

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	17 Y, 0 N	Clenord	McElroy
2) Health Care Appropriations Subcommittee		Aderibigbe	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The transition to parenthood is an overwhelming life event with more than half of parents reporting feeling inadequately prepared. Florida provides numerous programs and resources to expectant and new families to assist with this transition. The Department of Health (DOH), Department of Children and Families (DCF), and the Agency for Health Care Administration (AHCA) provide information related to a variety of pregnancy and parenting resources on their respective websites. However, unlike other states such as South Dakota, Texas, and North Dakota, Florida does not currently have a comprehensive state website containing information related to available public and private pregnancy and parenting resources.

HB 415 requires DOH, in partnership with DCF and AHCA, to contract with a third-party to create a website that provides information and links to public and private pregnancy and parenting resources. The website must include, at a minimum, information on resources related to:

- Educational materials on pregnancy and parenting;
- Maternal health services;
- Prenatal and postnatal services;
- Educational and mentorship programs for fathers;
- Social services;
- Financial assistance;
- Adoption services.

The bill also requires DOH, DCF, and AHCA to include a clear and conspicuous link to the website on their respective websites. The pregnancy and parenting resources website must be functional by January 1, 2025.

The bill has a significant, negative fiscal impact on DOH and no fiscal impact on local governments.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

In 2022, there were 224,403 recorded births in Florida.[1] The transition to parenthood is an overwhelming life event with more than half of parents' report feeling inadequately prepared.[2] Florida provides a variety of resources, private and public, that can help expectant families and new parents to assist with this transition. The Department of Health (DOH), Department of Children and Families (DCF) and Agency for Health Care Administration (AHCA) provide information related to pregnancy and parenting resources on their respective websites. Florida does not currently have a comprehensive state website containing information related to available public and private pregnancy and parenting resources.

Department of Health

DOH is the designated agency for administering maternal and child health services.[3] DOH provides the following links related to pregnancy and parenting resources on its website:[4]

- After Pregnancy
- Community Involvement
- Count the Kicks
- Emergency Preparedness for Pregnant Women
- Family Health Line
- Florida Birth Defects Registry
- Florida Pregnancy Support Services Program
- Flu and Pregnancy
- Healthy Start
- High Blood Pressure and Preeclampsia
- Perinatal Hepatitis B
- Preconception Health
- Pregnancy and Diabetes
- Prenatal Care
- Safe Haven for Newborns
- Text4baby
- Tobacco Use in Pregnancy
- Umbilical Cord Blood Banking
- Zika Virus

DOH does not provide an explanation for the content of each of these topics. Instead, a user must explore each one of these items and determine if it contains the information they are seeking. This reduces ease of use and may potentially create confusion for individuals who are not familiar with pregnancy and parenting resources and programs. Additionally, the public and private resources identified in the website are generally limited to the types of services offered by DOH.

Department of Children and Families

[1] FL Health Charts, *Birth Counts Query System*, https://www.flhealthcharts.gov/FLQUERY_New/Birth/Count (last visited January 9, 2024).
[2] National Library of Medicine, *Preparing Parents for Parenthood: Protocol for a randomized controlled Trial of a Preventative Parenting Intervention for Expectant Parents*, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6064107/ (last visited Jan. 9, 2024).
[3] S. 383.011 (1), F.S.
[4] Florida Department of Health, *Pregnancy*, https://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/index.html (last visited Jan. 9, 2024).

DCF's mission is to promote strong and economically self-sufficient families and advance personal and family recovery and resiliency.[5] DCF's website provides information on resources available to pregnant women and families related to food and cash assistance, Medicaid eligibility determination and resources for people experiencing homelessness, among other programs. The public and private resources identified in the website are generally limited to the types of services offered by DCF.

Agency for Health Care Administration

AHCA is the chief health policy and planning entity for the state and is responsible for implementation of the Medicaid program.[6] AHCA's website provides resources on the Medicaid program, including reproductive services available to Medicaid recipients. This includes a list of the procedures Medicaid reimburses such as prenatal visits, testing for sexually transmitted diseases, counseling, surgical excision during pregnancy and cesarean section, among others.[7] Similar to the DOH and DCF websites, the information provided on the AHCA website is limited to the types of services and programs that AHCA offers.

States with Comprehensive Pregnancy and Parenting Resource Websites

Several states have comprehensive pregnancy and parenting resource websites. For example, South Dakota, Texas, and North Dakota have comprehensive pregnancy and parenting resources websites which vary slightly and include:

- South Dakota - pregnancy, parenting, financial assistance, and adoption.[8]
- Texas - pregnancy support, parenting and caregiving, health care and financial assistance, adoption, and services available through Texas state agencies.[9]
- North Dakota - parenting, pregnancy, finance, behavioral health, programs, and locations.[10]

Below is an example of South Dakota's comprehensive website.

[5] S. 20.19 (1), F.S.
[6] S. 20.42 (3), F.S.
[7] Florida Agency for Health Care Administration, *Reproductive Services*, Reproductive Services (myflorida.com) (last visited Jan. 8, 2024).
[8] SD Life, *Helping Mothers and their Babies Before Birth and After*, SD Life - SD Life (last visited Jan. 8, 2024).
[9] Family Resources, *Resources for Families in all Stages of Life*, https://www.familyresources.texas.gov/ (last visited Jan. 8, 2024)
[10] Life ND, *Welcome to North Dakota's Pregnancy and Parenting Website*, https://www.life.nd.gov/ (last visited Jan. 8, 2024).

Comprehensive websites make it easier for expectant and new families to access available resources.

Effect of the Bill

HB 415 requires DOH, in partnership with DCF and AHCA, to contract with a third-party to create a comprehensive website that provides information and links to public and private pregnancy and parenting resources. The website must include, at a minimum, information on resources related to:

- Educational materials on pregnancy and parenting;
- Maternal health services;
- Prenatal and postnatal services;
- Educational and mentorship programs for fathers;
- Social services;
- Financial assistance;
- Adoption services.

DOH, DCF, and AHCA must include a clear and conspicuous link to the website on their respective websites. The pregnancy and parenting resources website must be functional by January 1, 2025.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Creates s. 383.0131, F.S., relating to pregnancy and parenting resources website.
Section 2: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH estimates the total cost to comply with the bill is $466,200.[11]

Service	Cost
URL Domain Name	$300
Advance Web Designer	$261,900
Project Management	$194,000
IT Support	$10,000

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

[11] Correspondence from DOH to Health Care Regulation Subcommittee staff on file with the Health Care Regulation Subcommittee.

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill does not appear to create a need for rule-making or rule-making authority

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to a pregnancy and parenting resources website; creating s. 383.0131, F.S.; requiring the Department of Health, in consultation with the Department of Children and Families and the Agency for Health Care Administration, to maintain a website that provides information and links to certain pregnancy and parenting resources; requiring each department and the agency to provide a clear and conspicuous link to the website on their respective websites; requiring the Department of Health to contract with a third party to develop the website by a specified date; providing an effective date.

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

Section 1. Section 383.0131, Florida Statutes, is created to read:

383.0131 Pregnancy and parenting resources website.—

(1) The Department of Health, in consultation with the Department of Children and Families and the Agency for Health Care Administration, shall maintain a website, distinct from their own websites, which provides information and links to public and private resources for expectant families and new parents, which resources include, but are not limited to:

(a) Educational materials on pregnancy and parenting.

(b) Maternal health services.

(c) Prenatal and postnatal services.

(d) Educational and mentorship programs for fathers.

(e) Social services.

(f) Financial assistance.

(g) Adoption services.

(2) The Department of Health, the Department of Children and Families, and the Agency for Health Care Administration shall include a clear and conspicuous link to the website on their respective websites.

(3) The Department of Health shall contract with a third party for the development of the website, which must be operational by January 1, 2025.

Section 2. This act shall take effect July 1, 2024.

Amendment No.1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Jacques offered the following:

Amendment (with title amendment)

Between lines 39 and 40, insert:

Section 2. For the 2024-2025 fiscal year, the sum of $466,200 in nonrecurring funds from the Administrative Trust Fund is provided to the Department of Health to implement the provisions of the bill.

T I T L E A M E N D M E N T

Remove line 13 and insert:

providing an appropriation; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1271 Individuals with Disabilities
SPONSOR(S): Children, Families & Seniors Subcommittee, Buchanan
TIED BILLS: **IDEN./SIM. BILLS:** SB 1758

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	15 Y, 0 N, As CS	Lloyd	Brazzell
2) Health Care Appropriations Subcommittee		Fontaine	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Agency for Persons with Disabilities (APD) provides services to individuals with certain developmental disabilities, including through a Medicaid Home and Community-Based Services (HCBS) waiver. The HCBS waiver allows these individuals to continue to live in their own homes or in another home-like setting and avoid institutionalization. Florida's HCBS waiver for individuals with developmental disabilities is called iBudget Florida (iBudget). Waiver applications are submitted through a paper-based process and then reviewed by APD based on statutory deadlines. Most eligible individuals are initially placed on a pre-enrollment list; some can wait for years before funding is available for waiver enrollment.

Applying and being determined eligible for the iBudget waiver can be confusing and frustrating. CS/HB 1271 enhances the individual's eligibility and enrollment experience through:

- Requiring an online application process;
- Specifying the steps or documentation required to meet the definition of a "complete application";
- Requiring APD to communicate with applicants about certain application actions;
- Specifying time standards for review and action on eligibility by pre-enrollment category.

The bill increases agency efficiency and improves access to services by:

- Reprioritizing individuals whose caregivers are between 60 and 69 years old higher on the pre-enrollment list (wait list);
- Creating care navigation to assist individuals waiting for services in accessing community resources;
- Limiting APD to developing support plans only for waiver enrollees;
- Authorizing funding for enrolling on the waiver individuals in pre-enrollment categories 3-5; and
- Requiring the Agency for Health Care Administration to contract with necessary experts, in consultation with APD, for the development of a plan for a new Medicaid waiver for clients transitioning into adulthood, which APD must submit by December 1, 2024.'

The bill has a significant, negative fiscal impact on state government and no impact on local governments. The bill provides a total appropriation of $38,852,223 to APD to enroll additional clients from the pre-enrollment list.

The bill has an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Agency for Persons with Disabilities

The Agency for Persons with Disabilities (APD) provides services to certain individuals with developmental disabilities.[1] APD supports these individuals and families in living, learning, and working within their communities by creating multiple pathways to be successful through a variety of social, medical, behavioral, residential, and therapeutic services.[2]

Chapter 393, F.S., provides the authority and guidance to the APD on what programs to develop, who is eligible, and how to manage those programs within available resources. In s. 393.062, F.S., the legislative findings and declaration of intent state:

> *The greatest priority shall be given to the development and implementation of community-based services that will enable individuals with developmental disabilities to achieve their greatest potential for independent and productive living, enable them to live in their own homes or in residences located in their own communities, and permit them to be diverted or removed from unnecessary institutional placements.*

One of the ways in which services are delivered to individuals with developmental disabilities is through federal waivers, such as a Home and Community Based Services (HCBS) waiver [3]. The HCBS waiver allows these individuals to continue to live in their own homes or in another home-like setting and avoid institutionalization.[4] To qualify for this waiver, an individual must meet the standards for institutional level of care.[5]

Home and Community Based Waiver Programs

iBudget Florida Program

The APD also administers the Medicaid HCBS waiver known as iBudget Florida (iBudget) for individuals with specified developmental disabilities who also meet Medicaid eligibility requirements. [6] The iBudget waiver provides home and community-based services and supports to eligible persons with developmental disabilities living at home or in a home-like setting, with the costs shared with the federal government. The services for this waiver are delivered through a Fee-For-Service (FFS) delivery model, which means that providers are enrolled and reimbursed for services directly by the Agency for Health Care Administration (AHCA).

The iBudget program allocates available funding to clients, providing each one with an established budget with the flexibility to choose from the authorized array of services that that best meet their individual needs within their community.[7] Each client has a waiver support coordinator who assists with determining needs and coordinating providers to meet them.

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[1] S. 393.062, F.S.
[2] Agency for Persons with Disabilities, *About Us,* available at About Us | APD - Agency for Persons with Disabilities - State of Florida (myflorida.com) (last visited January 22, 2024).
[3] Medicaid.gov, *Home and Community Based Services – 1915(c),* available at https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html (last visited January 22, 2024).
[4] Rule 59G-13.080(1), F.A.C.
[5] Id.
[6] S. 392.00662, F.S.
[7] Id.

The iBudget program was phased in across the state beginning in May 2011 with the final area transitioned from the old system on July 1, 2013.[8] The iBudget program uses an algorithm or formula to set each participant's funding allocation under the waiver.[9] According to APD, over 35,000 enrolled individuals are currently receiving their services under the iBudget waiver program, and 21,000 individuals are on the pre-enrollment (wait) list for waiver services (see below).

Consumer Directed Care Plus Program

An individual who is enrolled on the iBudget waiver may choose to instead receive services through the Consumer Directed Care Plus Program, or CDC+, Program. The CDC+ Program allows individuals greater flexibility in the selection of providers and types of services and supports that may be purchased using the individual's budget. For instance, under CDC+, an individual and his or her family can directly hire personal caregivers instead of using a Medicaid-enrolled provider. As in the waiver, a support coordinator assists the individual and their families in identifying appropriate services and supports and making those selections through the system, though under CDC+, this individual is known as a consultant and has a more limited role.[10]

Program Eligibility

To receive services from APD, an individual must be found eligible through a paper application submission process. Information from the paper application is manually keyed into an electronic client data management system and reviewed both for eligibility based on information on the application and to identify if any additional information is needed. The APD determines eligibility based on Florida statutes and rules.

To be eligible, an individual must:

- Demonstrate evidence that one of the following developmental diagnoses manifested itself before the age of 18 and can reasonably be expected to continue indefinitely:
    - Intellectual disability.
    - Spina Bifida.
    - Cerebral palsy.
    - Autism.
    - Down syndrome.
    - Phelan McDermid syndrome.
    - Prader-Willi syndrome. [11]
- Be domiciled in Florida;[12] and
- Be at least three years of age.[13]

The APD must review an application within 60 days depending on individual circumstances and the documentation received.[14] Additional time to work with the applicant may be needed, for example, to conduct a comprehensive assessment to determine if the individual meets the clinical eligibility requirements.

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[8] The Agency for Persons with Disabilities, *Quarterly Report on Agency Services to Floridians with Developmental Disabilities and their Costs: First Quarter Fiscal Year 2022-23,* p.2, November 15, 2022, available at https://apd.myflorida.com/publications/reports/ (last visited January 22, 2024).
[9] Id.
[10] A support coordinator is defined in s. 393.063(37), F.S. Further responsibilities are also included in the Agency for Health Care Administration, *Consumer Directed Care Plus Program Coverage, Limitations, and Reimbursement Handbook (October 2015),* available at https://apd.myflorida.com/cdcplus/docs/CDC_Plus_Program_Handbook_2015.pdf (last visited January 22, 2024).
[11] S. 393.063(11), F.S. and 393.065, F.S.
[12] S. 393.063(13), F.S. and 393.065, F.S.
[13] *Supra,* note 2.
[14] S. 393.065(1), F.S.

For an applicant deemed in crisis, APD must expedite the application review to within 45 days.[15] If additional documentation is needed, APD may pend the application until that information is provided which would toll the clock until the information was provided by the applicant. Eligible individuals are either enrolled in the program (provided a slot) or placed on the pre-enrollment list if the demand exceeds the available funding.[16]

The APD assigns each waitlisted client to a pre-enrollment category based on their needs and prioritized in the following decreasing order of priority:[17]

- Category 1: Clients deemed to be in crisis.
- Category 2: Children in the child welfare system at the time of permanency or turning 18.
- Category 3: Intensive Needs
- Category 4 : Caregiver over the age of 70
- Category 5: Transition from School
- Category 6: Age 21 and Over
- Category 7: Age under 21

Eligible individuals that meet the criteria for Categories 1 or 2 are directly enrolled onto the iBudget waiver. Currently, there is a higher demand for iBudget services than the funding available, which means individuals who require services are put on the pre-enrollment list based on the categorization of their needs.

As of December 2023, as the table shows below, over 21,000 individuals were waiting for services, with approximately 50 percent of those between 25 through 59 years old.[18]

iBudget Pre-Enrollment List December 2023[19]		
Category	**Description**	**Total Clients**
Category 1	Crisis	0
Category 2	Children in welfare system at the time of permanency or turning 18	0
Category 3	Intensive Needs	210
Category 4	Caregiver over age 70	83
Category 5	Transition from School	20
Category 6	Age 21 and Over	12,809
Category 7	Age under 21	8,464
	Grand Total:	**21,587**

For each client in a pre-enrollment category, APD develops a support plan and sends an annual status letter. During this annual check-in, APD verifies contact information, provides resources information, and also provides the family an opportunity to indicate if there are any new unmet needs or other changes that may impact the individual's eligibility.[20] The APD has recently begun providing care navigation to these clients, using positions that were repurposed for that effort.

When an individual is deemed eligible for services, the APD is required to consult with the client, if the client is competent, if not then the client's parent or guardian to devise a support plan. For children ages 3 to 18 and other individuals, the support plan must include the most appropriate, the least

[15] Id.
[16] Rule 65G-1.047, F.A.C. The rule provides that the severity of the crisis is determined by the risk to the health, safety, and welfare of each applicant relative to other applicant. Rule 65G-11.004 provides a procedure for determining if a client is considered to be in crisis.
[17] *Supra,* note 12.
[18] Id.
[19] *Supra,* note 12.
[20] Id.

restrictive, and most cost beneficial environment for the individual's progress, and have the appropriate specification for the services authorized.[21]

Effect of the Bill

Care Navigators

CS/HB 1271 authorizes the APD to offer clients and their caregivers care navigation services within available resources at the time of application and as part of any eligibility or renewal review. A care navigator would assist the client and the client's family with navigating the systems and accessing services, supports, and available resources to meet an individual non-waiver enrolled client's needs, as well as identifying and addressing any barriers preventing individuals from accomplishing their goals. The care navigator would also connect individuals to supports and services in a timely manner and address immediate or critical needs to stabilize the individual seeking assistance before the individual reaches a crisis point.

Under s. 393.064, F.S., a care navigator would be involved in activities such as assessing client needs, developing care plans, and connecting individuals to resources that address the individual's immediate, intermediate, and long-term needs, goals leading to increased opportunities in education, employment, social engagement, community integration, and caregiver support.

For an individual who is also a public school student, the student's Individuals with Disabilities Education Act (I.D.E.A.) plan, as amended, would also be incorporated into the care plan.

Online Application

CS/HB 1271 modernizes the application and eligibility processes at APD to incorporate a requirement for an online application, identify the federal time standards for eligibility review and processing, specify the steps for a complete application, and provide specificity for eligibility determination time standards.

With only a paper application currently available, CS/HB 1271 requires APD to develop and implement an online application process and system that meets certain minimum requirements, including the directive to:

- Create and maintain a paperless, electronic application.
- Maintain access to a printable, paper application on the APD website.
- Provide paper applications upon request.
- Designate a central or regional address for submission of paper applications via regular U.S. mail or via confidential fax.
- Provide immediate confirmation of receipt in the same manner as application was submitted, unless the applicant has designated otherwise.

For those individuals seeking enrollment in the HCBS waiver program who identify as being in crisis, the APD must make an eligibility determination in an expedited manner of 15 calendar days after receipt of a completed application. To be considered a completed application, the application must:

- Include a signature and date by the applicant or someone with legal authority to apply for public benefits on behalf of the applicant.
- Be responsive on all parts of the application.
- Contain documentation of a diagnosis.

For individuals with developmental disabilities who meet the criteria in s. 393.065(5)(b), F.S., which are children who are in the child welfare system (Category 2 on the pre-enrollment list), the APD must make eligibility determinations as soon as practicable. For the remaining categories under s. 393.065, F.S., CS/HB 1271 requires an eligibility determination standard of 60 days after receipt of a complete application. The APD may toll the clock on the 60 day time period if documentation is missing; however,

[21] S. 393.0651, F.S.

APD must convey this delay to the client verbally as soon as the action is taken and follow up with a written confirmation which details the anticipated length of the delay and a contact person for the client to reach should he or she have questions.

The bill amends the individual support plan requirement in s. 393.0651, F.S., to limit that requirement to only individuals served by the current iBudget waiver. CS/HB 1271 adds a time standard of 60 calendar days after an APD eligibility determination for the development of the individual support plan and a requirement that the waiver support coordinator specifically inform the client, the client's parent or guardian about the CDC+ program. This will ensure that individuals eligible for CBC+ are informed about the opportunity.

Category 4 Expansion

The Category 4 pre-enrollment category is also modified. Instead of this category including those individuals whose caregivers are aged 70 of age or older, and for whom a caregiver is required but no alternate caregiver is available, CS/HB 1271 reduces the qualifying age in the category for the caregiver to 60 years old. This will make more individuals eligible in a higher priority category, likely moving from category 6 up to category 5, and providing help to caregivers sooner.

Waiver Study

The AHCA, APD, and other stakeholders are directed to work together to jointly develop a comprehensive plan for the administration, finance, and delivery of a new HCBS Medicaid waiver program focused on successfully transitioning clients into adulthood and proactively preventing crisis situations. The AHCA is authorized to contract with the necessary experts, in consultation with APD, to develop the plan. APD; however, is responsible for the submission of the final report, in consultation with AHCA, to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2024. The report must specifically address, at a minimum:

- The purpose, rationale, and expected benefits of the new waiver program.
- The proposed eligibility criteria for clients and the service benefit package to be offered through the waiver.
- A proposed implementation plan and timeline, including the recommended number of clients to be served at implementation and at different program intervals.
- Proposals for how clients may transition off and on the program and between other designated waiver programs.
- The fiscal impact of the program for the implementation year and over the next five fiscal years, determined on an actuarially sound basis.
- An analysis of the availability of the services that would be offered under the waiver program and recommendations for how to increase access, if necessary.
- A list of participating stakeholders, public and private, involved in or consulted about the proposed waiver program.

The effective date of the bill is July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 393.064; F.S.; Care navigation.
Section 2: Amends s. 393.065, F.S.; Application and eligibility determination.
Section 3: Amends s. 393.0651, F.S.; Family or individual support plan.
Section 4: Provides an appropriation.
Section 5: Creates an unnumbered section of law, related to a report.
Section 6: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill appropriates a recurring total of $38,852,223 ($16,333,475 from the General Revenue Fund and $22,518,748 the Operations and Maintenance Trust Fund) to expand HCBS waiver services to additional clients. This funding is expected to offer waiver services to individuals from pre-enrollment categories 3, 4, and 5.

The bill requires the agency to implement an electronic application process. The agency indicates a cost of between $1,750,000 to $1,850,000 to develop the system, based upon the level of sophistication desired. Total implementation may take longer than a year.[22] Based on a review of historical reversions, the agency has sufficient existing resources to begin system development during FY 2024-25. APD can submit a Legislative Budget Request for the following year to request the additional resources needed to complete the system and for recurring maintenance needs.

The bill requires APD to collaborate with AHCA and other stakeholders to develop a plan for the administration, finance, and delivery of a new HCBS Medicaid waiver. The new program will transition clients into adulthood by offering services to prevent crisis situations. The House proposed General Appropriations Act for FY 2024-25 provides $800,000 for actuarial services to determine appropriate capitation rates for the newly-created program.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

The bill does not appear to affect local governments.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Those individuals enrolled on the waiver under the bill will receive additional supports and services. The number of individuals who will be enrolled on the waiver under the bill is unknown, as under the iBudget waiver the specific budget for each individual is determined after enrollment.

Providers of services to these individuals will have increased revenue.

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:

[22] *Supra,* Note 12.

None.

B. RULE-MAKING AUTHORITY:

The Agency for Persons with Disabilities has sufficient rule-making authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 24, 2024, the Children, Families, and Seniors Subcommittee adopted two amendments and reported the bill favorably as a committee substitute. The amendments:

- Define the term “complete application,” which means an application that:
  - Has been signed and dated,
  - Is responsive on all parts, and
  - Contains documentation of a diagnosis.

- Identify the Agency for Persons with Disabilities (APD) as responsible for the report on the waiver study, and require the Agency for Health Care Administration (AHCA) to consult APD when hiring any experts to assist with the study.

The 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 individuals with disabilities; amending s. 393.064, F.S.; requiring the Agency for Persons with Disabilities to offer voluntary participation care navigation services to certain persons under certain circumstances; providing goals and requirements for care navigation services; amending s. 393.065, F.S.; requiring the agency to develop and implement an electronic application process; requiring the agency to maintain a printable paper application on its website and, upon request, provide a printed paper application to an applicant; requiring the agency to provide applicants with specified information upon receipt of an application for services; defining the term "complete application"; revising timeframes within which the agency must make eligibility determinations for services; lowering the age that a caregiver must be for an individual to be placed in a certain preenrollment category; amending s. 393.0651, F.S.; requiring the agency to provide an individual support plan for each client served by the home and community-based services Medicaid waiver program; providing appropriations; requiring the Agency for Persons with Disabilities, in consultation with Agency for Health

Care Administration, to jointly develop a comprehensive plan for the administration, finance, and delivery of home and community-based services through a new home and community-based services Medicaid waiver program; providing requirements for the waiver program; requiring the Agency for Health Care Administration to submit a specified report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by a specified date; providing an effective date.

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

Section 1. Subsection (1) of section 393.064, Florida Statutes, is amended to read:

393.064 Care navigation ~~Prevention~~.—

(1) Within available resources, the agency must offer to clients and their caregivers, care navigation services for voluntary participation at time of application and as part of any eligibility or renewal review. The goals of care navigation are to create a seamless network of community resources and supports for the client and the client's family as a whole to support a client in daily living, community integration, and achievement of individual goals. Care navigation services shall involve assessing client needs, developing care plans, and

implementing care plans, including, but not limited to, connecting a client to resources and supports. At a minimum, a care plan shall address immediate, intermediate, and long term needs and goals to promote and increase well-being and opportunities for education, employment, social engagement, community integration, and caregiver support. For a client who is a public school student entitled to a free appropriate public education under the Individuals with Disabilities Education Act, I.D.E.A., as amended, the care plan shall be integrated with the student's individual education plan (IEP). The care plan and IEP must be implemented to maximize the attainment of educational and habilitation goals ~~shall give priority to the development, planning, and implementation of programs which have the potential to prevent, correct, cure, or reduce the severity of developmental disabilities. The agency shall direct an interagency and interprogram effort for the continued development of a prevention plan and program. The agency shall identify, through demonstration projects, through program evaluation, and through monitoring of programs and projects conducted outside of the agency, any medical, social, economic, or educational methods, techniques, or procedures that have the potential to effectively ameliorate, correct, or cure developmental disabilities. The agency shall determine the costs and benefits that would be associated with such prevention efforts and shall implement, or recommend the implementation of,~~

~~those methods, techniques, or procedures which are found likely to be cost-beneficial~~.

Section 2. Subsection (1) and paragraph (d) of subsection (5) of section 393.065, Florida Statutes, are amended to read:

393.065 Application and eligibility determination.—

(1)(a) The agency shall develop and implement an online application process that, at a minimum, supports paperless electronic application submissions with immediate e-mail confirmation to each applicant to acknowledge receipt of application upon submission.

(b) The agency shall maintain access to a printable paper application on its website and, upon request, must provide an applicant with a printed paper application. Paper applications may ~~Application for services shall~~ be submitted ~~made~~ in writing to the agency, in the region in which the applicant resides, sent to a central or regional address via regular United States mail, or faxed to a central or regional confidential fax number. All applications, regardless of manner of submission, must be acknowledged as received, with an immediate receipt confirmation in the same manner as the application had been received unless the applicant has designated an alternative, preferred communication method on the submitted application.

(c) The agency must ~~shall~~ review each submitted application in accordance with federal time standards. ~~and make an eligibility determination within 60 days after receipt of the~~

~~signed application. If, at the time of the application, an applicant is requesting enrollment in the home and community-based services Medicaid waiver program for individuals with developmental disabilities deemed to be in crisis, as described in paragraph (5)(a), the agency shall complete an eligibility determination within 45 days after receipt of the signed application.~~

1.~~(a)~~ If the agency determines additional documentation is necessary to make an eligibility determination, the agency may request the additional documentation from the applicant.

2.~~(b)~~ When necessary to definitively identify individual conditions or needs, the agency or its designee must provide a comprehensive assessment.

~~(c) If the agency requests additional documentation from the applicant or provides or arranges for a comprehensive assessment, the agency's eligibility determination must be completed within 90 days after receipt of the signed application.~~

(d)1. For purposes of this paragraph, the term "complete application" means an application submitted to the agency which is signed and dated by the applicant or an individual with legal authority to apply for public benefits on behalf of the applicant, is responsive on all parts of the application, and contains documentation of a diagnosis.

2. If the applicant requesting enrollment in the home and

community-based services Medicaid waiver program for individuals with developmental disabilities is deemed to be in crisis as described in paragraph (5)(a), the agency must make an eligibility determination within 15 calendar days after receipt of a complete application.

3. If the applicant meets the criteria specified in paragraph (5)(b), the agency must review and make an eligibility determination as soon as practicable after receipt of a complete application.

4. If the application meets the criteria specified in paragraphs (5)(c)-(g), the agency shall make an eligibility determination within 60 days after receipt of a complete application. Any delays in the eligibility determination process or any tolling of the time standard until certain information or actions have been completed, must be conveyed to the client as soon as such delays are known with a verbal contact to the client or the client's designated caregiver and confirmed by a written notice of the delay, the anticipated length of delay, and a contact person for the client.

(5) Except as provided in subsections (6) and (7), if a client seeking enrollment in the developmental disabilities home and community-based services Medicaid waiver program meets the level of care requirement for an intermediate care facility for individuals with intellectual disabilities pursuant to 42 C.F.R. ss. 435.217(b)(1) and 440.150, the agency must assign the client

to an appropriate preenrollment category pursuant to this subsection and must provide priority to clients waiting for waiver services in the following order:

(d) Category 4, which includes, but is not required to be limited to, clients whose caregivers are 60 ~~70~~ years of age or older and for whom a caregiver is required but no alternate caregiver is available.

Within preenrollment categories 3, 4, 5, 6, and 7, the agency shall prioritize clients in the order of the date that the client is determined eligible for waiver services.

Section 3. Section 393.0651, Florida Statutes, is amended to read:

393.0651 Family or individual support plan.—The agency shall provide directly or contract for the development of a family support plan for children ages 3 to 18 years of age and an individual support plan for each client served by the home and community-based services Medicaid waiver program under s. 393.0662. The client, if competent, the client's parent or guardian, or, when appropriate, the client advocate, shall be consulted in the development of the plan and shall receive a copy of the plan. Each plan must include the most appropriate, least restrictive, and most cost-beneficial environment for accomplishment of the objectives for client progress and a specification of all services authorized. The plan must include

provisions for the most appropriate level of care for the client. Within the specification of needs and services for each client, when residential care is necessary, the agency shall move toward placement of clients in residential facilities based within the client's community. The ultimate goal of each plan, whenever possible, shall be to enable the client to live a dignified life in the least restrictive setting, be that in the home or in the community. The family or individual support plan must be developed within 60 calendar days after the agency determines the client eligible pursuant to s. 393.065(3). When developing or reviewing the support plan, the waiver support coordinator must inform the client, the client's parent or guardian, or, when appropriate, the client advocate about the consumer-directed care program under s. 409.221.

(1) The agency shall develop and specify by rule the core components of support plans.

(2) The family or individual support plan shall be integrated with the individual education plan (IEP) for all clients who are public school students entitled to a free appropriate public education under the Individuals with Disabilities Education Act, I.D.E.A., as amended. The family or individual support plan and IEP must be implemented to maximize the attainment of educational and habilitation goals.

(a) If the IEP for a student enrolled in a public school program indicates placement in a public or private residential

program is necessary to provide special education and related services to a client, the local education agency must provide for the costs of that service in accordance with the requirements of the Individuals with Disabilities Education Act, I.D.E.A., as amended. This does not preclude local education agencies and the agency from sharing the residential service costs of students who are clients and require residential placement.

(b) For clients who are entering or exiting the school system, an interdepartmental staffing team composed of representatives of the agency and the local school system shall develop a written transitional living and training plan with the participation of the client or with the parent or guardian of the client, or the client advocate, as appropriate.

(3) Each family or individual support plan shall be facilitated through case management designed solely to advance the individual needs of the client.

(4) In the development of the family or individual support plan, a client advocate may be appointed by the support planning team for a client who is a minor or for a client who is not capable of express and informed consent when:

(a) The parent or guardian cannot be identified;

(b) The whereabouts of the parent or guardian cannot be discovered; or

(c) The state is the only legal representative of the

client.

Such appointment may not be construed to extend the powers of the client advocate to include any of those powers delegated by law to a legal guardian.

(5) The agency shall place a client in the most appropriate and least restrictive, and cost-beneficial, residential facility according to his or her individual support plan. The client, if competent, the client's parent or guardian, or, when appropriate, the client advocate, and the administrator of the facility to which placement is proposed shall be consulted in determining the appropriate placement for the client. Considerations for placement shall be made in the following order:

(a) Client's own home or the home of a family member or direct service provider.

(b) Foster care facility.

(c) Group home facility.

(d) Intermediate care facility for the developmentally disabled.

(e) Other facilities licensed by the agency which offer special programs for people with developmental disabilities.

(f) Developmental disabilities center.

(6) In developing a client's annual family or individual support plan, the individual or family with the assistance of

the support planning team shall identify measurable objectives for client progress and shall specify a time period expected for achievement of each objective.

(7) The individual, family, and support coordinator shall review progress in achieving the objectives specified in each client's family or individual support plan, and shall revise the plan annually, following consultation with the client, if competent, or with the parent or guardian of the client, or, when appropriate, the client advocate. The agency or designated contractor shall annually report in writing to the client, if competent, or to the parent or guardian of the client, or to the client advocate, when appropriate, with respect to the client's habilitative and medical progress.

(8) Any client, or any parent of a minor client, or guardian, authorized guardian advocate, or client advocate for a client, who is substantially affected by the client's initial family or individual support plan, or the annual review thereof, shall have the right to file a notice to challenge the decision pursuant to ss. 120.569 and 120.57. Notice of such right to appeal shall be included in all support plans provided by the agency.

Section 4. For the 2024-2025 fiscal year, the sums of $16,333,475 in recurring funds from the General Revenue Fund and $22,518,748 in recurring funds from the Operations and Maintenance Trust Fund are appropriated in the Home and

Community Based Services Waiver category to the Agency for Persons with Disabilities to offer waiver services to the greatest number of individuals permissible under the appropriation from preenrollment categories 3, 4, and 5, including individuals whose caregiver is age 60 or older in category 4, established in s. 393.065, Florida Statutes, as amended by this act. For the 2024-2025 fiscal year, the sum of $38,852,223 in recurring funds from the Medical Care Trust Fund is appropriated in the Home and Community Based Services Waiver category to the Agency for Health Care Administration to establish budget authority for Medicaid services.

Section 5. The Agency for Health Care Administration and the Agency for Persons with Disabilities, in consultation with other stakeholders, shall jointly develop a comprehensive plan for the administration, finance, and delivery of home and community-based services through a new home and community-based services Medicaid waiver program. The waiver program shall be for clients transitioning into adulthood and shall be designed to prevent future crisis enrollment into the waiver authorized under s. 393.0662, Florida Statutes. The Agency for Health Care Administration is authorized to contract with necessary experts, in consultation with the Agency for Persons with Disabilities, to assist in developing the plan. The Agency for Persons with Disabilities, in consultation with the Agency for Health Care Administration, must submit a report to the Governor, the

President of the Senate, and the Speaker of the House of Representatives by December 1, 2024, addressing, at a minimum, all of the following:

(1) The purpose, rationale, and expected benefits of the new waiver program.

(2) The proposed eligibility criteria for clients and service benefit package to be offered through the waiver program.

(3) A proposed implementation plan and timeline, including recommendations for number of clients served by the waiver program at initial implementation, changes over time, and any per-client benefit caps.

(4) Proposals for how clients will transition onto and off of the waiver, including, but not limited to, transitions between this waiver and the waiver established under s. 393.0662, Florida Statutes.

(5) The fiscal impact for the implementation year and projections for the next 5 years, determined on an actuarially-sound basis.

(6) An analysis of the availability of services that would be offered under the waiver program and recommendations to increase availability of such services, if necessary.

(7) A list of all stakeholders, public and private, who were consulted or contacted as part of the waiver program.

Section 6. This act shall take effect July 1, 2024.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	___ (Y/N)
ADOPTED AS AMENDED	___ (Y/N)
ADOPTED W/O OBJECTION	___ (Y/N)
FAILED TO ADOPT	___ (Y/N)
WITHDRAWN	___ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Buchanan offered the following:

Amendment

Remove lines 272-286 and insert:

Section 4. For the 2024-2025 fiscal year, the sums of $16,562,703 in recurring funds from the General Revenue Fund and $22,289,520 in recurring funds from the Operations and Maintenance Trust Fund are appropriated in the Home and Community Based Services Waiver category to the Agency for Persons with Disabilities to offer waiver services to the greatest number of individuals permissible under the appropriation from preenrollment categories 3, 4, and 5, including individuals whose caregiver is age 60 or older in

category 4, established in s. 393.065, Florida Statutes, as amended by this act.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1441 Department of Health
SPONSOR(S): Anderson
TIED BILLS: **IDEN./SIM. BILLS:** SB 1582

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	19 Y, 0 N	Osborne	McElroy
2) Health Care Appropriations Subcommittee		Aderibigbe	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 1441 makes changes to several programs administered under the Department of Health (DOH).

Environmental health professionals (EHPs) are certified by DOH to perform evaluations of environmental or sanitary conditions in two environmental health program areas: food hygiene and onsite sewage treatment and disposal. The bill creates an environmental health technician certification for candidates to work under the supervision of a certified EHP.

The Legislature established the Rare Disease Advisory Council (RDAC) in 2021 to assist DOH in providing recommendations to improve health outcomes for individuals with rare diseases residing in the state. In the United States, a rare disease is any condition that nationally affects fewer than 200,000 people. There may be as many as 7,000 rare diseases impacting the lives of 25-30 million Americans and their families. The bill creates the Andrew John Anderson Pediatric Rare Disease Grant Program within DOH with the purpose of advancing the progress of research and cures for rare pediatric diseases through the award of grants by a competitive, peer-reviewed process. Grants shall be awarded by DOH, after consultation with the RDAC.

Sickle cell disease is a rare disease affecting approximately 100,000 Americans. In 2023, the Legislature directed DOH to partner with a community-based sickle cell disease medical treatment and research center to establish and maintain a registry to track outcome measures of newborns who are identified as carrying a sickle cell hemoglobin variant. The bill revises certain requirements for the registry related to who may be included in the registry, and the process by which parents can opt their newborns out of the registry.

The Florida Newborn Screening Program (NSP) promotes the screening of all newborns for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect. The NSP also promotes the identification and screening of all newborns in the state and their families for environmental risk factors. The bill revises the certain aspects of the NSP to specify the responsibilities of relevant health care practitioners and repeal obsolete provisions.

Newborns are also required to undergo hearing screening before they are discharged from the hospital. The bill standardizes hearing screening practices for newborns born in licensed birth facilities and requires screening results for children up to 36 months of age be reported to DOH.

In 2021, the Legislature created the Telehealth Minority Maternity Care Pilot Program in Duval and Orange counties to increase positive maternal health outcomes in racial and ethnic minority populations. The bill authorizes DOH to expand the program to other counties dependent upon available funding.

The bill has an insignificant, negative fiscal impact on DOH, which current resources are adequate to absorb. The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Environmental Health Professionals

Current Situation

Environmental health professionals (EHPs) are certified by the Department of Health (DOH) to perform evaluations of environmental or sanitary conditions in two environmental health program areas: food hygiene and onsite sewage treatment and disposal.[1]

DOH currently employs 448 certified EHPs, most of which are housed in county health departments to perform health evaluations at public food establishments and sanitary evaluations on private and business properties where onsite wastewater treatment and disposal systems are in use.[2]

EHPs must be certified by DOH to perform evaluations of environmental or sanitary conditions in food hygiene or onsite sewage treatment and disposal. Current law requires an EHP to have graduated from an accredited four-year college or university with a degree or major coursework in public health, environmental health, environmental science, or a physical or biological science to be certified.[3] According to DOH, county health departments are experiencing a shortage of qualified applicants to the food hygiene and onsite sewage treatment and disposal programs due to the requirement for a four-year degree.[4]

In 2020, the Legislature transferred the Onsite Sewage Program from DOH to the Department of Environmental Protection (DEP). In establishing the transfer, the Legislature also required that the agencies enter into an interagency agreement for a period of no less than five years in order to coordinate the logistics relating to collaboration with the county health departments and the transfer or shared use of buildings or facilities owned by DOH.[5]

Effect of Proposed Changes – Environmental Health Professionals

The bill creates a certification for environmental health technicians who will be authorized to conduct septic tank inspections under the supervision of an environmental health professional who is certified in onsite sewage treatment and disposal.

The bill directs DOH, in conjunction with DEP, to adopt rules to establish standards for environmental health technicians, as well as, relevant administrative processes. To obtain and maintain certification as an environmental health technician, one must:

- Be certified by examination to be knowledgeable in the area of onsite sewage treatment and disposal;
- Have a high school diploma, or its equivalent;
- Be employed by a department as defined in s. 20.03;
- Complete supervised field inspection work as prescribed by rule before examination;
- Renew certification biennially by completing at least 24 contact hours of continuing education; and
- Notify the department within 60 days after any change of name or address.

[1] S. 381.0101(4), F.S.
[2] This excludes establishments licensed under Ch. 509, F.S., which operate under separate standards. *See*, Department of Health, *Agency Analysis of HB 1441* (2024). On file with the Healthcare Regulation Subcommittee.
[3] S. 381.0101(4)(e), F.S.
[4] *Supra*, note 2.
[5] Ch. 2020-150, L.O.F.

Rare Diseases

Current Situation

In the United States, a rare disease is any condition that nationally affects fewer than 200,000 people. There may be as many as 7,000 rare diseases impacting the lives of 25-30 million Americans and their families.[6] So, while the individual diseases may be rare, the total number of people impacted by a rare disease is large.

Rare diseases include genetic disorders, infectious diseases, cancers, and various other pediatric and adult conditions. A rare disease can affect anyone at any point in their life, and can be acute or chronic. It is estimated that 80 percent or more of rare diseases are genetic. For genetic rare diseases, genetic testing is often the only way to make a definitive diagnosis. Rare diseases present a fundamentally different array of challenges compared to those of more common diseases; often patients are set on a "diagnostic odyssey," in order to determine the cause of their symptoms as they seek treatment in health care settings where their condition may have never been seen before.[7]

In 2023, the Legislature allocated $500,000 in General Revenue funds in the General Appropriations Act for pediatric rare disease research grants.[8]

Rare Disease Advisory Council

The Legislature established the Rare Disease Advisory Council (RDAC) in 2021 to assist DOH in providing recommendations to improve health outcomes for individuals with rare diseases residing in the state.[9]

The establishment of RDACs across the country is an initiative spearheaded by the National Organization for Rare Disorders (NORD),[10] a national nonprofit group advocating for individuals and families affected by rare diseases.[11] Florida was the 19th state to establish a RDAC through legislation.[12]

Florida's RDAC is directed to:[13]

- Consult with experts on rare diseases and solicit public comment to assist in developing recommendations on improving the treatment of rare diseases in Florida;
- Develop recommended strategies for academic research institutions in Florida to facilitate continued research on rare diseases;
- Develop recommended strategies for health care providers to be informed on how to more efficiently recognize and diagnose rare diseases in order to effectively treat patients; and
- Provide input and feedback in writing to DOH, the Medicaid program, and other state agencies on matters that affect people who have been diagnosed with rare diseases.

Rare Disease Registries – Sickle Cell Disease

[6] National Organization for Rare Diseases, *Rare Disease Day: Frequently Asked Questions*. Available at https://rarediseases.org/wp-content/uploads/2019/01/RDD-FAQ-2019.pdf (last visited January 19, 2024).
[7] Department of Health, *Rare Disease Advisory Council: Legislative Report, Fiscal Year 2022-2023* (2023). Available at https://www.floridahealth.gov/provider-and-partner-resources/rdac/_documents/RDACLegislativeReport2023Final_Draft.pdf (last visited January 20, 2024).
[8] Ch. 2023-239, L.O.F., line item 539A; *See also*, Department of Health, *Agency Analysis of HB 1441* (2024). On file with the Healthcare Regulation Subcommittee.
[9] S. 381.99, F.S.
[10] National Organization for Rare Disorders (NORD). *Project RDAC Year One* (2021). Available at https://rarediseases.org/wp-content/uploads/2021/11/NRD-2200-RDAC-Year1-Highlights_FNL.pdf (last visited January 20, 2024).
[11] National Organization for Rare Disorders (NORD). *About Us*. Available at https://rarediseases.org/about-us/ (last visited January 20, 2024).
[12] *Supra*, note 7.
[13] S. 381.99(4), F.S.; *See also*, the Rare Disease Advisory Council's 2nd Legislative Report at: https://www.floridahealth.gov/provider-and-partner-resources/rdac/_documents/RDACLegislativeReport2023Final_Draft.pdf

In addition to the diagnostic challenges presented by rare diseases, difficulties abound in the research of rare diseases. Due to the inherently small population affected by each rare disease, gathering sufficient sample sizes to conduct clinical trials is difficult. Patient data is scarce, and small sample sizes limit research possibilities. Patient registries are a means of overcoming some of the research limitations that exist due to the nature of rare diseases. Patient registries are organized systems that allow for the use of observational study methods to collect uniform data and evaluate specified outcomes for a population defined by a particular disease.[14]

Sickle cell disease (SCD) affects approximately 100,000 Americans, well within the definition of a rare disease, and is also the most prevalent inherited blood disorder in the US.[15] SCD affects mostly, but not exclusively, Americans of African ancestry. SCD is a group of inherited disorders in which abnormal hemoglobin cause red blood cells to buckle into the iconic sickle shape; the deformed red blood cells damage blood vessels and over time contribute to a cascade of negative health effects beginning in infancy, such as intense vaso-occlusive pain episodes, strokes, organ failure, and recurrent infections.[16] The severity of complications generally worsens as people age, but treatment and prevention strategies can mitigate complications and lengthen the lives of people with SCD.[17]

A person who carries a single gene for SCD has sickle cell trait. People with sickle cell trait do not have SCD, and under normal conditions they are generally asymptomatic. However, they are carriers of SCD and have an increased likelihood of having a child with SCD. It is estimated that 8 to 10 percent of African Americans carry sickle cell trait.[18]

While SCD is the most common inherited blood disorder in the US and is often diagnosed at birth through newborn screening programs,[19] patients with SCD experience many of the other trials associated with treating a rare disease. Until recently there was very little research development in the areas of managing, treating, or curing SCD, and a lack of understanding of SCD persists among many health care professionals.[20]

In 2023, the Legislature directed DOH to partner with a community-based sickle cell disease medical treatment and research center to establish and maintain a registry to track outcome measures of newborns who are identified as carrying a sickle cell hemoglobin variant.[21] DOH has since contracted with the Foundation for Sickle Cell Research for the implementation of the registry.[22] Under current law, only newborns who have been detected as carrying a sickle cell hemoglobin variant through the Newborn Screening Program are included in the registry. Parents may choose to have their child removed from the registry by submitting a form provided by DOH.[23] There is not a mechanism under current law for adults with SCD to be included in the registry.

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[14] Hageman, I.C., van Rooij, I.A., de Blaauw, I., et al. *A systematic overview of rare disease patient registries: challenges in design, quality management, and maintenance* (2023). Orphanet Journal of Rare Diseases 18, 106. https://doi.org/10.1186/s13023-023-02719-0

[15] National Heart, Lung, and Blood Institute, *What is Sickle Cell Disease?* Available at https://www.nhlbi.nih.gov/health/sickle-cell-disease (last visited June 26, 2023).

[16] Centers for Disease Control and Prevention, *What is Sickle Cell Disease?* Available at https://www.cdc.gov/ncbddd/sicklecell/facts.html (last visited January 24, 2024). See also, AHCA (2023) *Florida Medicaid Study of Enrollees with Sickle Cell Disease*. Available at https://ahca.myflorida.com/content/download/20771/file/Florida_Medicaid_Study_of_Enrollees_with_Sickle_Cell_Disease.pdf (last visited January 24, 2024).

[17] Centers for Disease Control and Prevention, *Complications of Sickle Cell Disease*. Available at https://www.cdc.gov/ncbddd/sicklecell/complications.html (last visited January 24, 2024).

[18] American Society of Hematology. ASH Position on Sickle Cell Trait (2021). Available at https://www.hematology.org/advocacy/policy-news-statements-testimony-and-correspondence/policy-statements/2021/ash-position-on-sickle-cell-trait (last visited January 20, 2024).

[19] Centers for Disease Control and Prevention. *Newborn Screening (NBS) Data* (2023). Available at https://www.cdc.gov/ncbddd/hemoglobinopathies/scdc-state-data/newborn-screening/index.html#:~:text=Newborn%20screening%20(NBS)%20for%20sickle,SCD%20living%20in%20a%20state. (last visited January 20, 2024).

[20] *See*, American Society of Hematology. *ASH Sickle Cell Disease Initiative*. Available at https://www.hematology.org/advocacy/sickle-cell-disease-initiative (last visited January 20, 2024).

[21] S. 383.147, F.S.

[22] Department of Health. *Contract Summary: Contract # CMO28*. On file with the Healthcare Regulation Subcommittee.

[23] S. 383.147, F.S.

Current law also directs the newborn's primary care physician to provide the parent or guardian of the newborn with information regarding the availability and benefits of genetic counseling.

Effect of Proposed Changes – Rare Diseases

Andrew John Anderson Pediatric Rare Disease Grant Program

HB 1441 establishes the Andrew John Anderson Pediatric Rare Disease Grant Program within DOH with the purpose of advancing the progress of research and cures for rare pediatric diseases through the award of grants through a competitive, peer-reviewed process. Grants are awarded by DOH, after consultation with the Rare Disease Advisory Council (RDAC).

Grants are awarded to universities or established research institutes in the state for scientific and clinical research to further the search for new diagnostics, treatments, and cures for rare pediatric diseases. The bill establishes a preference for grant proposals which foster collaboration among institutions, researchers, and community practitioners.

The bill directs DOH to appoint peer review panels of independent, scientifically qualified individuals to review the scientific merit of each proposal, and to share the results of such reviews with the RDAC which are to be considered in the recommendations for funding. The RDAC and peer review panels are to establish and follow rigorous guidelines for ethical conduct and adhere to a strict policy with regard to conflicts of interest.

Sickle Cell Disease Registry

HB 1441 creates a process through which parents may opt-out of their child's inclusion in the registry through a proactive process, rather than retroactively removing a child from the registry upon the parent's request. Parents may opt-out through a form obtained from DOH, or otherwise indicating their objection to DOH in writing.

The bill transfers the responsibility of informing parents of the availability and benefits of genetic counseling from the infant's primary care physician to DOH.

The bill also creates a mechanism for adults with SCD who are Florida residents to choose to be included in the registry. The bill directs DOH to prescribe by rule the process for an adult to opt into the registry.

Florida Newborn Screening Program

Current Situation

The Legislature created the Florida Newborn Screening Program (NSP) within DOH, to promote the screening of all newborns for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect.[24] The NSP also promotes the identification and screening of all newborns in the 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.[25]

The NSP involves coordination across several entities, including the Bureau of Public Health Laboratories Newborn Screening Laboratory in Jacksonville (state laboratory), DOH Children's Medical Services (CMS) Newborn Screening Follow-up Program in Tallahassee, referral centers, birthing centers, and physicians throughout the state.[26] Health care providers in hospitals, birthing centers,

[24] S. 383.14(1), F.S.
[25] *Id*.
[26] S. 383.14, F.S.

perinatal centers, county health departments, and school health programs provide screening as part of the multilevel NSP screening process.[27] This includes a risk assessment for prenatal women, and risk factor analysis and screening for postnatal women and newborns as well as laboratory screening for select disorders in newborns.[28] The NSP attempts to screen all newborns for hearing impairment and to identify, diagnose, and manage newborns at risk for select disorders that, without detection and treatment, can lead to permanent developmental and physical damage or death.[29] The NSP is intended to screen all prenatal women and newborns, however, parents and guardians may choose to decline the screening.[30]

Health care providers perform non-laboratory NSP screening, such as hearing and risk factor analysis, and report the results to the Office of Vital Statistics. If necessary, health care providers refer patients to the appropriate health, education, and social services.[31] Health care providers in hospitals and birthing centers perform specimen collection for laboratory NSP screening by collecting a few drops of blood from the newborn's heel on a standardized specimen collection card. [32] The specimen card is then sent to the state laboratory for testing and the results are released to the newborn's health care provider. In the event that a newborn screen has an abnormal result, the newborn's health care practitioner,[33] or a nurse or specialist from NSP's Follow-up Program provides follow-up services and referrals for the child and his or her family.[34]

To administer the NSP, DOH is authorized to charge and collect a fee not to exceed $15 per live birth occurring in a hospital or birth center.[35] DOH must calculate the annual assessment for each hospital and birth center, and then quarterly generate and mail each hospital and birth center a statement of the amount due.[36] DOH bills hospitals and birth centers quarterly using vital statistics data to determine the amount to be billed.[37] DOH is authorized to bill third-party payers for the NSP tests and bills insurers directly for the cost of the screening.[38] DOH does not bill families that do not have insurance coverage.[39]

The Legislature established the Florida Genetics and Newborn Screening Advisory Council to advise DOH on disorders to be included in the NSP panel of screened disorders and the procedures for collecting and transmitting specimens.[40] Florida's NSP currently screens for 58 conditions, 55 of which are screened through the collection of blood spots. Screening of the other three conditions – hearing screening, critical congenital heart defect (CCHD) or pulse oximetry, and congenital cytomegalovirus (CCMV) targeted screening—are completed at the birthing facility through point-of-care testing.[41]

Newborn Hearing Screening

Section 383.145, F.S., requires a newborn hearing screening for all newborns in hospitals before discharge. The newborn hearing screening program (NBHS) is housed within DOH, which is

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[27] *Id.*
[28] *Id*.
[29] Florida Department of Health, *Florida Newborn Screening Guidelines*. Available at https://floridanewbornscreening.com/wp-content/uploads/NBS-Protocols-2022-FINAL.pdf (last visited December 27, 2023).
[30] S. 383.14(4), F.S.; Rule 64C-7.008, F.A.C.; The health care provider must attempt to get a written statement of objection to be placed in the medical record.
[31] *Id*.
[32] Florida Newborn Screening, *What is Newborn Screening?* Available at https://floridanewbornscreening.com/parents/what-is-newborn-screening/ (last visited December 27, 2023). *See also,* Florida Newborn Screening, *Specimen Collection Card*. Available at http://floridanewbornscreening.com/wp-content/uploads/Order-Form.png (last visited December 27, 2023).
[33] Current law allows for the screening results to be released to specified health care practitioners including: allopathic and osteopathic physicians and physician assistants licensed under chs. 458 and 459, F.S., advanced practice registered nurses, registered nurses, and licensed practical nurses licensed under ch. 464, F.S., a midwife licensed under ch. 467, F.S., a speech-language pathologist or audiologist licensed under part I of ch. 468, F.S., or a dietician or nutritionist licensed under part X of ch. 468, F.S.
[34] *Id*.
[35] S. 383.145(3)(g)1., F.S.
[36] *Id.*
[37] S. 383.145(3)(g), F.S.
[38] S. 383.145(3)(h), F.S.
[39] *Supra*, note 26.
[40] S. 383.14(5), F.S.
[41] Department of Health, *Agency Analysis of HB 1441* (2024). On file with the Healthcare Regulation Subcommittee.

responsible for coordinating the statewide hearing screening and follow-up referral system. The NBHS program is funded through donations trust and federal grants from the Centers for Disease Control and Prevention and the Health Resources and Services Administration (HRSA).[42]

Before a newborn is discharged from a hospital or other state-licensed birthing facility, and unless objected to by the parent or legal guardian, the newborn must be screened for the detection of hearing loss to prevent the consequences of unidentified disorders.[43] For births occurring in a non-hospital setting, specifically a licensed birth center or private home, the facility or attending health care provider is responsible for providing a referral to an audiologist, a hospital, or other newborn hearing screening provider within 7 days after the birth or discharge from the facility.[44]

All screenings must be conducted by a licensed audiologist, a licensed physician, or appropriately supervised individual who has completed documented training specifically for newborn hearing screening.[45] When ordered by the treating physician, screening of a newborn's hearing must include auditory brainstem responses, or evoked otoacoustic emissions, or appropriate technology as approved by the United States Food and Drug Administration (FDA).[46]

NBHS staff provide follow-up to parents of infants who do not pass the newborn hearing screen to ensure timely diagnosis and enrollment in early intervention for children diagnosed with hearing loss.[47] A child who is diagnosed as having a permanent hearing impairment must be referred by the licensee or individual who conducted the screening to the primary care physician for medical management, treatment, and follow-up services. Furthermore, any child from birth to 36 months of age who is diagnosed as having a hearing impairment that requires ongoing special hearing services must be referred to the Children's Medical Services Early Intervention Program by the licensee or individual who conducted the screening serving the geographical area in which the child resides.

Hearing loss is one of the most common birth defects in the United States, with approximately 2 newborns per 1,000 born having hearing loss each year. It is estimated that only half of early childhood hearing loss is detected through newborn hearing screening. To further support early identification of hearing loss prior to school entry to prevent the consequences of unidentified disorders, the HRSA federal grant requires collection of hearing screening data for infants and toddlers up to age 36 months.[48]

In 2020, 98% of newborns in Florida received a hearing screen. In 2020, 9,500 infants did not pass the hearing screening, and 261 infants were diagnosed with hearing loss. It is estimated that 71% (814) of infants born in birthing centers in 2020 did not receive a hearing screen.[49]

Effect of Proposed Changes – Florida Newborn Screening Program

HB 1441 expressly states that the health care practitioner present at birth, or responsible for primary care during the neonatal period, has the responsibility for administering the newborn screenings. The bill requires that health care practitioners responsible for administering newborn screenings shall prepare and send all specimen cards to the State Public Health Laboratory. The bill provides DOH rulemaking authority to implement these provisions.

The bill adds genetic counselors to the list of health care practitioners to whom the state laboratory may release NBS results.

[42] *Id*.
[43] S. 383.145(3), F.S. If the screening is not completed before discharge due to scheduling or temporary staffing limitations, the screening must be completed within 21 days after the birth.
[44] S. 383.145(3)(d), F.S.
[45] S. 383.145(3)(f), F.S.
[46] S. 383.145(3)(i), F.S.
[47] *Supra*, note 42.
[48] *Id.*
[49] *Id.*

The bill deletes several obsolete provisions related to the NBS program, including:

- The requirement that the NBS program and Healthy Start to coordinate with the Florida Department of Education;
- Statutory references to a specific disease, phenylketonuria, which is included in the NBS program regimen;
- The requirement for DOH's Office of Inspector General to certify the financial operations of the NBS program;[50]
- The requirement for DOH to furnish physicians, county health departments, perinatal centers, birth centers, and hospitals with forms related in NBS.

Environmental Risk Screening

The bill removes current language relating to environmental risk screening from the NBS program and creates a separate section of law wherein the requirements for environmental risk screening are outlined. The requirements for environmental risk screening under the bill are consistent with current law.

Newborn Hearing Screening

The bill requires licensed birth centers to conduct newborn screenings before the newborn is discharged, rather than requiring the newborn be referred for testing outside of the birth center. The bill also requires that all newborns who do not pass the hearing screening are, within seven days of birth, referred for congenital cytomegalovirus testing to occur before the infant is 21 days of age.

The bill defines "toddler," as a child from 12 months to 36 months of age. Under current law, a physician-ordered hearing screening of a newborn must include auditory brainstem responses, or evoked otoacoustic emissions, or appropriate technology as approved by the US Food and Drug Administration. The bill expands these requirements to apply to physician-ordered screenings for infants and toddlers. The results of such tests must be reported to DOH within seven days of the receipt of test results.

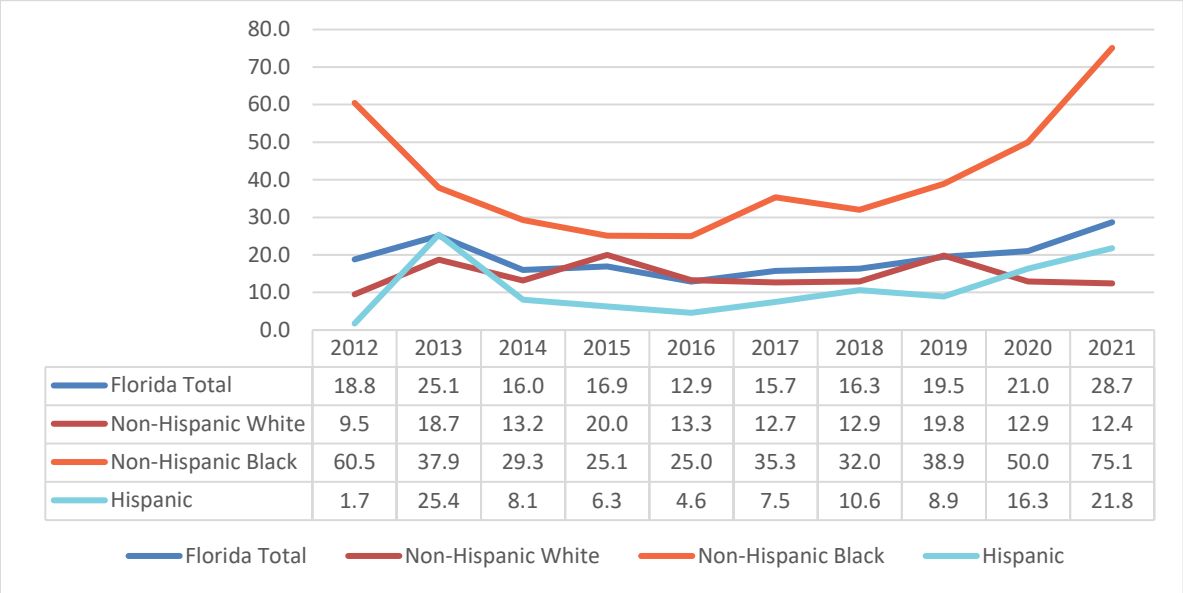
Maternal Health Outcomes

Current Situation

Maternal mortality refers to deaths occurring during pregnancy or within 42 days of the end of pregnancy, regardless of the duration of the pregnancy, from any cause related to or aggravated by the pregnancy, but not from accidental or incidental causes.[51] In 2021, more than 1,200 women died of maternal causes in the United States compared with 861 in 2020 and 754 in 2019.[52] The national maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births.[53] Racial and ethnic gaps exist between non-Hispanic black, non-Hispanic white, and Hispanic women. The maternal mortality rate of these groups is 69.9, 26.6, and 28.0 deaths per 100,000 live births, respectively.[54] The overall number and rate of maternal deaths increased in 2020 and 2021 during the COVID-19 pandemic.[55]

[50] *Id*. DOH reports that the current process is duplicative as NBS program funds are placed in a state trust fund subject to the rules governing state trust funds.
[51] U.S. Department of Health and Human Services, *The Surgeon General's Call to Action to Improve Maternal Health* (2020). Available at https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf (last visited December 5, 2023).
[52] Donna L. Hoyert, Ph.D., Division of Vital Statistics, National Center for Health Statistics, *Maternal Mortality Rates in the United States, 2021* (2023). Available at https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf https://www.cdc.gov/reproductivehealth/maternal-mortality/index.html(last visited January 8, 2024).
[53] *Id.*
[54] *Id*.
[55] United States Government Accountability Office, *Maternal Health Outcomes Worsened and Disparities Persisted During the Pandemic*, (Oct. 2022), available at https://www.gao.gov/assets/gao-23-105871.pdf (last visited December 5, 2023).

Although Florida's maternal mortality rate is lower than the national rate, it has been increasing in recent years. As of 2021, the maternal mortality rate in Florida is 28.7 deaths per 100,000 live births, an increase from a low of 12.9 deaths per 100,000 live births in 2016.[56] Similar to the national trend, racial and ethnic disparities exist in the maternal mortality rates in Florida as evidenced in the following chart:



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Florida Total	18.8	25.1	16.0	16.9	12.9	15.7	16.3	19.5	21.0	28.7
Non-Hispanic White	9.5	18.7	13.2	20.0	13.3	12.7	12.9	19.8	12.9	12.4
Non-Hispanic Black	60.5	37.9	29.3	25.1	25.0	35.3	32.0	38.9	50.0	75.1
Hispanic	1.7	25.4	8.1	6.3	4.6	7.5	10.6	8.9	16.3	21.8

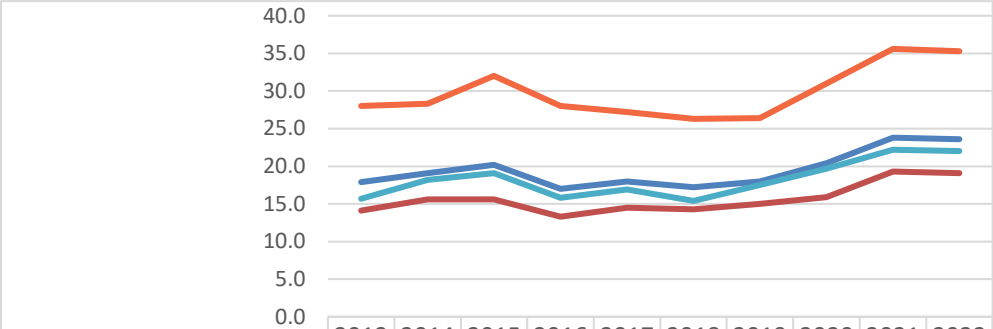
For every maternal death, 100 women suffer a severe obstetric morbidity, a life-threatening diagnosis, or undergo a lifesaving procedure during their delivery hospitalization.[57] Severe maternal morbidity (SMM) includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. SMM has been steadily increasing in recent years.[58]

The consequences of the increasing SMM prevalence, in addition to the health effects for the woman, are wide-ranging and include increased medical costs and longer hospitalization stays.[59] The leading causes of SMM in 2021 were:

- Blood transfusion;
- Disseminated intravascular coagulation;
- Acute renal failure;
- Sepsis;
- Adult respiratory distress syndrome;
- Hysterectomy;
- Shock;
- Ventilation; and
- Eclampsia.[60]

[56] Presentation by Kenneth Scheppke, M.d., F.A.E.M.S., Deputy Sec'y for Health, DOH, before the Senate Committee on Health Policy (Nov. 14, 2023). Available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited January 8, 2024).
[57] Elizabeth A. Howell, MD, MPP, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61(2) CLINICAL OBSTETRICS AND GYNECOLOGY 387 (2018). Available at https://journals.lww.com/clinicalobgyn/abstract/2018/06000/reducing_disparities_in_severe_maternal_morbidity.22.aspx (last visited January 8, 2024).
[58] *Id.,* and CDC, *Severe Maternal Morbidity in the United States* (2023). Available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last visited January 8, 2024).
[59] CDC, *Severe Maternal Morbidity in the United States* (2023). Available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last visited January 8, 2024).
[60] Florida Perinatal Quality Collaborative, *Opportunities for Florida Hospital Participation*, (Aug. 23, 2022), available at https://health.usf.edu/-/media/Files/Public-Health/Chiles-Center/FPQC/FPQC-Informational-Webinar-FINAL-23-AUG-22.ashx?la=en&hash=93B16B88819045E16DA5C84EEE3A6C416B3E457A (last visited January 8, 2024).

From 2013 to 2022, there were 51,454 cases of SMM among delivery hospitalization in Florida.[61] Similar to maternal mortality rates, rates of SMM are higher in racial and ethnic minority women.[62] The following figure shows the trend over time for SMM rates in Florida per 1,000 delivery hospitalizations:[63]



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Florida Total	17.9	19.1	20.2	17.0	18.0	17.2	18.0	20.4	23.8	23.6
Non-Hispanic White	14.1	15.6	15.6	13.3	14.5	14.3	15.0	15.9	19.3	19.1
Non-Hispanic Black	28.0	28.3	32.0	28.0	27.2	26.3	26.4	31.0	35.6	35.3
Hispanic	15.7	18.2	19.1	15.8	16.9	15.4	17.5	19.7	22.2	22.0

Telehealth Minority Maternity Care Pilot Program

In 2021, the Legislature created the Telehealth Minority Maternity Care Pilot Program in Duval and Orange counties to increase positive maternal health outcomes in racial and ethnic minority populations.[64]

DOH received funding in the 2023-2024 FY[65] to expand the pilot program to an additional 18 counties.[66] The additional counties are Brevard, Broward, Collier, Escambia, Hillsborough, Lake, Lee, Leon, Manatee, Marion, Miami-Dade, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, and Volusia.

The pilot programs use telehealth to coordinate with prenatal home visiting programs to provide the following services and education to eligible pregnant women[67] up to the last day of their postpartum period:

- Referrals to Healthy Start's[68] coordinated intake and referral program to offer families prenatal home visiting services;
- Services and education addressing social determinants of health;[69]

[61] *Supra*, note 56.
[62] *Supra*, note 57.
[63] *Id.*
[64] Chapter 2021-238, Laws of Florida, codified at s. 381.2163, F.S.
[65] Chapter 2023-239, Laws of Florida, line item 435.
[66] Florida Department of Health, Office of Minority Health, *Request for Applications: Programs to Reduce Severe Maternal Morbidity through Telehealth (SMMT) in Florida, RFA #22-002*, (April 19, 2023). Available at https://www.floridahealth.gov/about/administrative-functions/purchasing/grant-funding-opportunities/RFA22-002.pdf#Open%20in%20new%20window (last visited January 8, 2024).
[67] An "eligible pregnant woman" is a pregnant woman who is receiving, or is eligible to receive, maternal or infant services from the DOH under ch. 381, F.S. or ch. 383, F.S.
[68] Healthy Start is a free home visiting program that provides education and care coordination to pregnant women and families of children under the age of three. The goal of the program is to lower risks factors associated with preterm birth, low birth weight, infant mortality, and poor development outcomes. *See* DOH, *Healthy Start*. Available at https://www.floridahealth.gov/programs-and-services/childrens-health/healthy-start/index.html (last visited January 8, 2024).
[69] Social determinants of health refer to the conditions in the places where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. They are grouped into five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environments, and social and community context. *See* U.S. Dep't of Health and Human Services, Office of Disease Prevention and Health Promotion, *Social Determinants of Health*. Available at https://health.gov/healthypeople/priority-areas/social-determinants-health (last visited January 8, 2024).

- Evidence-based health literacy and pregnancy, childbirth, and parenting education for women in prenatal and postpartum periods;
- For women during their pregnancies through the postpartum periods, connection to support from doulas and other perinatal health workers; and
- Medical devices for prenatal women to conduct key components of maternal wellness checks.[70]

The pilot programs also provide training to participating health care practitioners on:

- Implicit and explicit biases, racism, and discrimination in the provision of maternity care and how to eliminate these barriers;
- The use of remote patient monitoring tools;
- How to screen for social determinants of health risks in prenatal and postpartum periods;
- Best practices to screen for, evaluate, and treat mental health conditions and substance use disorders, as needed; and
- Collection of information, recording, and evaluation activities for program and patient evaluations.[71]

According to DOH, since the program's implementation, it has served more than 2,500 women in Duval and Orange counties, and 95 percent of the participants have reported that the program addressed an unmet social need.[72] The five most prevalent critical factors were food scarcity, childcare, paid work opportunities, affordability and access to utilities such as the Internet, and access to stable housing.

Additionally, 71 percent of the enrolled women in Duval County and 85 percent of enrolled women in Orange County reported high satisfaction with the implementation of the technology in the pilot program.[73] The enrolled women were provided blood pressure cuffs, scales, and glucose monitors to remotely screen and treat common pregnancy-related complications.

Effect of Proposed Changes – Telehealth Minority Maternity Care Pilot Program

The bill authorizes DOH to expand the Telehealth Minority Maternity Care Program statewide, contingent on funding. The bill allows DOH to implement local programs through community-based organizations.

B. SECTION DIRECTORY:

Section 1: Amends s. 381.0101, F.S., relating to environmental health professionals.
Section 2: Creates s. 381.991, F.S., relating to the Andrew John Anderson Pediatric Rare Disease Grant Program.
Section 3: Amends s. 383.14, F.S., relating to screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.
Section 4: Amends s. 383.145, F.S., relating to newborn and infant hearing screening.
Section 5: Amends s. 383.147, F.S., relating to newborn and infant screenings for sickle cell hemoglobin variants; registry.
Section 6: Creates s. 383.148, F.S., relating to environmental risk screening.
Section 7: Amends s. 383.2163, F.S., relating to telehealth minority maternity care pilot programs.
Section 8: Amends s. 383.318, F.S., relating to postpartum care for birth center clients and infants.
Section 9: Amends s. 395.1053, F.S., relating to postpartum education.
Section 10: Amends s. 456.0496, F.S., relating to provision of information on eye and vision disorders to parents during planned out-of-hospital births.
Section 11: Provides an effective date of July 1, 2024.

[70] Section 383.2163(3), F.S.
[71] Section 383.2163(4), F.S.
[72] Department of Health, Office of Minority Health and Health Equity. *Pilot Programs to Reduce Racial and Ethnic Disparities in Severe Maternal Morbidity through Telehealth: Final Report* (2023). On file with the Healthcare Regulation Subcommittee.
[73] *Id.*

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The provisions of Section 2 (the Andrew John Anderson Pediatric Rare Disease Grant Program) and Section 7 (the Telehealth Minority Maternity Care Programs) of the bill are subject to appropriation. The bill does not currently include an appropriation for these provisions.[74]

See *Fiscal Comments*.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Private research institutions who are eligible for the Andrew John Anderson Pediatric Rare Disease Grant Program may experience a positive fiscal impact from access to this additional funding.

D. FISCAL COMMENTS:

Andrew John Anderson Pediatric Rare Disease Grant Program

According to DOH, the $500,000 that was allocated in the 2023 General Appropriations Act to fund research grants for pediatric rare diseases is intended fund the inaugural year of the Andrew John Anderson Pediatric Rare Disease Grant Program.[75]

Telehealth Minority Maternity Care Program

DOH estimates that a statewide expansion of the telehealth minority maternity care program will cost approximately $23,357,876.[76]

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.

[74] *Supra*, note 41.
[75] *Id*.
[76] *Id*.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the Department of Health; amending s. 381.0101, F.S.; defining the term "environmental health technician"; exempting environmental health technicians from certain certification requirements under certain circumstances; requiring the department, in conjunction with the Department of Environmental Protection, to adopt rules that establish certain standards for environmental health technician certification; requiring the Department of Health to adopt by rule certain standards for environmental health technician certification; revising provisions related to exemptions and fees to conform to changes made by the act; creating s. 381.991, F.S.; creating the Andrew John Anderson Rare Pediatric Disease Grant Program within the department for a specified purpose; subject to an appropriation by the Legislature, requiring the program to award grants for certain scientific and clinical research; specifying entities eligible to apply for the grants; specifying the types of applications that may be considered for grant funding; providing for a competitive, peer-reviewed application and selection process; providing that the remaining balance of appropriations for the program as of a specified date may be carried forward for a

specified timeframe under certain circumstances; amending s. 383.14, F.S.; providing that any health care practitioner present at a birth or responsible for primary care during the neonatal period has the primary responsibility of administering certain screenings; defining the term "health care practitioner"; deleting identification and screening requirements for newborns and their families for certain environmental and health risk factors; deleting certain related duties of the department; revising the definition of the term "health care practitioner" to include licensed genetic counselors; requiring that blood specimens for screenings of newborns be collected before a specified age; requiring that newborns have a blood specimen collected for newborn screenings, rather than only a test for phenylketonuria, before a specified age; deleting certain rulemaking authority of the department; deleting a requirement that the department furnish certain forms to specified entities; deleting the requirement that such entities report the results of certain screenings to the department; making technical and conforming changes; deleting a requirement that the department submit certain certifications as part of its legislative budget

request; requiring certain health care practitioners to prepare and send all newborn screening specimen cards to the State Public Health Laboratory; defining the term "health care practitioner"; amending s. 383.145, F.S.; defining the term "toddler"; revising hearing loss screening requirements to include infants and toddlers; revising hearing loss screening requirements for licensed birth centers; revising the timeframe in which a newborn's primary health care provider must refer a newborn for congenital cytomegalovirus screening after the newborn fails the hearing loss screening; requiring licensed birth centers to complete newborn hearing loss screenings before discharge, with an exception; amending s. 383.147, F.S.; revising sickle cell disease and sickle cell trait screening requirements; requiring screening providers to notify a newborn's parent or guardian, rather than the newborn's primary care physician, of certain information; authorizing the parents or guardians of a newborn to opt out of the newborn's inclusion in the sickle cell registry; specifying the manner in which a parent or guardian may opt out; authorizing certain persons other than newborns who have been identified as having sickle cell disease or carrying a sickle cell trait to choose to be included

in the registry; creating s. 383.148, F.S.; requiring the department to promote the screening of pregnant women and infants for specified environmental risk factors; requiring the department to develop a multilevel screening process for prenatal and postnatal risk screenings; specifying requirements for such screening processes; providing construction; requiring persons who object to a screening to give a written statement of such objection to the physician or other person required to administer and report the screening; amending s. 383.2163, F.S.; expanding the telehealth minority maternity care pilot program to a full program available in any county in this state, contingent upon available funding; making conforming changes; revising the source of funding for the program; amending ss. 383.318, 395.1053, and 456.0496, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Present subsections (5), (6), and (7) of section 381.0101, Florida Statutes, are redesignated as subsections (6), (7), and (8), respectively, a new subsection (5) is added to that section, and subsections (1), (2), and (4)

and present subsections (5) and (6) of that section are amended, to read:

381.0101 Environmental health professionals.—

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

(a) "Board" means the Environmental Health Professionals Advisory Board.

(c) ~~(b)~~ "Department" means the Department of Health.

(d) ~~(c)~~ "Environmental health" means that segment of public health work which deals with the examination of those factors in the human environment which may impact adversely on the health status of an individual or the public.

(e) ~~(d)~~ "Environmental health professional" means a person who is employed or assigned the responsibility for assessing the environmental health or sanitary conditions, as defined by the department, within a building, on an individual's property, or within the community at large, and who has the knowledge, skills, and abilities to carry out these tasks. Environmental health professionals may be either field, supervisory, or administrative staff members.

(b) ~~(e)~~ "Certified" means a person who has displayed competency to perform evaluations of environmental or sanitary conditions through examination.

(f) "Environmental health technician" means a person who is employed or assigned the responsibility for conducting septic inspections under the supervision of a certified environmental

health professional. An environmental health technician must have completed training approved by the department and have the knowledge, skills, and abilities to carry out these tasks.

(h) ~~(f)~~ "Registered sanitarian," "R.S.," "Registered Environmental Health Specialist," or "R.E.H.S." means a person who has been certified by either the National Environmental Health Association or the Florida Environmental Health Association as knowledgeable in the environmental health profession.

(g) "Primary environmental health program" means those programs determined by the department to be essential for providing basic environmental and sanitary protection to the public. At a minimum, these programs shall include food protection program work.

(2) CERTIFICATION; EXEMPTIONS ~~REQUIRED~~.—A person may not perform environmental health or sanitary evaluations in any primary program area of environmental health without being certified by the department as competent to perform such evaluations. This section does not apply to any of the following:

(a) Persons performing inspections of public food service establishments licensed under chapter 509.~~; or~~

(b) Persons performing site evaluations in order to determine proper placement and installation of onsite wastewater treatment and disposal systems who have successfully completed a

department-approved soils morphology course and who are working under the direct responsible charge of an engineer licensed under chapter 471.

(c) Environmental health technicians employed by a department as defined in s. 20.03 who are assigned the responsibility for conducting septic tank inspections under the supervision of an environmental health professional certified in onsite sewage treatment and disposal.

(4) STANDARDS FOR CERTIFICATION.—The department shall adopt rules that establish definitions of terms and minimum standards of education, training, or experience for those persons subject to this subsection ~~section~~. The rules must also address the process for application, examination, issuance, expiration, and renewal of certification and ethical standards of practice for the profession.

(a) Persons employed as environmental health professionals shall exhibit a knowledge of rules and principles of environmental and public health law in Florida through examination. A person may not conduct environmental health evaluations in a primary program area unless he or she is currently certified in that program area or works under the direct supervision of a certified environmental health professional.

1. All persons who begin employment in a primary environmental health program on or after September 21, 1994,

must be certified in that program within 6 months after employment.

2. Persons employed in the primary environmental health program of a food protection program or an onsite sewage treatment and disposal system prior to September 21, 1994, shall be considered certified while employed in that position and shall be required to adhere to any professional standards established by the department pursuant to paragraph (b), complete any continuing education requirements imposed under paragraph (d), and pay the certificate renewal fee imposed under subsection (7) ~~(6)~~.

3. Persons employed in the primary environmental health program of a food protection program or an onsite sewage treatment and disposal system prior to September 21, 1994, who change positions or program areas and transfer into another primary environmental health program area on or after September 21, 1994, must be certified in that program within 6 months after such transfer, except that they will not be required to possess the college degree required under paragraph (e).

4. Registered sanitarians shall be considered certified and shall be required to adhere to any professional standards established by the department pursuant to paragraph (b).

(b) At a minimum, the department shall establish standards for professionals in the areas of food hygiene and onsite sewage treatment and disposal.

(c) Those persons conducting primary environmental health evaluations shall be certified by examination to be knowledgeable in any primary area of environmental health in which they are routinely assigned duties.

(d) Persons who are certified shall renew their certification biennially by completing not less than 24 contact hours of continuing education for each program area in which they maintain certification, subject to a maximum of 48 hours for multiprogram certification.

(e) Applicants for certification shall have graduated from an accredited 4-year college or university with a degree or major coursework in public health, environmental health, environmental science, or a physical or biological science.

(f) A certificateholder shall notify the department within 60 days after any change of name or address from that which appears on the current certificate.

(5) STANDARDS FOR ENVIRONMENTAL HEALTH TECHNICIAN CERTIFICATION.—The department, in conjunction with the Department of Environmental Protection, shall adopt rules that establish definitions of terms and minimum standards of education, training, and experience for those persons subject to this subsection. The rules must also address the process for application, examination, issuance, expiration, and renewal of certification, and ethical standards of practice for the profession.

(a) At a minimum, the department shall establish standards for technicians in the areas of onsite sewage treatment and disposal.

(b) A person conducting septic inspections must be certified by examination to be knowledgeable in the area of onsite sewage treatment and disposal.

(c) An applicant for certification as an environmental health technician must, at a minimum, have received a high school diploma or its equivalent.

(d) An applicant for certification as an environmental health technician must be employed by a department as defined in s. 20.03.

(e) An applicant for certification as an environmental health technician must complete supervised field inspection work as prescribed by department rule before examination.

(f) A certified environmental health technician must renew his or her certification biennially by completing at least 24 contact hours of continuing education for each program area in which he or she maintains certification, subject to a maximum of 48 hours for multiprogram certification.

(g) A certified environmental health technician shall notify the department within 60 days after any change of name or address from that which appears on the current certificate.

(6)~~(5)~~ EXEMPTIONS.—A person who conducts primary environmental evaluation activities and maintains a current

registration or certification from another state agency which examined the person's knowledge of the primary program area and requires comparable continuing education to maintain the certificate shall not be required to be certified by this section. ~~Examples of persons not subject to certification are physicians, registered dietitians, certified laboratory personnel, and nurses.~~

(7)~~(6)~~ FEES.—The department shall charge fees in amounts necessary to meet the cost of providing environmental health professional certification. Fees for certification shall be not less than $10 or more than $300 and shall be set by rule. Application, examination, and certification costs shall be included in this fee. Fees for renewal of a certificate shall be no less than $25 nor more than $150 per biennium.

Section 2. Section 381.991, Florida Statutes, is created to read:

381.991 Andrew John Anderson Pediatric Rare Disease Grant Program.—

(1)(a) There is created within the Department of Health the Andrew John Anderson Rare Pediatric Disease Grant Program. The purpose of the program is to advance the progress of research and cures for rare pediatric diseases by awarding grants through a competitive, peer-reviewed process.

(b) Subject to an annual appropriation by the Legislature, the program shall award grants for scientific and clinical

research to further the search for new diagnostics, treatments, and cures for rare pediatric diseases.

(2)(a) Applications for grants for rare pediatric disease research may be submitted by any university or established research institute in the state. All qualified investigators in the state, regardless of institutional affiliation, shall have equal access and opportunity to compete for the research funding. Preference may be given to grant proposals that foster collaboration among institutions, researchers, and community practitioners, as such proposals support the advancement of treatments and cures of rare pediatric diseases through basic or applied research. Grants shall be awarded by the department, after consultation with the Rare Disease Advisory Council, pursuant to s. 381.99, on the basis of scientific merit, as determined by the competitive, peer-reviewed process to ensure objectivity, consistency, and high quality. The following types of applications may be considered for funding:

1. Investigator-initiated research grants.

2. Institutional research grants.

3. Collaborative research grants, including those that advance the finding of treatment and cures through basic or applied research.

(b) To ensure appropriate and fair evaluation of grant applications based on scientific merit, the department shall appoint peer review panels of independent, scientifically

qualified individuals to review the scientific merit of each proposal and establish its priority score. The priority scores shall be forwarded to the council and must be considered in determining which proposals shall be recommended for funding.

(c) The council and the peer review panels shall establish and follow rigorous guidelines for ethical conduct and adhere to a strict policy with regard to conflicts of interest. A member of the council or panel may not participate in any discussion or decision of the council or panel with respect to a research proposal by any firm, entity, or agency that the member is associated with as a member of the governing body or as an employee or with which the member has entered into a contractual arrangement.

(d) Notwithstanding s. 216.301 and pursuant to s. 216.351, the balance of any appropriation from the General Revenue Fund for the Andrew John Anderson Pediatric Rare Disease Grant Program that is not disbursed but that is obligated pursuant to contract or committed to be expended by June 30 of the fiscal year in which the funds are appropriated may be carried forward for up to 5 years after the effective date of the original appropriation.

Section 3. Present subsection (5) of section 383.14, Florida Statutes, is redesignated as subsection (6), a new subsection (5) is added to that section, and subsections (1), (2), and (3) of that section 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. Any health care practitioner present at a birth or responsible for primary care during the neonatal period has the primary responsibility of administering screenings as required in ss. 383.14 and 383.145. As used in this subsection, 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 practice registered nurse licensed under part I of chapter 464, or a midwife licensed under chapter 467 ~~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.~~

~~(a) *Prenatal screening.*—The department shall develop a multilevel screening process that includes a risk assessment instrument to identify women at risk for a preterm birth or other high-risk condition. The primary health care provider shall complete the risk assessment instrument and report the results to the Office of Vital Statistics so that the woman may immediately be notified and referred to appropriate health, education, and social services.~~

~~(b) *Postnatal screening.*—A risk factor analysis using the department's designated risk assessment instrument shall also be conducted as part of the medical screening process upon the birth of a child and submitted to the department's Office of Vital Statistics for recording and other purposes provided for in this chapter. The department's screening process for risk assessment shall include a scoring mechanism and procedures that establish thresholds for notification, further assessment, referral, and eligibility for services by professionals or~~

~~paraprofessionals consistent with the level of risk. Procedures for developing and using the screening instrument, notification, referral, and care coordination services, reporting requirements, management information, and maintenance of a computer-driven registry in the Office of Vital Statistics which ensures privacy safeguards must be consistent with the provisions and plans established under chapter 411, Pub. L. No. 99-457, and this chapter. Procedures established for reporting information and maintaining a confidential registry must include a mechanism for a centralized information depository at the state and county levels. The department shall coordinate with existing risk assessment systems and information registries. The department must ensure, to the maximum extent possible, that the screening information registry is integrated with the department's automated data systems, including the Florida On-line Recipient Integrated Data Access (FLORIDA) system~~.

(a) *Blood specimens for newborn screenings.*—Newborn ~~Tests and~~ screenings must be performed by the State Public Health Laboratory, in coordination with Children's Medical Services, at such times and in such manner as is prescribed by the department after consultation with the Genetics and Newborn Screening Advisory Council ~~and the Department of Education~~.

(b) ~~(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 practice registered nurse, 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; or a genetic counselor licensed under part III of chapter 483.

(2) RULES.—

(a) After consultation with the Genetics and Newborn Screening Advisory Council, the department shall adopt and enforce rules requiring that every newborn in this state shall:

1. Before becoming 1 week of age, have a blood specimen collected for newborn screenings ~~be subjected to a test for phenylketonuria~~;

2. Be tested for any condition included on the federal Recommended Uniform Screening Panel which the council advises the department should be included under the state's screening program. After the council recommends that a condition be

included, the department shall submit a legislative budget request to seek an appropriation to add testing of the condition to the newborn screening program. The department shall expand statewide screening of newborns to include screening for such conditions within 18 months after the council renders such advice, if a test approved by the United States Food and Drug Administration or a test offered by an alternative vendor is available. If such a test is not available within 18 months after the council makes its recommendation, the department shall implement such screening as soon as a test offered by the United States Food and Drug Administration or by an alternative vendor is available; and

3. At the appropriate age, be tested for such other metabolic diseases and hereditary or congenital disorders as the department may deem necessary ~~from time to time~~.

~~(b) After consultation with the Department of Education, the department shall adopt and enforce rules requiring every newborn in this state to be screened for environmental risk factors that place children and their families at risk for increased morbidity, mortality, and other negative outcomes.~~

(b) ~~(c)~~ The department shall adopt such additional rules as are found necessary for the administration of this section and ss. 383.145 and 383.148 ~~s. 383.145~~, including rules providing definitions of terms, rules relating to the methods used and time or times for testing as accepted medical practice

indicates, rules relating to charging and collecting fees for the administration of the newborn screening program authorized by this section, rules for processing requests and releasing test and screening results, and rules requiring mandatory reporting of the results of tests and screenings for these conditions to the department.

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

(a) Assure the availability and quality of the necessary laboratory tests and materials.

(b) ~~Furnish all physicians, county health departments, perinatal centers, birthing centers, and hospitals forms on which environmental screening and the results of tests for phenylketonuria and such other disorders for which testing may be required from time to time shall be reported to the department.~~

~~(c)~~ Promote education of the public about the prevention and management of metabolic, hereditary, and congenital disorders ~~and dangers associated with environmental risk factors~~.

(c)~~(d)~~ Maintain a confidential registry of cases, including information of importance for the purpose of follow-up ~~followup~~ services to prevent intellectual disabilities, to correct or ameliorate physical disabilities, and for

epidemiologic studies, if indicated. Such registry shall be exempt from the provisions of s. 119.07(1).

(d) ~~(c)~~ Supply the necessary dietary treatment products where practicable for diagnosed cases of ~~phenylketonuria and other~~ metabolic diseases for as long as medically indicated when the products are not otherwise available. Provide nutrition education and supplemental foods to those families eligible for the Special Supplemental Nutrition Program for Women, Infants, and Children as provided in s. 383.011.

(e) ~~(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.

(f) ~~(g)~~ Have the authority to charge and collect fees for the administration of the newborn screening program. ~~authorized in this section, as follows:~~

~~1.~~ A fee not to exceed $15 will be charged for each live birth, as recorded by the Office of Vital Statistics, occurring in a hospital licensed under part I of chapter 395 or a birth center licensed under s. 383.305 ~~per year~~. The department shall calculate the ~~annual~~ assessment for each hospital and birth center, and this assessment must be paid ~~in equal amounts~~ quarterly. ~~Quarterly,~~ The department shall generate and issue ~~mail to~~ each hospital and birth center a statement of the amount due.

~~2. As part of the department's legislative budget request prepared pursuant to chapter 216, the department shall submit a certification by the department's inspector general, or the director of auditing within the inspector general's office, of the annual costs of the uniform testing and reporting procedures of the newborn screening program. In certifying the annual costs, the department's inspector general or the director of auditing within the inspector general's office shall calculate the direct costs of the uniform testing and reporting procedures, including applicable administrative costs. Administrative costs shall be limited to those department costs which are reasonably and directly associated with the administration of the uniform testing and reporting procedures of the newborn screening program.~~

(g) ~~(h)~~ Have the authority to bill third-party payors for newborn screening tests.

(h) ~~(i)~~ Create and make available electronically a pamphlet with information on screening for, and the treatment of, preventable infant and childhood eye and vision disorders, including, but not limited to, retinoblastoma and amblyopia.

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) SUBMISSION OF NEWBORN SCREENING SPECIMEN CARDS.—Any

health care practitioner whose duty it is to administer screenings under this section shall prepare and send all newborn screening specimen cards to the State Public Health Laboratory in accordance with rules adopted under this section. As used in this subsection, 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 practice registered nurse licensed under part I of chapter 464, or a midwife licensed under chapter 467.

Section 4. Paragraph (k) is added to subsection (2) of Section 383.145, Florida Statutes, and subsection (3) of that section is amended, to read:

383.145 Newborn, ~~and~~ infant, and toddler hearing screening.—

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

(k) "Toddler" means a child from 12 months to 36 months of age.

(3) REQUIREMENTS FOR SCREENING OF NEWBORNS, INFANTS, AND TODDLERS; INSURANCE COVERAGE; REFERRAL FOR ONGOING SERVICES.—

(a) Each hospital or other state-licensed birth ~~birthing~~ facility that provides maternity and newborn care services shall ensure that all newborns are, before discharge, screened for the detection of hearing loss to prevent the consequences of unidentified disorders. If a newborn fails the screening for the

detection of hearing loss, the hospital or other state-licensed birth ~~birthing~~ facility must administer a test approved by the United States Food and Drug Administration or another diagnostically equivalent test on the newborn to screen for congenital cytomegalovirus before the newborn becomes 21 days of age or before discharge, whichever occurs earlier.

(b) Each licensed birth center that provides maternity and newborn care services shall ensure that all newborns are, before discharge, screened for the detection of hearing loss. Within 7 days after the birth, the licensed birth center must ensure that all newborns who do not pass the hearing screening are referred for ~~to~~ an appointment ~~audiologist, a hospital, or another newborn hearing screening provider~~ for a test to screen for congenital cytomegalovirus before the newborn becomes 21 days of age ~~screening for the detection of hearing loss to prevent the consequences of unidentified disorders. The referral for appointment must be made within 7 days after discharge~~. Written documentation of the referral must be placed in the newborn's medical chart.

(c) If the parent or legal guardian of the newborn objects to the screening, the screening must not be completed. In such case, the physician, midwife, or other person attending the newborn shall maintain a record that the screening has not been performed and attach a written objection that must be signed by the parent or guardian.

(d) For home births, the health care provider in attendance is responsible for coordination and referral to an audiologist, a hospital, or another newborn hearing screening provider. The health care provider in attendance must make the referral for appointment within 7 days after the birth. In cases in which the home birth is not attended by a health care provider, the newborn's primary health care provider is responsible for coordinating the referral.

(e) For home births and births in a licensed birth center, if a newborn is referred to a newborn hearing screening provider and the newborn fails the screening for the detection of hearing loss, the newborn's primary health care provider must refer the newborn for administration of a test approved by the United States Food and Drug Administration or another diagnostically equivalent test on the newborn to screen for congenital cytomegalovirus before the newborn becomes 21 days of age.

(f) All newborn and infant hearing screenings must be conducted by an audiologist, a physician, or an appropriately supervised individual who has completed documented training specifically for newborn hearing screening. Every hospital that provides maternity or newborn care services shall obtain the services of an audiologist, a physician, or another newborn hearing screening provider, through employment or contract or written memorandum of understanding, for the purposes of appropriate staff training, screening program supervision,

monitoring the scoring and interpretation of test results, rendering of appropriate recommendations, and coordination of appropriate follow-up services. Appropriate documentation of the screening completion, results, interpretation, and recommendations must be placed in the medical record within 24 hours after completion of the screening procedure.

(g) The screening of a newborn's hearing must be completed before the newborn is discharged from the hospital or licensed birth center. However, if the screening is not completed before discharge due to scheduling or temporary staffing limitations, the screening must be completed within 21 days after the birth. Screenings completed after discharge or performed because of initial screening failure must be completed by an audiologist, a physician, a hospital, or another newborn hearing screening provider.

(h) Each hospital shall formally designate a lead physician responsible for programmatic oversight for newborn hearing screening. Each birth center shall designate a licensed health care provider to provide such programmatic oversight and to ensure that the appropriate referrals are being completed.

(i) When ordered by the treating physician, screening of a newborn's, infant's, or toddler's hearing must include auditory brainstem responses, or evoked otoacoustic emissions, or appropriate technology as approved by the United States Food and Drug Administration.

(j) The results of any test conducted pursuant to this section, including, but not limited to, newborn hearing loss screening, congenital cytomegalovirus testing, and any related diagnostic testing, must be reported to the department within 7 days after receipt of such results.

(k) The initial procedure for screening the hearing of the newborn or infant and any medically necessary follow-up reevaluations leading to diagnosis shall be a covered benefit for Medicaid patients covered by a fee-for-service program. For Medicaid patients enrolled in HMOs, providers shall be reimbursed directly by the Medicaid Program Office at the Medicaid rate. This service may not be considered a covered service for the purposes of establishing the payment rate for Medicaid HMOs. All health insurance policies and health maintenance organizations as provided under ss. 627.6416, 627.6579, and 641.31(30), except for supplemental policies that only provide coverage for specific diseases, hospital indemnity, or Medicare supplement, or to the supplemental policies, shall compensate providers for the covered benefit at the contracted rate. Nonhospital-based providers are eligible to bill Medicaid for the professional and technical component of each procedure code.

(l) A child who is diagnosed as having permanent hearing loss must be referred to the primary care physician for medical management, treatment, and follow-up services. Furthermore, in

accordance with Part C of the Individuals with Disabilities Education Act, Pub. L. No. 108-446, Infants and Toddlers with Disabilities, any child from birth to 36 months of age who is diagnosed as having hearing loss that requires ongoing special hearing services must be referred to the Children's Medical Services Early Intervention Program serving the geographical area in which the child resides.

Section 5. Section 383.147, Florida Statutes, is amended to read:

383.147 ~~Newborn and infant screenings for~~ Sickle cell disease and sickle cell trait ~~hemoglobin variants;~~ registry.—

(1) If ~~a screening provider detects that~~ a newborn as ~~or an infant, as those terms are~~ defined in s. 383.145(2)~~,~~ is identified as having sickle cell disease or carrying a sickle cell trait through the newborn screening program as described in s. 383.14, the department ~~hemoglobin variant, it~~ must:

(a) Notify the parent or guardian of the newborn and provide information regarding the availability and benefits of genetic counseling. ~~primary care physician of the newborn or infant and~~

(b) Submit the results of such screening ~~to the Department of Health~~ for inclusion in the sickle cell registry established under paragraph (2)(a), unless the parent or guardian of the newborn provides an opt-out form obtained from the department, or otherwise indicates in writing to the department his or her

objection to having the newborn included in the sickle cell registry. ~~The primary care physician must provide to the parent or guardian of the newborn or infant information regarding the availability and benefits of genetic counseling.~~

(2)(a) The Department of Health shall contract with a community-based sickle cell disease medical treatment and research center to establish and maintain a registry for individuals ~~newborns and infants~~ who are identified as having sickle cell disease or carrying a sickle cell trait ~~hemoglobin variant~~. The sickle cell registry must track sickle cell disease outcome measures, except as provided in paragraph (1)(b). ~~A parent or guardian of a newborn or an infant in the registry may request to have his or her child removed from the registry by submitting a form prescribed by the department by rule.~~

(b) In addition to newborns identified and included in the registry under subsection (1), persons living in this state who have been identified as having sickle cell disease or carrying a sickle cell trait may choose to be included in the registry by providing the department with notification as prescribed by rule.

(c) The Department of Health shall also establish a system to ensure that the community-based sickle cell disease medical treatment and research center notifies the parent or guardian of a child who has been included in the registry that a follow-up consultation with a physician is recommended. Such notice must

be provided to the parent or guardian of such child at least once during early adolescence and once during late adolescence. The department shall make every reasonable effort to notify persons included in the registry who are 18 years of age that they may request to be removed from the registry by submitting a form prescribed by the department by rule. The department shall also provide to such persons information regarding available educational services, genetic counseling, and other beneficial resources.

(3) The Department of Health shall adopt rules to implement this section.

Section 6. Section 383.148, Florida Statutes, is created to read:

383.148 ENVIRONMENTAL RISK SCREENING.—

(1) RISK SCREENING.—To help ensure access to the maternal and child health care system, the Department of Health shall promote the screening of all pregnant women and infants in this state for environmental risk factors, such as low income, poor education, maternal and family stress, mental health, substance use disorder, and other high-risk conditions, and promote education of the public about the dangers associated with environmental risk factors.

(2) PRENATAL RISK SCREENING REQUIREMENTS.—The department shall develop a multilevel screening process that includes a risk assessment instrument to identify women at risk for a

preterm birth or other high-risk condition.

(a) A primary health care provider must complete the risk screening at a pregnant woman's first prenatal visit using the form and in the manner prescribed by rules adopted under this section, so that the woman may immediately be notified and referred to appropriate health, education, and social services.

(b) This subsection does not apply if the pregnant woman objects to the screening in a manner prescribed by department rule.

(3) POSTNATAL RISK SCREENING REQUIREMENTS.—The department shall develop a multilevel screening process that includes a risk assessment instrument to identify factors 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.

(a) A hospital or birth center must complete the risk screening immediately following the birth of the infant, before discharge from the hospital or birth center, using the form and in the manner prescribed by rules adopted under this section.

(b) This subsection does not apply if a parent or guardian of the newborn objects to the screening in a manner prescribed by department rule.

Section 7. Section 383.2163, Florida Statutes, is amended to read:

383.2163 Telehealth minority maternity care program ~~pilot programs~~.~~—By July 1, 2022,~~ The department shall establish a telehealth minority maternity care ~~pilot~~ program ~~in Duval County and Orange County~~ which uses telehealth to expand the capacity for positive maternal health outcomes in racial and ethnic minority populations. The department shall ~~direct and assist the county health departments in Duval County and Orange County to~~ implement local ~~the~~ programs contingent upon available funding.

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

(a) "Department" means the Department of Health.

(b) "Eligible pregnant woman" means a pregnant woman who is receiving, or is eligible to receive, maternal or infant care services from the department under chapter 381 or this chapter.

(c) "Health care practitioner" has the same meaning as in s. 456.001.

(d) "Health professional shortage area" means a geographic area designated as such by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(e) "Indigenous population" means any Indian tribe, band, or nation or other organized group or community of Indians recognized as eligible for services provided to Indians by the United States Secretary of the Interior because of their status as Indians, including any Alaskan native village as defined in 43 U.S.C. s. 1602(c), the Alaska Native Claims Settlement Act,

as that definition existed on the effective date of this act.

(f) "Maternal mortality" means a death occurring during pregnancy or the postpartum period which is caused by pregnancy or childbirth complications.

(g) "Medically underserved population" means the population of an urban or rural area designated by the United States Secretary of Health and Human Services as an area with a shortage of personal health care services or a population group designated by the United States Secretary of Health and Human Services as having a shortage of such services.

(h) "Perinatal professionals" means doulas, personnel from Healthy Start and home visiting programs, childbirth educators, community health workers, peer supporters, certified lactation consultants, nutritionists and dietitians, social workers, and other licensed and nonlicensed professionals who assist women through their prenatal or postpartum periods.

(i) "Postpartum" means the 1-year period beginning on the last day of a woman's pregnancy.

(j) "Severe maternal morbidity" means an unexpected outcome caused by a woman's labor and delivery which results in significant short-term or long-term consequences to the woman's health.

(k) "Technology-enabled collaborative learning and capacity building model" means a distance health care education model that connects health care professionals, particularly

specialists, with other health care professionals through simultaneous interactive videoconferencing for the purpose of facilitating case-based learning, disseminating best practices, and evaluating outcomes in the context of maternal health care.

(2) PURPOSE.—The purpose of the program ~~pilot programs~~ is to:

(a) Expand the use of technology-enabled collaborative learning and capacity building models to improve maternal health outcomes for the following populations and demographics:

1. Ethnic and minority populations.

2. Health professional shortage areas.

3. Areas with significant racial and ethnic disparities in maternal health outcomes and high rates of adverse maternal health outcomes, including, but not limited to, maternal mortality and severe maternal morbidity.

4. Medically underserved populations.

5. Indigenous populations.

(b) Provide for the adoption of and use of telehealth services that allow for screening and treatment of common pregnancy-related complications, including, but not limited to, anxiety, depression, substance use disorder, hemorrhage, infection, amniotic fluid embolism, thrombotic pulmonary or other embolism, hypertensive disorders relating to pregnancy, diabetes, cerebrovascular accidents, cardiomyopathy, and other cardiovascular conditions.

(3) TELEHEALTH SERVICES AND EDUCATION.—The program ~~pilot programs~~ shall adopt the use of telehealth or coordinate with prenatal home visiting programs to provide all of the following services and education to eligible pregnant women up to the last day of their postpartum periods, as applicable:

(a) Referrals to Healthy Start's coordinated intake and referral program to offer families prenatal home visiting services.

(b) Services and education addressing social determinants of health, including, but not limited to, all of the following:

1. Housing placement options.

2. Transportation services or information on how to access such services.

3. Nutrition counseling.

4. Access to healthy foods.

5. Lactation support.

6. Lead abatement and other efforts to improve air and water quality.

7. Child care options.

8. Car seat installation and training.

9. Wellness and stress management programs.

10. Coordination across safety net and social support services and programs.

(c) Evidence-based health literacy and pregnancy, childbirth, and parenting education for women in the prenatal

and postpartum periods.

(d) For women during their pregnancies through the postpartum periods, connection to support from doulas and other perinatal health workers.

(e) Tools for prenatal women to conduct key components of maternal wellness checks, including, but not limited to, all of the following:

1. A device to measure body weight, such as a scale.

2. A device to measure blood pressure which has a verbal reader to assist the pregnant woman in reading the device and to ensure that the health care practitioner performing the wellness check through telehealth is able to hear the reading.

3. A device to measure blood sugar levels with a verbal reader to assist the pregnant woman in reading the device and to ensure that the health care practitioner performing the wellness check through telehealth is able to hear the reading.

4. Any other device that the health care practitioner performing wellness checks through telehealth deems necessary.

(4) TRAINING.—The program ~~pilot programs~~ shall provide training to participating health care practitioners and other perinatal professionals on all of the following:

(a) Implicit and explicit biases, racism, and discrimination in the provision of maternity care and how to eliminate these barriers to accessing adequate and competent maternity care.

(b) The use of remote patient monitoring tools for pregnancy-related complications.

(c) How to screen for social determinants of health risks in the prenatal and postpartum periods, such as inadequate housing, lack of access to nutritional foods, environmental risks, transportation barriers, and lack of continuity of care.

(d) Best practices in screening for and, as needed, evaluating and treating maternal mental health conditions and substance use disorders.

(e) Information collection, recording, and evaluation activities to:

1. Study the impact of the ~~pilot~~ program;

2. Ensure access to and the quality of care;

3. Evaluate patient outcomes as a result of the pilot program;

4. Measure patient experience; and

5. Identify best practices for the future expansion of the ~~pilot~~ program.

(5) FUNDING.—The program ~~pilot programs~~ shall be funded using funds appropriated by the Legislature ~~for the Closing the Gap grant program~~. The department's Division of Community Health Promotion and Office of Minority Health and Health Equity shall also work in partnership to apply for federal funds that are available to assist the department in accomplishing the program's purpose and successfully implementing the program

through community-based organizations ~~pilot programs~~.

(6) RULES.—The department may adopt rules to implement this section.

Section 8. Paragraph (i) of subsection (3) of section 383.318, Florida Statutes, is amended to read:

383.318 Postpartum care for birth center clients and infants.—

(3) The birth center shall provide a postpartum evaluation and followup care that includes all of the following:

(i) Provision of the informational pamphlet on infant and childhood eye and vision disorders created by the department pursuant to s. 383.14(3)(h) ~~s. 383.14(3)(i)~~.

Section 9. Section 395.1053, Florida Statutes, is amended to read:

395.1053 Postpartum education.—A hospital that provides birthing services shall incorporate information on safe sleep practices and the possible causes of Sudden Unexpected Infant Death into the hospital's postpartum instruction on the care of newborns and provide to each parent the informational pamphlet on infant and childhood eye and vision disorders created by the department pursuant to s. 383.14(3)(h) ~~s. 383.14(3)(i)~~.

Section 10. Section 456.0496, Florida Statutes, is amended to read:

456.0496 Provision of information on eye and vision disorders to parents during planned out-of-hospital births.—A

health care practitioner who attends an out-of-hospital birth must ensure that the informational pamphlet on infant and childhood eye and vision disorders created by the department pursuant to s. 383.14(3)(h) ~~s. 383.14(3)(i)~~ is provided to each parent after such a birth.

Section 11. This act shall take effect July 1, 2024.

Amendment No.1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	_____	

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Anderson offered the following:

Amendment (with title amendment)

Remove lines 749-903

T I T L E A M E N D M E N T

Remove lines 86-91 and insert:

screening; amending ss. 383.318, 395.1053, and 456.0496,

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1561 Office Surgeries
SPONSOR(S): Busatta Cabrera
TIED BILLS: **IDEN./SIM. BILLS:** SB 1188

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	16 Y, 0 N	Guzzo	McElroy
2) Health Care Appropriations Subcommittee		Smith	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The bill provides additional enforcement authority to the Department of Health (DOH) over offices in which physicians perform certain liposuction procedures, including gluteal fat grafting procedures.

Current law requires a physician to register their office with DOH if they perform liposuction procedures in which more than 1,000 cubic centimeters of supernatant fat is removed. The bill requires them to register if the fat is temporarily or permanently removed, thus removing a loophole from registration because gluteal fat grafting procedures involve removing (temporarily) and then reinserting the fat in the patient.

The bill requires physicians to register their office with DOH if they perform gluteal fat grafting procedures. Additionally, the bill requires a physician to register their office with DOH if they perform a liposuction procedure in which the patient is rotated 180 degrees or more during the procedure.

Further, the bill requires physicians who have already registered their offices prior to July 1, 2024, to reregister their offices, in accordance with a schedule developed by DOH, if they perform gluteal fat grafting procedures, or if they perform liposuction procedures in which the patient is rotated 180 degrees or more. If during the reregistration process, DOH determines that the procedures being performed in such an office create a significant risk to patient safety and that the office should be licensed and regulated as an ambulatory surgical center (ASC), DOH must notify the Agency for Health Care Administration (AHCA) and AHCA must inspect the office to confirm that the office should be licensed as an ASC. If AHCA determines that the office should be licensed as an ASC, they must notify the office and DOH, and the office must cease performing procedures that require registration. The office is prohibited from performing such procedures until it relinquishes its registration and obtains an ASC license. The bill requires DOH to complete reregistration by December 1, 2024.

Current law authorizes DOH to impose a fine of $5,000 per day on a physician who performs a gluteal fat grafting procedure in an office that is not registered with DOH.. The bill changes the fine to $5,000 per incident to allow DOH to fine a physician for multiple offenses committed during the same day.

The bill has an indeterminate, yet likely insignificant, fiscal impact on AHCA and DOH and no impact on local government.

The bill is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Gluteal Fat Grafting

Gluteal fat grafting, commonly known as a "Brazilian butt lift" or BBL, is the fastest-growing plastic surgery procedure in the U.S. The procedure involves liposuction in areas where fat removal will improve the contour of the body. Typically, fat is harvested from two or more regions which may include the flanks (love handles), abdomen, or back. The harvested fat is purified to optimize the viability of fat cells and stem cells before it is injected into the subcutaneous layer (below the skin, but above the muscle) of the buttocks.[1]

The rate of fatal complications from gluteal fat grafting is higher than any other cosmetic procedure.[2] South Florida carries the highest BBL mortality rate by far in the nation with 25 deaths occurring between 2010 and 2022.[3] According to a study on the deaths that occurred in South Florida, the surgical setting and the short surgical times for these cases were the most significant contributing factors to the deaths.[4] Of the 25 deaths, 23 of the surgeries were performed at high-volume, low budget clinics. These clinics employ a practice model based on high-volume and minimal-patient-interaction. All of the deaths resulted from pulmonary fat embolism, which occurs when a vein wall is injured during the injection process allowing fat to enter the pulmonary vessels.[5]

Regulation of Office Surgeries

The Board of Medicine and the Board of Osteopathic Medicine (collectively, boards) have authority to adopt rules to regulate practice of medicine and osteopathic medicine, respectively.[6] The boards have authority to establish, by rule, standards of practice and standards of care for particular settings.[7] Such standards may include education and training, assistance of and delegation to other personnel, sterilization, performance of complex or multiple procedures, records, informed consent, and policy and procedures manuals.[8]

The boards establish the standards of care that must be met for office surgeries. An office surgery is any surgery that is performed outside a facility licensed under ch. 390, F.S., or ch. 395, F.S.[9] There are several levels of office surgeries governed by rules adopted by the boards, which establish the scope of each level of office surgeries, the equipment and medications that must be available, and the training requirements for personnel present during the surgery.

Registration

[1] O'Neill RC, Abu-Ghname A, Davis MJ, Chamata E, Rammos CK, Winocour SJ. *The Role of Fat Grafting in Buttock Augmentation*, Seminars in Plastic Surgery (February 15, 2020) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7023974/#:~:text=First%2C%20fat%20is%20harvested%20from,figure%20with%20an%20augmented%20buttock (last visited January 25, 2024).
[2] Pat Pazmiño, Onelio Garcia, *Brazilian Butt Lift–Associated Mortality: The South Florida Experience*, Aesthetic Surgery Journal, Volume 43, Issue 2, February 2023, Pages 162–178, https://doi.org/10.1093/asj/sjac224 (last visited January 25, 2024).
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] Chapter 458, F.S., regulates the practice of allopathic medicine, and ch. 459, F.S., regulates the practice of osteopathic medicine.
[7] Ss. 458.331(v) and 459.015(z), F.S.
[8] *Id.*
[9] Rules 64B8-9.009(1)(d) and 64B15-14.007(1)(d), F.A.C. Abortion clinics are licensed under ch. 390, F.S., and facilities licensed under ch. 395, F.S., include hospitals, ASCs, mobile surgical facilities, and certain intensive residential treatment programs. Office surgery is a surgery performed at an office that primarily serves as the doctor's office where he or she regularly performs consultations, presurgical exams, and postoperative observation and care, and where patient medical records are maintained and available.

A physician is required to register their office with DOH to perform liposuction procedures in which more than 1,000 cubic centimeters of supernatant fat is removed, a level II office surgery, or a level III office surgery.[10]

Each registered office must designate a physician who is responsible for complying with all laws and regulations establishing safety requirements for such offices.[11] The designated physician is required to notify DOH within 10 days of hiring any new recovery or surgical team personnel.[12] The office must notify DOH within 10 calendar days after the termination of a designated physician relationship.[13]

DOH must inspect any office where office surgeries will be done before the office is registered.[14] If the office refuses such inspection, it will not be registered until the inspection can be completed. If an office that has already been registered with DOH refuses inspection its registration will be immediately suspended and remain suspended until the inspection is completed, and the office must close for 14 days.[15]

DOH must inspect each registered office annually unless the office is accredited by a nationally recognized accrediting agency approved by the respective board. Such inspections may be unannounced.[16]

Currently, there are 724 offices registered with DOH.[17]

Standards of Care

Prior to performing any surgery, a physician must evaluate the risk of anesthesia and of the surgical procedure to be performed.[18] A physician must maintain a complete record of each surgical procedure, including the anesthesia record, if applicable, and written informed consent.[19] The written consent must reflect the patient's knowledge of identified risks, consent to the procedure, type of anesthesia and anesthesia provider, and that a choice of anesthesia provider exists.[20]

Physicians performing office surgeries must maintain a log of all liposuction procedures in which more than 1,000 cubic centimeters of supernatant fat is removed and Level II and Level III surgical procedures performed,[21] which includes:[22]

- A confidential patient identifier;
- The time the patient arrives in the operating suite;
- The name of the physician who provided medical clearance;
- The surgeon's name;
- The diagnosis;
- The CPT Codes for the procedures performed;
- The patient's ASA classification;
- The type of procedure performed;
- The level of surgery;

[10] Ss. 458.328(1) and 459.0138(1), F.S.
[11] Rule 64B8-9.0091(1) and 64B15-14.0076(1), F.A.C.
[12] *Id.*
[13] *Id.*
[14] *Supra* note 10.
[15] *Id.*
[16] *Id.*
[17] Department of Health, *License Verification – Office Surgery Registration, Practicing Statuses Only*, March 21, 2023, available at https://mqa-internet.doh.state.fl.us/MQASearchServices/HealthCareProviders (last visited January 25, 2024).
[18] Rules 64B8-9.009(2) and 64B15-14.007(2), F.A.C.
[19] *Id.* A physician does not need to obtain written informed consent for minor Level I procedures limited to the skin and mucosa.
[20] *Id.* A patient may use an anesthesiologist, anesthesiologist assistant, another appropriately trained physician, certified registered nurse anesthetist, or physician assistant.
[21] Level I office surgeries involves the most minor of surgeries, which require minimal sedation or local or topical anesthesia, and have a remote chance of complications requiring hospitalization. Level II office surgeries involve moderate sedation and require the physician office to have a transfer agreement with a licensed hospital that is no more than 30 minutes from the office. Level IIA office surgeries are those Level II surgeries with a maximum planned duration of 5 minutes or less and in which chances of complications requiring hospitalization are remote. Level III office surgeries are the most complex and require deep sedation or general anesthesia. Rules 64B8-9.009(3)-(6) and 64B15-14.007(3)-(6), F.A.C.
[22] Rules 64B8-9.009(2)(c) and 64B15-14.007(2)(c), F.A.C.

- The anesthesia provider;
- The type of anesthesia used;
- The duration of the procedure;
- The type of post-operative care;
- The duration of recovery;
- The disposition of the patient upon discharge;
- A list of medications used during surgery and recovery; and
- Any adverse incidents.

Such log must be maintained for at least six years from the last patient contact and must be provided to DOH investigators upon request.[23]

For elective cosmetic and plastic surgery procedures performed in a physician's office:[24]

- The maximum planned duration of all planned procedures cannot exceed eight hours.
- A physician must discharge the patient within 24 hours, and overnight stay may not exceed 23 hours and 59 minutes.
- The overnight stay is strictly limited to the physician's office.
- If the patient has not sufficiently recovered to be safely discharged within the 24-hour period, the patient must be transferred to a hospital for continued post-operative care.

Office surgeries are prohibited from:

- Resulting in blood loss greater than 10 percent of blood volume in a patient with normal hemoglobin;
- Requiring major or prolonged intracranial, intrathoracic, abdominal, or joint replacement procedures, excluding laparoscopy;
- Involving a major blood vessel with direct visualization by open exposure of the vessel, not including percutaneous endovascular treatment[25]; or
- Being emergent or life threatening.

Adverse Incident Reporting

A physician must report any adverse incident that occurs in an office practice setting to DOH within 15 days after the occurrence any adverse incident.[26] An adverse incident in an office setting is defined as an event over which the physician or licensee could exercise control and which is associated with a medical intervention and results in one of the following patient injuries:[27]

- The death of a patient;
- Brain or spinal damage to a patient;
- The performance of a surgical procedure on the wrong patient;
- If the procedure results in death; brain or spinal damage; permanent disfigurement; the fracture or dislocation of bones or joints; a limitation of neurological, physical, or sensory functions; or any condition that required the transfer of a patient, the performance of:
    - A wrong-site surgical procedure;
    - A wrong surgical procedure; or
    - A surgical repair of damage to a patient resulting from a planned surgical procedure where the damage is not a recognized specific risk as disclosed to the patient and documented through the informed consent process;
- A procedure to remove unplanned foreign objects remaining from a surgical procedure; or

[23] *Id*.
[24] Rules 64B8-9.009(2)(g) and 64B15-14.007(2)(g), F.A.C.
[25] Such treatment addresses conditions such as peripheral artery disease and other arterial blockages.
[26] Ss. 458.351 and 459.026, F.S.
[27] Ss. 458.351(4) and 459.026(4), F.S.

- Any condition that required the transfer of a patient to a hospital from an ASC or any facility or any office maintained by a physician for the practice of medicine which is not licensed under ch. 395, F.S.

DOH must review each adverse incident report to determine if discipline against the practitioner's license is warranted.[28]

Office Surgeries – Gluteal Fat Procedures

Current law establishes standards of practice for physicians performing gluteal fat grafting procedures in office surgery settings.

A physician providing gluteal fat grafting procedures must adhere to the standards of practice in statute and in rule. A physician or osteopathic physician performing such procedures must conduct an in-person exam of the patient, while physically present in the same room as the patient, no later than the day before the procedure.

Any duty delegated by the physician and performed during the gluteal fat grafting procedure must be completed under the direct supervision of the physician. Gluteal fat injections and fat extraction may not be delegated. Gluteal fat injections must be done under ultrasound guidance, or guidance with other technology authorized by rule that equals or exceeds the quality of ultrasound, to ensure the fat is injected into the subcutaneous space. Gluteal fat may only be injected into the subcutaneous space and may not cross the fascia covering gluteal muscle. Intramuscular and submuscular fat injections are prohibited.

Enforcement Authority

DOH may deny or revoke an office registration if any of its physicians, owners, or operators do not comply with any office surgery laws or rules. Also, DOH may deny a person applying for a facility registration if he or she was named in the registration document of an office whose registration is revoked for five years after the revocation date.

DOH may impose penalties on the designated physician if the registered office is not in compliance with safety requirements, including:[29]

- Suspension or permanent revocation of a license;
- Restriction of license;
- Imposition of an administrative fine not to exceed $10,000 for each count or separate offense. If the violation is for fraud or making a false or fraudulent representation, the board, or the department if there is no board, must impose a fine of $10,000 per count or offense.;
- Issuance of a reprimand or letter of concern.
- Placement of the licensee on probation for a period of time and subject to such conditions as the board;
- Corrective action;
- Imposition of an administrative fine in accordance with s. 381.0261 for violations regarding patient rights;
- Refund of fees billed and collected from the patient or a third party on behalf of the patient; or
- Requirement that the licensee undergo remedial education.

DOH can also issue an emergency order suspending or restricting the registration of a facility if there is probable cause that:

- The office or its physicians are not in compliance with the board rule on the standards of practice; or

[28] Ss. 458.351(5) and 459.026(5), F.S.
[29] S. 456.072(2), F.S.

- The licensee or registrant is practicing or offering to practice beyond the scope allowed by law or beyond his or her competence to perform; and
- Such noncompliance constitutes an immediate danger to the public.

The boards must adopt rules establishing the standards of practice for physicians who perform office surgery. The boards must fine physicians who perform office surgeries in an unregistered facility $5,000 per day. Lastly, performing office surgery in a facility that is not registered with DOH is grounds for disciplinary action against a physician's license.

In 2023, the Legislature provided further enforcement authority to DOH and the boards to regulate offices in which certain liposuction procedures and office surgeries.[30]

Ambulatory Surgical Centers

An ambulatory surgical center, or ASC, is a facility, that is not a part of a hospital, the primary purpose of which is to provide elective surgical care, in which the patient is admitted and discharged within 24 hours.[31] If a provider anticipates or knows that they will be discharging patients beyond 24 hours, they must self-designate as an ASC by applying for ASC licensure with the Agency for Health Care Administration (AHCA).[32]

ASCs are licensed and regulated by AHCA under the same regulatory framework as hospitals.[33] Currently, there are 520 licensed ASCs in Florida.[34]

Effect of the Bill

Current law requires a physician who performs liposuction procedures in which more than 1,000 cubic centimeters of supernatant fat is removed to register his or her office with DOH. The bill requires physicians to register if the fat is temporarily or permanently removed, thus removing a loophole from registration because gluteal fat grafting procedures involve temporarily removing the fat and then reinserting it into the patient.

The bill requires physicians to register their office with DOH if they perform gluteal fat grafting procedures. Additionally, the bill requires a physician to register their office with DOH if they perform a liposuction procedure in which the patient is rotated 180 degrees or more during the procedure.

Further, the bill requires physicians who have already registered their offices prior to July 1, 2024, to reregister their offices, in accordance with a schedule developed by DOH, if they perform gluteal fat grafting procedures, or if they perform liposuction procedures in which the patient is rotated 180 degrees or more. The bill requires DOH to complete reregistration by December 1, 2024.

If during the reregistration process, DOH determines that the procedures being performed in such an office create a significant risk to patient safety and that the office should be licensed and regulated as an ASC, DOH must notify AHCA and AHCA must inspect the office to confirm whether the office should be licensed as an ASC. If AHCA determines that the office should be licensed as an ASC, they must notify the office and DOH and the office must cease performing procedures that require registration. The office is prohibited from performing such procedures until it relinquishes its registration and obtains an ASC license.

Current law authorizes DOH to impose a fine of $5,000 per day on a physician who performs a gluteal fat grafting procedure in an office that is not registered with DOH. . The bill changes the fine to $5,000 per incident, to allow DOH to fine a physician for multiple offenses committed during the same day.

[30] Ch.23-307, Laws of Fla.
[31] S. 395.002(3), F.S.
[32] Agency for Health Care Administration, Agency Analysis of HB 1561 (Jan. 18, 2024).
[33] SS. 395.001-.1065, F.S., and Part II, Chapter 408, F.S.
[34] *Supra* note 32.

The bill is effective upon becoming law.

B. SECTION DIRECTORY:

Section 1: Amends s. 458.328, F.S., relating to office surgeries.
Section 2: Amends s. 459.0138, F.S., relating to office surgeries.
Section 3: In an unnumbered section of law, requires DOH to develop a schedule for reregistration of medical offices affected by the bill, to be completed by a specified date.
Section 4: Provides the bill is effective upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill would have an indeterminate, positive fiscal impact on the DOH Medical Quality Assurance Trust Fund, to the extent the number of annual office incidents exceeds one per day.

2. Expenditures:

The bill has an indeterminate, yet likely insignificant, negative fiscal impact on AHCA for additional staff to conduct survey inspections of physician offices. According to AHCA, the number of additional surveys is unknown, so it is unknown if additional staff would be needed to cover the workload.[35]

DOH will experience a non-recurring increase in workload and costs associated with updating the Licensing and Enforcement Information Database System (LEIDS) and Iron Data Mobile (IDM) inspection software to update inspection requirements; DOH will also experience a non-recurring workload increase to update the artificial intelligence virtual agent (ELI) for voice and web, Search Services application, data reporting, and board and DOH websites. Additionally, DOH may be required to create data exchange services with the AHCA.[36] The workload and costs associated with the bill can be absorbed within existing resources.

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

[35] *Id.*
[36] Department of Health, *2024 Agency Legislative Bill Analysis: SB 1188*, (Jan. 11, 2024)

2. Other:

None.

B. RULE-MAKING AUTHORITY:

DOH has sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to office surgeries; amending ss. 458.328 and 459.0138, F.S.; revising the types of procedures for which a medical office must register with the Department of Health to perform office surgeries; deleting obsolete language; making technical and clarifying changes; revising standards of practice for office surgeries; requiring medical offices already registered with the department to perform certain office surgeries as of a specified date to reregister if such offices perform specified procedures; specifying notification and inspection procedures for the department and the Agency for Health Care Administration in the event that, during the reregistration process, the department determines that the performance of specified procedures in an office creates a risk of patient safety such that the office should instead be regulated as an ambulatory surgical center; requiring an office to cease performing the specified procedures and relinquish its office surgery registration and instead seek licensure as an ambulatory surgical center under such circumstances; requiring the department to develop a schedule for reregistration of medical offices affected by this act, to be completed by a specified

date; providing an effective date.

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

Section 1. Paragraphs (a), (b), and (h) of subsection (1) and subsection (2) of section 458.328, Florida Statutes, are amended, and subsection (4) is added to that section, to read:

458.328 Office surgeries.—

(1) REGISTRATION.—

(a)1. An office in which a physician performs a liposuction procedure in which more than 1,000 cubic centimeters of supernatant fat is temporarily or permanently removed, a liposuction procedure in which the patient is rotated 180 degrees or more during the procedure, a gluteal fat grafting procedure, a Level II office surgery, or a Level III office surgery must register with the department. ~~unless the office is licensed as~~ A facility licensed under chapter 390 or chapter 395 may not be registered under this section.

2. The department must complete an inspection of any office seeking registration under this section before the office may be registered.

(b) ~~By January 1, 2020,~~ Each office registered under this section or s. 459.0138 must designate a physician who is responsible for the office's compliance with the office health and safety requirements of this section and rules adopted

hereunder. A designated physician must have a full, active, and unencumbered license under this chapter or chapter 459 and shall practice at the office for which he or she has assumed responsibility. Within 10 calendar days after the termination of a designated physician relationship, the office must notify the department of the designation of another physician to serve as the designated physician. The department may suspend the registration of an office if the office fails to comply with the requirements of this paragraph.

~~(h) A physician may only perform a procedure or surgery identified in paragraph (a) in an office that is registered with the department. The board shall impose a fine of $5,000 per day on a physician who performs a procedure or surgery in an office that is not registered with the department.~~

(2) STANDARDS OF PRACTICE.—

(a) A physician may not perform any surgery or procedure identified in paragraph (1)(a) in a setting other than an office registered under this section or a facility licensed under chapter 390 or chapter 395, as applicable. The board shall impose a fine of $5,000 per incident on a physician who violates this paragraph ~~performing a gluteal fat grafting procedure in an office surgery setting shall adhere to standards of practice pursuant to this subsection and rules adopted by the board~~.

(b) Office surgeries may not:

1. Be a type of surgery that generally results in blood

loss of more than 10 percent of estimated blood volume in a patient with a normal hemoglobin level;

2. Require major or prolonged intracranial, intrathoracic, abdominal, or joint replacement procedures, except for laparoscopic procedures;

3. Involve major blood vessels and be performed with direct visualization by open exposure of the major blood vessel, except for percutaneous endovascular intervention; or

4. Be emergent or life threatening.

(c) A physician performing a gluteal fat grafting procedure in an office surgery setting shall adhere to standards of practice under this subsection and rules adopted by the board, which include, but are not limited to, all of the following:

1. A physician performing a gluteal fat grafting procedure must conduct an in-person examination of the patient while physically present in the same room as the patient no later than the day before the procedure.

2. Before a physician may delegate any duties during a gluteal fat grafting procedure, the patient must provide written, informed consent for such delegation. Any duty delegated by a physician during a gluteal fat grafting procedure must be performed under the direct supervision of the physician performing such procedure. Fat extraction and gluteal fat injections must be performed by the physician and may not be

delegated.

3. Fat may only be injected into the subcutaneous space of the patient and may not cross the fascia overlying the gluteal muscle. Intramuscular or submuscular fat injections are prohibited.

4. When the physician performing a gluteal fat grafting procedure injects fat into the subcutaneous space of the patient, the physician must use ultrasound guidance, or guidance with other technology authorized under board rule which equals or exceeds the quality of ultrasound, during the placement and navigation of the cannula to ensure that the fat is injected into the subcutaneous space of the patient above the fascia overlying the gluteal muscle. Such guidance with the use of ultrasound or other technology is not required for other portions of such procedure.

5. An office in which a physician performs gluteal fat grafting procedures must at all times maintain a ratio of one physician to one patient during all phases of the procedure, beginning with the administration of anesthesia to the patient and concluding with the extubation of the patient. After a physician has commenced, and while he or she is engaged in, a gluteal fat grafting procedure, the physician may not commence or engage in another gluteal fat grafting procedure or any other procedure with another patient at the same time.

(d) If a procedure in an office surgery setting results in

hospitalization, the incident must be reported as an adverse incident pursuant to s. 458.351.

~~(c) An office in which a physician performs gluteal fat grafting procedures must at all times maintain a ratio of one physician to one patient during all phases of the procedure, beginning with the administration of anesthesia to the patient and concluding with the extubation of the patient. After a physician has commenced, and while he or she is engaged in, a gluteal fat grafting procedure, the physician may not commence or engage in another gluteal fat grafting procedure or any other procedure with another patient at the same time.~~

(4) REREGISTRATION.—An office that registered under this section before July 1, 2024, in which a physician performs liposuction procedures that include a patient being rotated 180 degrees or more during the procedure or in which a physician performs gluteal fat grafting procedures must seek reregistration with the department consistent with the parameters of initial registration under subsection (1) according to a schedule developed by the department. During the reregistration process, if the department determines that the performance of such procedures in the office creates a significant risk to patient safety and that the interests of patient safety would be better served if such procedures were instead regulated under the requirements of ambulatory surgical center licensure under chapter 395:

(a) The department must notify the Agency for Health Care Administration of its determination;

(b) The agency must inspect the office and determine, in the interest of patient safety, whether the office is a candidate for ambulatory surgical center licensure notwithstanding the office's failure to meet all requirements associated with such licensure at the time of inspection and notwithstanding the exceptions provided under s. 395.002(3).

If the agency determines that an office is a candidate for ambulatory surgical center licensure under paragraph (b), the agency must notify the office and the department, and the office must cease performing procedures described in this subsection. The office may not recommence performing such procedures without first relinquishing its registration under this section and attaining ambulatory surgery center licensure under chapter 395.

Section 2. Paragraphs (a), (b), and (h) of subsection (1) and subsection (2) of section 459.0138, Florida Statutes, are amended, and subsection (4) is added to that section, to read:

459.0138 Office surgeries.—

(1) REGISTRATION.—

(a)1. An office in which a physician performs a liposuction procedure in which more than 1,000 cubic centimeters of supernatant fat is temporarily or permanently removed, a liposuction procedure in which the patient is rotated 180

degrees or more during the procedure, a gluteal fat grafting procedure, a Level II office surgery, or a Level III office surgery must register with the department. ~~unless the office is licensed as~~ A facility licensed under chapter 390 or chapter 395 may not be registered under this section.

2. The department must complete an inspection of any office seeking registration under this section before the office may be registered.

(b) ~~By January 1, 2020,~~ Each office registered under this section or s. 458.328 must designate a physician who is responsible for the office's compliance with the office health and safety requirements of this section and rules adopted hereunder. A designated physician must have a full, active, and unencumbered license under this chapter or chapter 458 and shall practice at the office for which he or she has assumed responsibility. Within 10 calendar days after the termination of a designated physician relationship, the office must notify the department of the designation of another physician to serve as the designated physician. The department may suspend a registration for an office if the office fails to comply with the requirements of this paragraph.

~~(h) A physician may only perform a procedure or surgery identified in paragraph (a) in an office that is registered with the department. The board shall impose a fine of $5,000 per day on a physician who performs a procedure or surgery in an office~~

~~that is not registered with the department.~~

(2) STANDARDS OF PRACTICE.—

(a) A physician may not perform any surgery or procedure identified in paragraph (1)(a) in a setting other than an office registered under this section or a facility licensed under chapter 390 or chapter 395, as applicable. The board shall impose a fine of $5,000 per incident on a physician who violates this paragraph ~~performing a gluteal fat grafting procedure in an office surgery setting shall adhere to standards of practice pursuant to this subsection and rules adopted by the board~~.

(b) Office surgeries may not:

1. Be a type of surgery that generally results in blood loss of more than 10 percent of estimated blood volume in a patient with a normal hemoglobin level;

2. Require major or prolonged intracranial, intrathoracic, abdominal, or joint replacement procedures, except for laparoscopic procedures;

3. Involve major blood vessels and be performed with direct visualization by open exposure of the major blood vessel, except for percutaneous endovascular intervention; or

4. Be emergent or life threatening.

(c) A physician performing a gluteal fat grafting procedure in an office surgery setting shall adhere to standards of practice under this subsection and rules adopted by the board, which include, but are not limited to, all of the

following:

1. A physician performing a gluteal fat grafting procedure must conduct an in-person examination of the patient while physically present in the same room as the patient no later than the day before the procedure.

2. Before a physician may delegate any duties during a gluteal fat grafting procedure, the patient must provide written, informed consent for such delegation. Any duty delegated by a physician during a gluteal fat grafting procedure must be performed under the direct supervision of the physician performing such procedure. Fat extraction and gluteal fat injections must be performed by the physician and may not be delegated.

3. Fat may only be injected into the subcutaneous space of the patient and may not cross the fascia overlying the gluteal muscle. Intramuscular or submuscular fat injections are prohibited.

4. When the physician performing a gluteal fat grafting procedure injects fat into the subcutaneous space of the patient, the physician must use ultrasound guidance, or guidance with other technology authorized under board rule which equals or exceeds the quality of ultrasound, during the placement and navigation of the cannula to ensure that the fat is injected into the subcutaneous space of the patient above the fascia overlying the gluteal muscle. Such guidance with the use of

ultrasound or other technology is not required for other portions of such procedure.

5. An office in which a physician performs gluteal fat grafting procedures must at all times maintain a ratio of one physician to one patient during all phases of the procedure, beginning with the administration of anesthesia to the patient and concluding with the extubation of the patient. After a physician has commenced, and while he or she is engaged in, a gluteal fat grafting procedure, the physician may not commence or engage in another gluteal fat grafting procedure or any other procedure with another patient at the same time.

(d) If a procedure in an office surgery setting results in hospitalization, the incident must be reported as an adverse incident pursuant to s. 458.351.

~~(e) An office in which a physician performs gluteal fat grafting procedures must at all times maintain a ratio of one physician to one patient during all phases of the procedure, beginning with the administration of anesthesia to the patient and concluding with the extubation of the patient. After a physician has commenced, and while he or she is engaged in, a gluteal fat grafting procedure, the physician may not commence or engage in another gluteal fat grafting procedure or any other procedure with another patient at the same time.~~

(4) REREGISTRATION.—An office that registered under this section before July 1, 2024, in which a physician performs

liposuction procedures that include a patient being rotated 180 degrees or more during the procedure or in which a physician performs gluteal fat grafting procedures must seek reregistration with the department consistent with the parameters of initial registration under subsection (1) according to a schedule developed by the department. During the reregistration process, if the department determines that the performance of such procedures in the office creates a significant risk to patient safety and that the interests of patient safety would be better served if such procedures were instead regulated under the requirements of ambulatory surgical center licensure under chapter 395:

(a) The department must notify the Agency for Health Care Administration of its determination;

(b) The agency must inspect the office and determine, in the interest of patient safety, whether the office is a candidate for ambulatory surgical center licensure notwithstanding the office's failure to meet all requirements associated with such licensure at the time of inspection and notwithstanding the exceptions provided under s. 395.002(3).

If the agency determines that an office is a candidate for ambulatory surgical center licensure under paragraph (b), the agency must notify the office and the department, and the office must cease performing procedures described in this subsection.

The office may not recommence performing such procedures without first relinquishing its registration under this section and attaining ambulatory surgery center licensure under chapter 395.

Section 3. The Department of Health shall develop a schedule for reregistration of offices affected by the amendments made to s. 458.328(1) or s. 459.0138(1), Florida Statutes, by this act. Registration of all such offices must be completed by December 1, 2024.

Section 4. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1609 Pregnancy Support Services
SPONSOR(S): Stevenson
TIED BILLS: **IDEN./SIM. BILLS:** SB 1442

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	16 Y, 0 N	Osborne	McElroy
2) Health Care Appropriations Subcommittee		Aderibigbe	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Social determinants of health are the external factors of a person's life that impact their health. These are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Housing is an important social determinant of health.

The United States is in the midst of a housing affordability crisis. Income growth has not kept up with rising housing costs, and the overall housing market has not responded adequately to the need for affordable housing. The national crisis is being acutely felt in Florida, with low-income renters being especially vulnerable to the rising cost of housing.

In 2022, there were 224,403 recorded births in Florida. Healthy pregnancies and childbirth are foundational to healthy families and communities. Nonetheless, pregnancy remains an essential but often dangerous experience with the potential for many avoidable complications. Maternal and infant health outcomes are an important marker of the overall health of a society. Florida's expecting mothers are not exempt from the state's affordable housing crisis. While the long-term effects of housing instability are detrimental to all who experience it, the impact on pregnant women is especially acute. Homelessness during pregnancy poses significant health risks for mothers and infants.

The bill creates that it is the Florida State Maternity Housing Grant Program within the Department of Health (DOH). The bill states that it is the intent of the Legislature to provide housing resources to resident women and families during the prenatal period, regardless of age or marital status, whose financial resources have been determined inadequate to meet residential costs.

The bill outlines expenses which grant funds may be allocated toward, and directs DOH to make rules for the implementation of the grant. The bill specifies that the total amount of grants awarded by DOH may not exceed the funding appropriated for the grant program.

The bill grants DOH rulemaking authority to adopt rules necessary for the administration of the program.

The provisions of the bill are subject to an appropriation. The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Social Determinants of Health

Social determinants of health (SDOH) are the external factors of a person's life that impact their health. These are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

There are five main categories of SDOH:[1]

- Economic stability;
- Education access and quality;
- Health care access and quality;
- Neighborhood and built environment; and
- Social and community context.

SDOH influence a persons' health in several ways. Some SDOH have causal relationships that are clear and relatively direct; for example, the presence of mold, or poor air and water quality, are part of the built environment that a person lives in and while consequences may be delayed, the causal relationship is easily established.[2] Living in such environmental conditions are often influenced by other SDOH, such as economic stability and community context where the connections to health outcomes are evident, but less easily conceptualized.[3]

Some aspects of health are especially sensitive to the environments that a person find themselves in.

Housing Insecurity

Housing is an important social determinant of health. The lack of housing, or poor-quality housing, negatively affects a person's health and well-being. Tangible housing defects resulting from damp and mold, unregulated indoor temperatures, overcrowding, and safety factors have a clear impact on physical and mental health. There are also pronounced psychosocial benefits to the concept of "home," which are tied to the social values of housing as reflecting stability, control, autonomy, status, and empowerment. Such qualities have a significant impact on a person's mental health and long-term stability.[4]

The US is in the midst of a housing affordability crisis.[5] Income growth has not kept up with rising housing costs, and the overall housing market has not responded adequately to the need for affordable

[1] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, *Social Determinants of Health*. Available at https://health.gov/healthypeople/priority-areas/social-determinants-health (last visited January 21, 2024).
[2] Braubach, M., Jacobs, D.E., & Ormandy, D. *Environmental burden of disease associated with inadequate housing: a method guide to the quantification of health effects of selected housing risks in the WHO European Region*. (2011). World Health Organization. Regional Office for Europe. https://iris.who.int/handle/10665/108587
[3] Braveman, P., & Gottlieb, L. *The social determinants of health: it's time to consider the causes of the causes*. (2014) Public health reports*, 129:2*, 19–31. https://doi.org/10.1177/00333549141291S206
[4] Rolfe, S., Garnham, L., Godwin, J. et al. *Housing as a social determinant of health and wellbeing: developing an empirically-informed realist theoretical framework* (2020). BMC Public Health 20, 1138. https://doi.org/10.1186/s12889-020-09224-0
[5] Desmond, M. *Unaffordable America: Poverty, Housing, and Eviction* (2022). American Journal of Sociology. In The Affordable Housing Reader (pp. 389-395). https://doi.org/10.4324/9780429299377-34

housing. The national crisis is being acutely felt in Florida, with one survey showing that 25 percent of Floridians identifying "housing costs," as the most important problem facing Florida today.[6]

The precise cause of the shortage of affordable housing is complex and multi-faceted, but it is an issue felt by would-be homebuyers and renters alike. In Florida, the median single-family home prices are approaching the boom-era costs of the mid-2000s; between 2011 and 2022, the median home price has risen 91 percent. Meanwhile, the situation in the rental market is dire for low-income renters. The state has added hundreds of thousands of rental units in the last decade, but simultaneously lost "affordable"[7] rental units.[8] Many low-income renters pay more than 40 percent of their income for housing, and there are only 26 affordable and available rental units for every 100 households with an extremely low income.[9]

As a result, more families and individuals are finding themselves in precarious housing situations.[10] Nationally, 5.52 million renter households reported being behind on their rent payment, with 1.87 million fearing imminent eviction in August 2023.[11]

While the majority of people experiencing homelessness are men, women and families constitute the fastest-growing segment of the homeless population.[12] Black and Hispanic women, particularly single mothers with children, are at the highest risk for housing insecurity. Women experiencing housing insecurity report barriers to health care generally, and as such tend to lack access to adequate contraceptive methods.[13]

Pregnancy Outcomes

In 2022, there were 224,403 recorded births in Florida.[14] Healthy pregnancies and childbirth are foundational to healthy families and communities. Nonetheless, pregnancy remains an essential but often dangerous experience with the potential for many avoidable complications.[15] Maternal and infant health outcomes are an important marker of the overall health of a society.

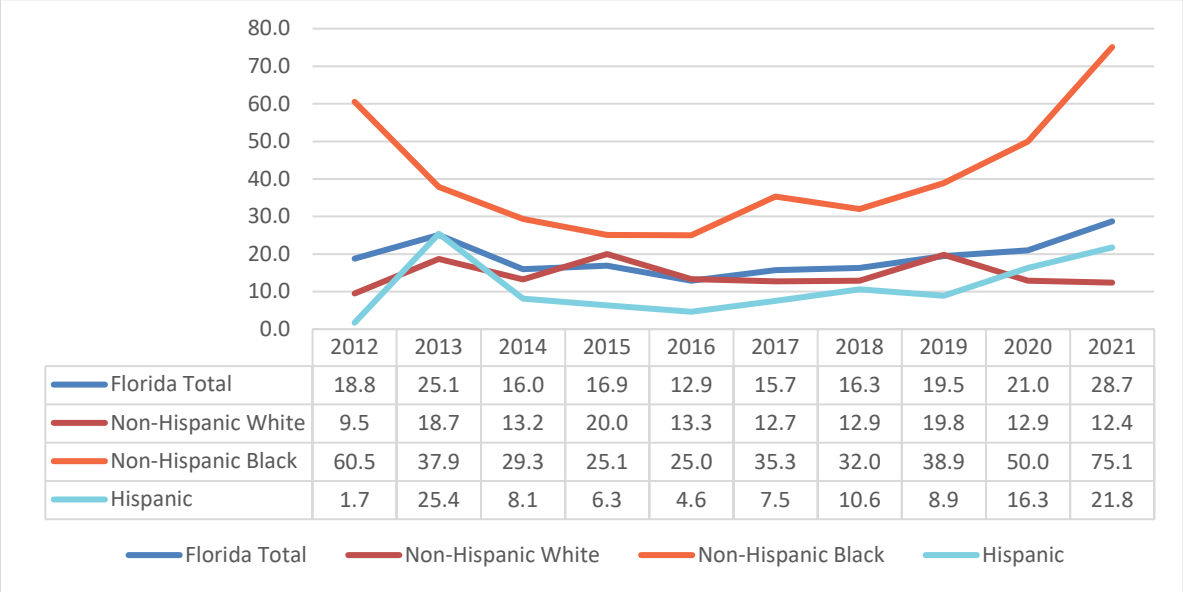
Maternal Health Outcomes

Maternal mortality refers to deaths occurring during pregnancy or within 42 days of the end of pregnancy, regardless of the duration of the pregnancy, from any cause related to or aggravated by the pregnancy, but not from accidental or incidental causes.[16] In 2021, more than 1,200 women died of

[6] University of North Florida, Public Opinion Research Lab, *Florida Republican Presidential Primary Polling* (2023). Available at https://www.unfporl.org/uploads/1/4/4/5/144559024/unf_mar_statewide_2023_ada.pdf (last visited January 21, 2024).
[7] "Affordable" rental units mean those renting for $1,000 or less per month.
[8] University of Florida, Shimberg Center for Housing Studies. *Florida Affordable Housing Trends* (2022). Available at http://www.shimberg.ufl.edu/publications/FL_presentation_121422.pdf (last visited January 22, 2024).
[9] *Id.*
[10] Greene, S., Richardson, T., Bryon, J., & Cho, R. *Rise in homelessness averted amidst worsening housing needs in 2021. What does this tell us about how to end homelessness in the U.S.?* (2023). HUD User. Available at https://www.huduser.gov/portal/pdredge/pdr-edge-frm-asst-sec-082223.html (last visited January 22, 2024).
[11] *Id.*
[12] Welch-Lazoritz, M.L., Whitbeck, L.B., & Armenta, B.E. *Characteristics of mothers caring for children during episodes of homelessness.* (2015). Community Ment Health J. 51(8):913-920. doi: 10.1007/s10597-014-9794-8
[13] Kozlowski, Z., Sanders, J.N., Panushka, K., Myers, K., Millar, M.M., & Gawron, L.M. "*It's a Vicious Cycle": A Mixed Methods Study of the Role of Family Planning in Housing Insecurity for Women* (2022). *Journal of Health Care for the Poor and Underserved 33*(1), 104-119. https://doi.org/10.1353/hpu.2022.0009
[14] FL Health Charts, *Birth Counts Query System*. Available at https://www.flhealthcharts.gov/FLQUERY_New/Birth/Count (last visited January 9, 2024).
[15] Hernandez, L., Thompson, A., & Burch, D. *Florida's Pregnancy-Associated Mortality Review 2015 Update* (2017). Florida Department of Health. Available at http://www.floridahealth.gov/statistics-and-data/PAMR/pamr-2015-update.pdf (last visited January 22, 2024).
[16] U.S. Dep't of Health and Human Services, *The Surgeon General's Call to Action to Improve Maternal Health* (2020). Available at https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf (last visited December 5, 2023).

maternal causes in the United States compared with 861 in 2020 and 754 in 2019.[17] The national maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births.[18] Racial and ethnic gaps exist between non-Hispanic black, non-Hispanic white, and Hispanic women. The maternal mortality rate of these groups is 69.9, 26.6, and 28.0 deaths per 100,000 live births, respectively.[19]

Although Florida's maternal mortality rate is lower than the national rate, it has been increasing in recent years. As of 2021, the maternal mortality rate in Florida is 28.7 deaths per 100,000 live births, an increase from a low of 12.9 deaths per 100,000 live births in 2016.[20] Similar to the national trend, racial and ethnic disparities exist in the maternal mortality rates in Florida as evidenced in the following chart:



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Florida Total	18.8	25.1	16.0	16.9	12.9	15.7	16.3	19.5	21.0	28.7
Non-Hispanic White	9.5	18.7	13.2	20.0	13.3	12.7	12.9	19.8	12.9	12.4
Non-Hispanic Black	60.5	37.9	29.3	25.1	25.0	35.3	32.0	38.9	50.0	75.1
Hispanic	1.7	25.4	8.1	6.3	4.6	7.5	10.6	8.9	16.3	21.8

For every maternal death, 100 women suffer a severe obstetric morbidity, a life-threatening diagnosis, or undergo a lifesaving procedure during their delivery hospitalization.[21] Severe maternal morbidity (SMM) includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. SMM has been steadily increasing in recent years.[22] The consequences of the increasing SMM prevalence, in addition to the health effects for the woman, are wide-ranging and include increased medical costs and longer hospitalization stays.[23]

From 2013 to 2022, there were 51,454 cases of SMM among delivery hospitalization in Florida.[24] Similar to maternal mortality rates, rates of SMM are higher in racial and ethnic minority women.[25]

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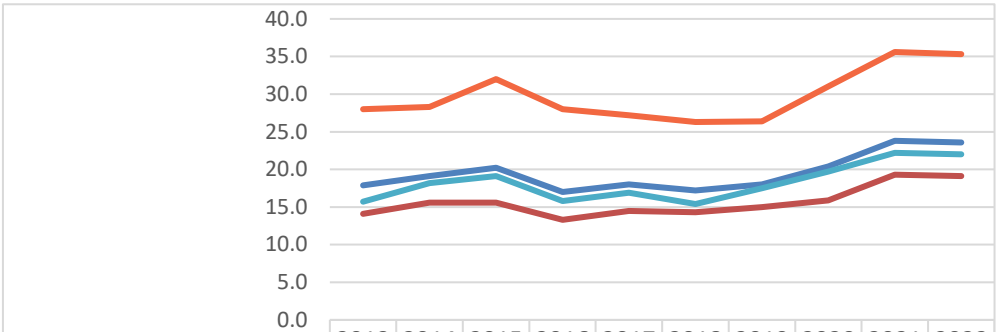
[17] Donna L. Hoyert, Ph.D., Division of Vital Statistics, National Center for Health Statistics, *Maternal Mortality Rates in the United States, 2021,* (March 2023). Available at https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf https://www.cdc.gov/reproductivehealth/maternal-mortality/index.html(last visited January 8, 2024).
[18] *Id.*
[19] *Id.*
[20] Presentation by Kenneth Scheppke, M.d., F.A.E.M.S., Deputy Sec'y for Health, DOH, before the Senate Committee on Health Policy (Nov. 14, 2023), available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited January 8, 2024).
[21] Elizabeth A. Howell, MD, MPP, *Reducing Disparities in Severe Maternal Morbidity and Mortality* (2018). CLINICAL OBSTETRICS AND GYNECOLOGY, 61(2). Available at https://journals.lww.com/clinicalobgyn/abstract/2018/06000/reducing_disparities_in_severe_maternal_morbidity.22.aspx (last visited January 8, 2024).
[22] *Id.,* and CDC, *Severe Maternal Morbidity in the United States* (2023). Available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last visited January 8, 2024).
[23] CDC, *Severe Maternal Morbidity in the United States* (2023). Available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last visited January 8, 2024).
[24] Presentation by Kenneth Scheppke, M.D., F.A.E.M.S., Deputy Sec'y for Health, DOH, before the Senate Committee on Health Policy (Nov. 14, 2023). Available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited January 8, 2024).

The following figure shows the trend over time for SMM rates in Florida per 1,000 delivery hospitalizations:[26]



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Florida Total	17.9	19.1	20.2	17.0	18.0	17.2	18.0	20.4	23.8	23.6
Non-Hispanic White	14.1	15.6	15.6	13.3	14.5	14.3	15.0	15.9	19.3	19.1
Non-Hispanic Black	28.0	28.3	32.0	28.0	27.2	26.3	26.4	31.0	35.6	35.3
Hispanic	15.7	18.2	19.1	15.8	16.9	15.4	17.5	19.7	22.2	22.0

The consequences of maternal death and severe maternal morbidity are felt throughout a community. High rates of maternal death are associated with infant and child mortality, loss of economic opportunities, and cycles of poverty extending from the family into the broader community.[27]

Infant Health Outcomes

Infant mortality is the death of an infant before the first birthday. The infant mortality rate is the number of infant deaths for every 1,000 live births. DOH reports annually on fetal and infant deaths through the Florida Vital Statistics Annual Report.[28] This report provides the number of fetal deaths per 1,000 live births, the number of deaths by race, and compares that data to national figures. Florida ranks 19th in the nation in infant mortality with a rate of 5.9 deaths per 1,000 live births (1,275 in 2021).[29]

In Florida, the leading causes of infant mortality, per 1,000 live births, are:[30]

- Birth defects;
- Preterm and low birth weight;
- Unintentional injuries;
- Maternal complications of pregnancy;
- Complications of placenta, cord, and membranes; and
- Sudden Infant Death Syndrome.

The relationship between infant health outcomes and adequate prenatal care is well established. Adequate prenatal care received regularly throughout a pregnancy can help to detect risks before they

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[25] *Supra*, note 21.
[26] *Id.*
[27] Miller, S., & Belizán, J. M. *The true cost of maternal death: individual tragedy impacts family, community and nations* (2015). Reproductive Health, 12(1), 56–56. https://doi.org/10.1186/s12978-015-0046-3
[28] Florida Department of Health, *Florida Vital Statistics Annual Report 2020*. Available at http://www.flpublichealth.com/VSbook/PDF/2020/Fetal.pdf (last visited January 22, 2024).
[29] Id. *See also* Centers for Disease Control and Prevention, *Infant Mortality Rates by State* (2019). Available at https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm (last visited Jan. 12, 2022).
[30] Presentation by Shay Chapman, BSN, MBA, Deputy Division Director, Community Health Promotion, Sept. 21, 2021 meeting of the Professions and Public Health Subcommittee. Available at https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3093&Session=2022&DocumentType=Meeting+Packets&FileName=pph+9-21-21.pdf (last visited January 22, 2024).

manifest dangerously, and can help women to manage both pregnancy and non-pregnancy related health conditions. This is especially important for marginalized populations for whom access to health care services before pregnancy may have been limited.[31] Adequate prenatal care is closely associated with improved birth weight and reduced rate of preterm births.[32]

Housing Insecurity and Pregnancy Outcomes

Florida's expecting mothers are not exempt from the state's affordable housing crisis. While the long-term effects of housing instability are detrimental to all who experience it, the impact on pregnant women is especially acute. Homelessness during pregnancy poses significant health risks for mothers and infants.

Extreme housing insecurity, in the form of homelessness or threatened eviction, among pregnant women is tied to significant pre-birth risk factors. This population is significantly more likely to have comorbidities and higher-risk pregnancies, including higher rates of substance use disorder and major mental health disorders.[33] The need for adequate perinatal health care is heightened for women with high-risk pregnancies, but pregnant women experiencing homelessness report barriers to prenatal health care, and lower rates of adequate prenatal care utilization, further increasing their risk of adverse birth outcomes.[34]

Women experiencing extreme housing insecurity experience worse birth outcomes than their securely housed counterparts, with higher rates of preterm birth and severe maternal morbidity.[35] Infants born to mothers experiencing homelessness or threatened eviction are at a significantly higher risk of being born preterm or with a low birth weight, require stays in neonatal intensive care units, and extended hospital stays after delivery.[36] More complex births and extended hospital stays lead to higher delivery-associated costs for this financially insecure population.[37]

Effect of the Bill

HB 1609 establishes the Florida State Maternity Housing Grant Program within DOH. The bill states the intent of the Legislature to provide housing resources to resident women and families during the prenatal period, regardless of age or marital status, whose financial resources have been determined inadequate to meet residential costs.

The bill outlines the types of expenses for which grant funding may be used, including:

- Housing in an authorized living arrangement for a period of time determined by the mother's due date;

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[31] Shah, J. S., Revere, F. L., & Toy, E. C. *Improving Rates of Early Entry Prenatal Care in an Underserved Population* (2018). Maternal & Child Health Journal, 22(12), 1738–1742. https://doi-org.proxy.lib.fsu.edu/10.1007/s10995-018-2569-z

[32] Alexander, G.R. & Kotelchuck, M. *Assessing the Role and Effectiveness of Prenatal Care: History, Challenges, and Directions for Future Research* (2001). Public Health Reports (1974-), 116(4), 306.

[33] Huang, K., Waken, R.J., Luke, A., Carter, E., Lindley, K., & Maddox, K. *Risk of Delivery Complications Among Pregnant People Experiencing Housing Insecurity* (2023). American Journal of Obstetrics & Gynecology, 5:2, https://doi.org/10.1016/j.ajogmf.2022.100819

[34] DiTosto, J., Holder, K., Soyemi, E., Beestrum, M., & Yee, L. *Housing Instability and Adverse Perinatal Outcomes: A Systematic Review* (2021). American Journal of Obstetrics & Gynecology, 3:1, https://doi.org/10.1016/j.ajogmf.2021.100477; see also, Bloom, K.C., Bednarzyk, M.S., Devitt, D.L., Renault, R.A., Teaman, V., & Van Loock, D.M. *Barriers to prenatal care for homeless pregnant women* (2004). J Obstet Gynecol Neonatal Nurs. 2004;33(4):428-435. doi: 10.1177/0884217504266775

[35] Leifheit, K.M., Schwartz, G.L., Pollack, C.E., Edin, K.J., Black, M.M., Jennings, J.M., & Althoff, K.N. *Severe Housing Insecurity during Pregnancy: Association with Adverse Birth and Infant Outcomes* (2020). International Journal of Environmental Research and Public Health. 2020; 17(22):8659. https://doi.org/10.3390/ijerph17228659

[36] *Id.*

[37] Yamamoto, A., Gelberg, L., Needleman, J., Kominski, G., Vangala, S., Miyawaki, A., & Tsugawa, Y. *Comparison of Childbirth Delivery Outcomes and Costs of Care Between Women Experiencing vs Not Experiencing Homelessness* (2021). JAMA network open, *4*(4), e217491. https://doi.org/10.1001/jamanetworkopen.2021.7491

- Services recommended by DOH to encourage economic independence and positive health outcomes;
- Staffing and reimbursements for housing providers; and
- All other costs related to the administration of the program, not to exceed 5 percent of the total grant funds.

The bill specifies that the total amount of grants awarded by DOH may not exceed the funding appropriated for the grant program.

The bill grants DOH rulemaking authority to adopt rules necessary for the administration of the program. The bill does not restrict the rules that DOH may adopt to administer the program, but provides that DOH may adopt rules pursuant to the following:

- A framework for the payment or reimbursement for expenses related to the "authorized living arrangement;"
- Eligibility criteria for expecting mothers and families seeking maternity housing services;
- Requirements for maternity housing grant applications; and
- Guidelines for assessing the appropriateness of living situations and the determination of approval.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Creates s. 381.97, F.S., relating to the Florida State Maternity Housing Grant Program.
Section 2: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

As written, the bill has no fiscal impact. The bill creates a framework for a grant program administered by DOH, but does not provide any funding. Implementation of the bill provisions are subject to an appropriation.

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:

The bill provides sufficient rulemaking authority for DOH to implement its provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to pregnancy support services; creating s. 381.97, F.S.; providing legislative intent; establishing the Florida State Maternity Housing Grant Program within the Department of Health; requiring the program to provide certain resources; requiring the department to use grant funds for specified expenses; providing a limitation on the amount of grants awarded under the program; authorizing the department to adopt rules necessary to administer the program; providing an effective date.

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

Section 1. Section 381.97, Florida Statutes, is created to read:

381.97 Florida State Maternity Housing Grant Program.—

(1) It is the intent of the Legislature to provide housing resources for resident women and families experiencing homelessness during the prenatal period, regardless of age or marital status, whose financial resources have been determined inadequate to meet residential costs.

(2) There is created within the department the Florida State Maternity Housing Grant Program to provide approved living arrangements for residents experiencing homelessness during the

prenatal period.

(3) The grant program shall provide resources for approved persons to reside in an alternative living arrangement for a period not to exceed 8 months, which includes a maximum of 6 weeks of postpartum care.

(4) The department shall use grant funds specifically appropriated for the grant program to cover expenses related to any of the following:

(a) Housing in an authorized living arrangement for a period of time determined by the mother's estimated delivery date.

(b) Services recommended by the department for women and families approved for the grant program to encourage economic independence and positive health outcomes for participants.

(c) Staffing and reimbursements for providers of authorized living arrangements.

(d) All other related costs for the administration of the program, not to exceed five percent of the total grant funds.

(5) The total amount of grants awarded may not exceed the funding appropriated for the grant program.

(6) The department may adopt rules necessary to administer the program. The rules may include, but need not be limited to:

(a) A framework for the payment or reimbursement of funds to the mother for authorized living arrangements.

(b) Eligibility criteria for pregnant mothers and

expecting families seeking maternity housing services, including a sliding fee scale for participants.

(c) Requirements for maternity housing grant program applications.

(d) Guidelines for assessing the appropriateness of authorized living arrangements and for a determination of approval for authorized living arrangements.

Section 2. This act shall take effect July 1, 2024.