Health Care Appropriations Subcommittee

Tuesday, February 13, 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: Tuesday, February 13, 2024 03:00 pm

End Date and Time: Tuesday, February 13, 2024 06:00 pm

Location: Morris Hall (17 HOB)

Duration: 3.00 hrs

Consideration of the following bill(s):

CS/HB 499 Congenital Cytomegalovirus Screening by Healthcare Regulation Subcommittee, Melo
HB 547 Dentistry by Altman
CS/HB 563 Persons With Lived Experience by Children, Families & Seniors Subcommittee, Campbell
CS/HB 783 Medicaid Managed Care Plan Performance Metrics by Select Committee on Health Innovation, Berfield
CS/HB 1061 Community-based Child Welfare Agencies by Children, Families & Seniors Subcommittee, McFarland
HB 1313 Clinical Laboratory Personnel by Chamberlin

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 02/09/2024 4:15PM by EHP

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 499 Congenital Cytomegalovirus Screenings
SPONSOR(S): Healthcare Regulation Subcommittee, Melo
TIED BILLS: **IDEN./SIM. BILLS:** SB 168

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	18 Y, 0 N, As CS	Osborne	McElroy
2) Health Care Appropriations Subcommittee		Aderibigbe	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Cytomegalovirus (CMV) is a common virus that infects people of all ages. Over half of adults are infected with CMV by age 40, and approximately one of every 200 babies is born with congenital CMV (CCMV). Some infants with CCMV infection have health problems that are apparent at birth or that develop later during infancy or childhood. About one in five babies with CCMV have long-term health problems, including hearing loss.

Florida's Newborn Screening Program (NSP), operated by the Department of Health (DOH), screens all newborns for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect, including hearing loss. In the event that a newborn screen has an abnormal result, the baby's health care provider, 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.

Current law requires all newborns be screened for hearing loss at birth, unless such screening is objected to by the newborn's parent or guardian; newborns who fail the hearing screening must also be screened for CCMV. In 2021, 8,500 newborns did not pass their hearing screening, of which, 300 were diagnosed with hearing loss.

CS/HB 499 expands the population which must undergo mandatory CCMV testing beyond the current population of infants who fail the required newborn hearing screening to include infants admitted to a neonatal intensive care unit within 21 days of birth for specified reasons, and newborns who are transferred to another facility for a higher level of care.

The bill also requires that children diagnosed with a congenital cytomegalovirus infection, with or without hearing loss, be referred to the Children's Medical Services Early Intervention Program and be deemed eligible for a baseline evaluation and any medically necessary follow-up reevaluations and monitoring.

The bill has an insignificant fiscal impact on the Department of Health that can be absorbed within existing resources. The bill has no fiscal 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 Newborn Screening Program

The Legislature created the Florida Newborn Screening Program (NSP) within the Department of Health (DOH), to promote the screening of all newborns for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect.[1] 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.[2]

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, and referral centers, birthing centers, and physicians throughout the state.[3] Health care providers in hospitals, birthing centers, perinatal centers, county health departments, and school health programs provide screening as part of the multilevel NSP screening process.[4] 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.[5] 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.[6] The NSP is intended to screen all prenatal women and newborns, however, parents and guardians may choose to decline the screening.[7]

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.[8] 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. [9] 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 baby's health care provider, 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.[10]

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[1] S. 383.14(1), F.S.
[2] *Id*.
[3] S. 383.14, F.S.
[4] *Id.*
[5] *Id*.
[6] Florida Department of Health, *Florida Newborn Screening Guidelines*. Available at https://floridanewbornscreening.com/wp-content/uploads/NBS-Protocols-2022-FINAL.pdf (last visited January 26, 2024).
[7] 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.
[8] *Id*.
[9] Florida Newborn Screening, *What is Newborn Screening?* Available at https://floridanewbornscreening.com/parents/what-is-newborn-screening/ (last visited January 26, 2024). *See also,* Florida Newborn Screening, *Specimen Collection Card*, http://floridanewbornscreening.com/wp-content/uploads/Order-Form.png (last visited January 26, 2024).
[10] *Id*.

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.[11] 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.[12] DOH bills hospitals and birth centers quarterly using vital statistics data to determine the amount to be billed.[13] DOH is authorized to bill third-party payers for the NSP tests and bills insurers directly for the cost of the screening.[14] DOH does not bill families that do not have insurance coverage.[15]

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.[16] 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 (POC) testing.[17]

Congenital Cytomegalovirus

Cytomegalovirus (CMV) is a common virus for people of all ages; however, a healthy person's immune system usually keeps the virus from causing illness.[18] In the United States, nearly one in three children are infected with CMV by age five. Over half of adults have been infected with CMV by age 40. Once CMV is in a person's body, it stays there for life and can reactivate. A person can also be re-infected with a different strain of the virus. Most people with CMV infection have no symptoms and aren't aware that they have been infected.[19]

CMV that is present in a newborn at birth is known as congenital CMV (CCMV). Congenital CMV occurs when the virus is present in a pregnant woman's blood and crosses the placenta to the fetus. This can happen if a woman is infected with CMV for the first time while she is pregnant, or is infected with CMV again during pregnancy.[20] In the most severe cases, a CMV infection can cause a woman to lose her pregnancy.

Some infants with CCMV infection have health problems that are apparent at birth or that develop later during infancy or childhood. CCMV is the most common infectious cause of birth defects in the United States; approximately one in 200 infants are born with CCMV.[21] Infants with CCMV infection may have signs at birth, which include:[22]

- Rash;
- Jaundice (yellowing of the skin or whites of the eyes);
- Microcephaly (small head);
- Low birth weight;
- Hepatosplenomegaly (enlarged liver and spleen);
- Seizures; and

[11] S. 383.145(3)(g)1., F.S.
[12] *Id.*
[13] S. 383.145(3)(g), F.S.
[14] S. 383.145(3)(h), F.S.
[15] *Supra*, note 3.
[16] S. 383.14(5), F.S.
[17] Department of Health, *Agency Analysis of HB 499* (2024). On file with the Healthcare Regulation Subcommittee.
[18] Centers for Disease Control and Prevention. *About Cytomegalovirus (CMV)*. Available at https://www.cdc.gov/cmv/overview.html (last visited January 26, 2024).
[19] *Id.*
[20] Centers for Disease Control and Prevention. *Babies Born with Congenital Cytomegalovirus (CMV)*. Available at https://www.cdc.gov/cmv/congenital-infection.html, (last visited January 26, 2024).
[21] Centers for Disease Control and Prevention. *CMV Fact Sheet for Healthcare Providers*. Available at https://www.cdc.gov/cmv/fact-sheets/healthcare-providers.html#:~:text=Cytomegalovirus%20(CMV)%20is%20the%20most,Hearing%20loss (last visited January 26, 2024).
[22] *Supra,* note 20.

- Retinitis (damaged eye retina).

Infants with signs of CCMV infection at birth may have long-term health problems, such as:[23]

- Hearing loss;
- Developmental and motor delay;
- Vision loss;
- Microcephaly (small head); and
- Seizures.

One out of five infants with CCMV will have symptoms or long-term health problems, such as hearing loss. Approximately 15% of infants with CCMV will not have signs at birth, but will later develop hearing loss.[24] Infants may have hearing loss that may or may not be detected by newborn hearing test. Hearing loss may be present at birth or may develop later, even in infants who passed the newborn hearing test.[25] Hearing loss may progress from mild to severe during the first two years of life, which is a critical period for language learning. Over time, hearing loss can affect a child's ability to develop communication, language, and social skills.[26]

CCMV infection is diagnosed by detection of CCMV DNA in the urine, saliva (preferred specimens), or blood, within three weeks after birth. Infection cannot be diagnosed using tests that detect antibodies to CCMV. CCMV infection cannot be diagnosed using samples collected more than three weeks after birth because testing after this time cannot distinguish between congenital infection and an infection acquired during or after delivery.[27] Infants who show signs of CCMV disease can be treated with medicines called antivirals. Antivirals may decrease the severity of hearing loss. Infants who get treated with antivirals should be closely monitored by their doctor for possible side effects.[28]

CCMV and the Newborn Screening Program

Section 383.145, F.S., requires a newborn hearing screening for all newborns in hospitals before discharge. 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.[29]

In 2022, the Legislature enacted a law to provide additional testing requirements for hearing loss in newborns.[30] Under current law, if a newborn fails the hearing screening, the hospital or birthing facility is required to administer an FDA-approved test, or other diagnostically equivalent test, on the newborn to screen for CCMV. The CCMV test must be administered before 21 days of age or before discharge, whichever occurs earlier.[31]

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

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[23] *Id.*
[24] *Supra*, note 21.
[25] *Id.*
[26] Centers for Disease Control and Prevention. *CMV Fact Sheet for Healthcare Providers*. Available at https://www.cdc.gov/cmv/fact-sheets/healthcare-providers.html#:~:text=Cytomegalovirus%20(CMV)%20is%20the%20most,Hearing%20loss (last visited January 26, 2024).
[27] Centers for Disease Control and Prevention. *About Cytomegalovirus (CMV).* Available at https://www.cdc.gov/cmv/overview.html (last visited January 26, 2024).
[28] Centers for Disease Control and Prevention. *Congenital CMV and Hearing Loss*. Available at https://www.cdc.gov/cmv/hearing-loss.html, (last visited January 26, 2024).
[29] 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.
[30] Ch. 2022-25, Laws of Fla.
[31] S. 383.145(3)(a), F.S.

facility.[32] 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.[33] 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).[34]

If an infant born in a licensed birth center or private home fails the hearing screening, the infant's primary care provider must refer the infant for the administration of an FDA-approved test, or other diagnostically equivalent test, on the newborn to screen for CCMV.[35]

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.[36]

In 2021, 8,500 newborns did not pass their hearing screenings and 300 were diagnosed with hearing loss.[37]

Effect of the Bill

CS/HB 499 expands the population which must undergo mandatory CCMV testing beyond the current population of infants who fail the required newborn hearing screening to include infants admitted to a neonatal intensive care unit within 21 days of birth for any of the following reasons:

- Premature birth prior to 35 weeks gestation;
- Cardiac care; or
- Medical or postsurgical treatment with an anticipated hospital stay greater than three weeks.

The bill requires that for an infant who is transferred to another facility for a higher level of care, the receiving hospital must initiate the CCMV screening of the infant, unless the screening was already performed by the transferring hospital or birthing facility. Infants who are admitted or transferred for intensive or prolonged care must be screened for CCMV regardless of whether they have failed a hearing screening.

The bill also requires that children diagnosed with a congenital cytomegalovirus infection, with or without hearing loss, be referred to the Children's Medical Services Early Intervention Program and be deemed eligible for a baseline evaluation and any medically necessary follow-up reevaluations and monitoring.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 383.145, F.S., relating to newborn and infant hearing screenings.
Section 2: Provides an effective date of July 1, 2024.

[32] S. 383.145(3)(d), F.S.
[33] S. 383.145(3)(f), F.S.
[34] S. 383.145(3)(i), F.S.
[35] S. 383.145(3)(e), F.S.
[36] S. 383.145(3)(l), F.S.
[37] *Supra* note 18.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill will negatively affect DOH due to the increase in workload for the NBHS program. DOH anticipates the need to hire one new FTE to support follow-up for the additional CCMV tests which would be necessitated by the provisions of the bill.[38] Based on a review of currently vacant positions within the Children's Medical Services Program, the department can absorb the workload within existing resources.

   DOH anticipates that the Early Steps Program, the Children's Medical Services Early Intervention Program, would require increased Federal Grants trust fund authority of approximately $917,490.[39] The department has the authority to request additional federal trust fund authority up to $1,000,000 pursuant to ss. 216.181(11) and 216.212, F.S., once DOH knows how many additional children will be eligible for evaluation and monitoring.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Medicaid, private insurers, and families would be billed for the CCMV tests. The estimated cost for CCMV testing by urine polymerase chain reaction range from $69 to $346 per test. Hospitals, birthing facilities, and primary care providers could also incur the cost for additional testing supplies and equipment if they are not equipped to test for CCMV.[40]

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:

[38] *Supra*, note 17.
[39] *Id*.
[40] Department of Health, *Agency Analysis of HB 435* (2023). On file with the Healthcare Regulation Subcommittee.

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On February 1, 2024, the Healthcare Regulation Subcommittee adopted an amendment to HB 499 and reported the bill favorably as a committee substitute. The amendment:

- Revised the conditions under which a newborn must be tested for CCMV; and
- Requires the receiving hospital to initiate CCMV testing for a newborn who has been transferred to another hospital for a higher level of care, unless already initiated by the birthing facility or transferring hospital.

The analysis is drafted to the bill as amended by the Healthcare Regulation Subcommittee.

A bill to be entitled

An act relating to congenital cytomegalovirus screenings; amending s. 383.145, F.S.; requiring certain hospitals to administer congenital cytomegalovirus screenings on newborns admitted to the hospital under specified circumstances; requiring that the screenings be initiated within a specified timeframe; providing construction; providing coverage under the Medicaid program for the screenings and any medically necessary follow-up reevaluations; requiring that newborns diagnosed with congenital cytomegalovirus be referred to a primary care physician for medical management, treatment, and follow-up services; requiring that children diagnosed with a congenital cytomegalovirus infection without hearing loss be referred to the Children's Medical Services Early Intervention Program and be deemed eligible for evaluation and any medically necessary follow-up reevaluations and monitoring under the program; providing an effective date.

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

Section 1. Paragraphs (a), (k), and (l) of subsection (3) of section 383.145, Florida Statutes, are amended to read:

383.145 Newborn and infant hearing screening.—

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

(a)1. Each hospital or other state-licensed 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 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.

2. Each hospital that provides neonatal intensive care services shall administer a test approved by the United States Food and Drug Administration or another diagnostically equivalent test to screen for congenital cytomegalovirus in each newborn admitted to the hospital as a result of a premature birth occurring before 35 weeks' gestation, for cardiac care, or for medical or surgical treatment requiring an anticipated stay of 3 weeks or longer. Such screening must be initiated before the newborn becomes 21 days of age.

3. If a newborn requires transfer to another hospital for a higher level of care, the receiving hospital must initiate the

congenital cytomegalovirus screening if the screening has not already been performed by the transferring hospital or the birthing facility. For newborns transferred or admitted for intensive and prolonged care, the congenital cytomegalovirus screening must be initiated regardless of whether the newborn failed a hearing screening.

(k) The initial procedures ~~procedure~~ for the congenital cytomegalovirus screening and the hearing screening of the newborn or infant and any medically necessary follow-up reevaluations leading to diagnosis are ~~shall be a~~ covered benefits ~~benefit~~ for Medicaid patients covered by a fee-for-service program. For Medicaid patients enrolled in HMOs, providers must ~~shall~~ be reimbursed directly by the Medicaid Program Office at the Medicaid rate. This service is ~~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, must ~~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 or a congenital cytomegalovirus infection 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. A child diagnosed with a congenital cytomegalovirus infection without hearing loss must be referred to the Children's Medical Services Early Intervention Program and be deemed eligible for a baseline evaluation and any medically necessary follow-up reevaluations and monitoring.

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

HB 547

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 547 Dentistry
SPONSOR(S): Altman
TIED BILLS: **IDEN./SIM. BILLS:**

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

The Board of Dentistry (BOD), within the Department of Health (DOH), regulates dental practice in Florida, including dentists, dental hygienists, and dental assistants licensed under the Dental Practice Act. A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures. There are currently 17,193 dentists with active licenses to practice in Florida.

Prior to October 2011, the dental licensure examination was developed and administered by the Board and the Department of Health. As of October 1, 2011, Florida stopped administering its own practical and clinical dental examinations, and the American Dental License Examination (ADEX), developed by the American Board of Dental Examiners, Inc., replaced the Florida Diagnostic Skills Examination as Florida's dental licensure exam. The ADEX is administered by the CDCA-WREB-CITA© (CDCA).

Current law includes requirements which are now obsolete as Florida no longer develops or administers its own dental licensure exam. Current law also specifies that a passing score on the ADEX is only valid for 365 days after the date that the results were published.

Current law requires all applicants for dental licensure who relocate to Florida and apply for dental licensure with ADEX scores obtained in a different state engage in full-time practice during their first year of licensure within the geographical bounds of Florida.

HB 547 significantly revises the dental licensure requirements relating to the dental licensure exam. The bill deletes language which has been made obsolete through the use of a national licensure exam.

The bill also deletes the language making ADEX scores valid for only 365 days after the scores were published. The bill revises experience requirements for licensure for dentists who have active, valid licensure in another United States jurisdiction. The bill deletes the requirement that out-of-state licensed dentists engage in full-time practice during their first year of licensure within the geographical bounds of Florida.

The bill has an insignificant, negative fiscal impact on DOH, and no fiscal 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

Regulation of Dental Practice in Florida

The Board of Dentistry (BOD), housed within the Department of Health (DOH), regulates dental practice in Florida, including dentists, dental hygienists, and dental assistants who are licensed under the Dental Practice Act.[1] A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures.[2]

There are currently 17,193 dentists with active licenses to practice in Florida. There are 41 out-of-state registered telehealth dentists.[3]

Dental Licensure

Any person wishing to practice dentistry in this state must meet specific education and examination requirements and apply to DOH for licensure. The applicant is required to submit two recent photographs with their application and verify the accuracy of their application by oath.[4]

To be eligible for dental licensure, an applicant must apply to the DOH to take and pass the following examinations:[5]

- The American Dental License Examination (ADEX); and
- An examination on Florida laws and rules relating to dentistry.

The American Dental License Examination (ADEX)

Prior to October 2011, the dental licensure examination was developed and administered by the Board and the Department of Health. As of October 1, 2011, Florida stopped administering its own practical and clinical dental examinations, and the American Dental License Examination (ADEX), developed by the American Board of Dental Examiners, Inc., replaced the Florida Diagnostic Skills Examination as Florida's dental licensure exam.[6] The ADEX is inclusive of a comprehensive diagnostic skills examination covering the full scope of the practice of dentistry.[7] The ADEX is administered by the CDCA-WREB-CITA© (CDCA).[8]

The ADEX is administered by the CDCA in two formats: the Curriculum Integrated Format (CIF) and the Traditional Format. The CIF is administered throughout the candidate's third and fourth year of dental school. The Traditional Format is administered during the candidate's fourth year. Due to this type of administration, dental students complete the ADEX prior to applying for licensure.[9] The ADEX examination fee is $2,795.00[10] and is paid directly to the CDCA by the applicant.[11] Current law requires

[1] S. 466.004, F.S.
[2] S. 466.003(3), F.S.
[3] *See*, Department of Health, *License Verification* web search. Available at https://mqa-internet.doh.state.fl.us/MQASearchServices/HealthCareProviders (last visited January 14, 2023).
[4] S. 466.006(1)(b), F.S.
[5] S. 466.006, F.S.
[6] Department of Health, Agency Bill Analysis for HB 547 (2024). On file with the Healthcare Regulation Subcommittee.
[7] Rule 64B5-2.013, F.A.C.
[8] *Supra*, note 6.
[9] *Id.*
[10] CDCA, ADEX Dental: Examination Overview. Available at https://adextesting.org/adex-dental/ (last visited January 31, 2024).
[11] *Supra*, note 6.

DOH to consult with the BOD in planning the times, places, physical facilities, training of personnel, and other arrangements concerning the administration on the examination.[12]

To take the ADEX clinical examination for dentists, an applicant must be at least 18 years of age and:

- Be a graduate of a dental school accredited by the American Dental Association (ADA) Commission on Dental Accreditation (CODA) or its successor entity, if any, or any other dental accrediting entity recognized by the US Department of Education;
- Be a dental student in the final year of a program at an ADA-CODA accredited dental school who has completed all the coursework necessary to prepare the student to perform the clinical and diagnostic procedures required to pass the examinations. A passing score on the examination is valid for 365 days;[13] and
- Have completed Part I and II of the National Board Dental Examination (NBDE), administered by the Joint Commission on National Dental Examinations (JCNDE);[14] or
- Have an active health access dental license in this state; and
    - The applicant has 5,000 hours within four consecutive years of clinical practice experience providing direct patient care in a health access setting; the applicant is a retired veteran dentist of any branch of the US Armed Services who has practiced dentistry while on active duty and has at least 3,000 hours within three consecutive years of clinical practice experience providing direct patient care in a health access setting, or the applicant has provided a portion of his or her salaried time teaching health profession students in any public education setting and has at least 3,000 hours within three consecutive years of clinical practice experience providing direct patient care in a health access setting; and
    - The applicant has not been disciplined by the BOD, except for citation offenses or minor violations;
    - No claim or action for damages for personal injury alleged to have been caused by error, omission, or negligence in the performance of the licensee's professional services has been reported to the Office of Insurance Regulation; and
    - The applicant has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession.

A person who has graduated from a dental school that is not accredited by the ADA-CODA, a US Department of Education-recognized dental accrediting entity, or otherwise approved by the BOD, may only sit for the ADEX after they submit proof of the following to the BOD:[15]

- At least two consecutive academic years at a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation. This program must provide didactic and clinical education at the level of a D.D.S. or D.M.D. program accredited by the ADA-CODA; and
- Successful completion of the National Board Dental Examination (Part I and II).

The BOD will then confirm an applicant's eligibility and notify the CDCA.[16]

Current law specifies that a passing score on the ADEX is only valid for 365 days after the date that the results were published.[17] This may cause issues for licensure applicants who completed the dental

[12] S. 466.006(5), F.S.
[13] S. 466.006(4), F.S.
[14] American Dental Association, Joint Commission on National Dental Examinations, *Upholding Quality Oral Care For All.* Available at https://jcnde.ada.org/ (last visited January 31, 2024).
[15] Florida Board of Dentistry, Dentist – Process. Available at https://floridasdentistry.gov/licensing/dentist/#tab-process (last visited January 31, 2024).
[16] *Id.*
[17] S. 466.006(4), F.S.

school and passed the ADEX both in Florida and out of state. A licensure applicant who graduated from an accredited Florida dental school may have passed the ADEX and then leave the state to complete a residency without first obtaining a Florida dental license. Upon returning to Florida, such person's ADEX scores will be invalid due to the length of time that has passed and the person will be required to take and pass the ADEX again to be eligible for licensure in Florida.[18]

The results of the ADEX administered out-of-state are valid for Florida licensure, however, such exam scores are also only valid for 365 days after the date that the results were published. A licensure applicant who passed the ADEX in another state more than 365 days prior is still eligible for licensure, but must meet the following additional requirements:[19]

- Confirmation that the applicant completed the ADEX examination after October 1, 2011.
- Graduation from a dental school accredited by the American Dental Association Commission on Dental Accreditation or its successor entity, if any, or any other dental accrediting organization recognized by the United States Department of Education. If the applicant did not graduate from such a dental school, the applicant may submit proof of having successfully completed a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation of at least two consecutive academic years at such accredited institution.
- Verification that the applicant currently possesses a valid and active dental license in good standing, with no restriction, which has never been revoked, suspended, restricted, or otherwise disciplined, from another state or territory.
- Submission of proof that the applicant has never been reported to the National Practitioner Data Bank (NPDB), the Healthcare Integrity and Protection Data Bank, or the American Association of Dental Boards Clearinghouse, unless successfully appealed.
- Submission of proof that the applicant has been consecutively engaged in the full-time[20] practice of dentistry in another state or territory in the five years, or since the date of initial licensure if less than five years, immediately preceding the date of application for licensure.

In fiscal year 2022-2023, 175 applicants applied for dental licensure in Florida with ADEX scores issued in another state and older than 365 days. Of the 175 applicants, 127 met the additional requirements to become licensed.[21]

All applicants for dental licensure who apply for dental licensure with ADEX scores obtained in a different state must engage in full-time practice during their first year of licensure within the geographical bounds of Florida. Full-time practice is defined as 1,200 hours. Thirty days prior to the expiration of license, the BOD is required to notify the licensee of the need to comply with the full-time practice requirement. If the BOD does not receive a response, the licensee must be served with a notice of pending expiration and be given 20 days to submit proof of full-time practice. If no response is received or the licensee if unable to prove full time practice, the BOD will enter an administrative order to expire the license.[22]

Continuing Education

Licensed dentists are required to complete at least 30 hours of continuing education (CE) in dental subjects biennially, as a condition of their licensure renewal. A minimum of two hours of CE must be on the safe and effective prescribing of controlled substances. The remaining CE courses must contribute

[18] *Supra*, note 6.
[19] S. 466.006(4)(b), F.S.
[20] *See*, S. 466.006(4)(b)2., F.S.; Full-time practice is defined as a minimum of 1,200 hours per year for each year in the consecutive 5-year period or since initial licensure, and must include any combination of the following active clinical practice of dentistry providing direct patient care, full-time practice as a faculty member employed by an accredited dental or dental hygiene school, or full-time practice as a student at an accredited postgraduate dental education program.
[21] *Supra*, note 6.
[22] S. 466.006(6), F.S.

directly to the dental education of the dentist and may include attendance at lectures, study clubs, college postgraduate courses, or scientific sessions of conventions; and research, graduate study, teaching, or service as a clinician. The BOD may authorize up to three hours of CE biennially for a practice management course that includes principles of ethical practice management, provides substance abuse, effective communication with patients, time management, and burnout prevention instruction.[23]

Effect of the Bill

HB 547 removes the BOD and DOH from the dental licensure examination administration process. The bill deletes language made obsolete due to the administration of the ADEX by CDCA and codifies the current examination process by eliminating the following requirements:

- Applicants must apply to DOH to sit for the ADEX, and reapply to retake the exam;
- Applicants must submit two photographs to DOH;
- The BOD must set the examination and reexamination fees.
- DOH must consult with the Board of Dentistry in planning all arrangements concerning the administration of the examination; and
- DOH must conduct a mandatory standardization exercise for all examiners.

Under the bill, an applicant who has passed the ADEX will be eligible for dental licensure upon applying to DOH and demonstrating that the applicant is at least 18 years of age and:

- A graduate of an accredited dental school;
- Has successfully completed the examination administered by the JCNDE (the NBDE); and
- Has successfully completed the laws and rules examination.

The bill deletes the provision that ADEX scores are only valid for 365 days.

The bill removes language related to an obsolete licensure pathway for full licensure for a Health Access Dentist which does not include passage of the examination of the NBDE. This language is inconsistent with s. 466.0067(6), F.S., which requires all applicants for a Health Access Dental license to have passed the examination of the NBDE.

The bill revises the requirements for an out-of-state applicant to prove their full-time practice history. The bill removes the requirement that an out of state applicant submit their proof of full-time practice under oath with penalties of perjury and the requirement that someone unrelated to the applicant submit an affidavit relating to the applicant's full-time practice. Under the bill, the applicant would instead be required to prove full-time practice by submitting their annual income tax return filed with the Internal Revenue Service. The bill authorizes the BOD to excuse applicants from the full-time practice requirement in the event of a hardship.

The bill removes the requirement for relocating licensees to engage in full-time practice, defined as a minimum of 1,200 hours, in Florida within one year of receiving such license in order to maintain active, valid licensure in the state.

The bill revises the CE requirements for dentists to allow that the BOD may authorize up to three hours of credit biennially for a practice management course that may include instruction on principles of ethical practice management, provides substance abuse, effective communication with patients, time management, or burnout prevention instruction. This revision clarifies the content of the course and provides than one or more of the listed subjects may be included, as opposed to the current requirement for all of them to be included.

[23] S. 466.0135, F.S.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 466.006, F.S., relating to the examination of dentists.
Section 2: Amends s. 466.009, F.S., relating to reexamination.
Section 3: Amends s. 466.0135, F.S., relating to continuing education; dentists.
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 has an insignificant, negative fiscal impact on DOH which current agency resources are adequate to absorb.[24]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Sufficient rule-making authority exists to implement the provisions of the bill.

[24] Department of Health, *Agency Bill Analysis for HB 547* (2024). On file with the Healthcare Regulation Subcommittee.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to dentistry; amending s. 466.006, F.S.; deleting the role of the Board of Dentistry in the administration of the licensure examination for dentists; deleting the requirement for the board to establish an examination fee; revising requirements for licensure as a dentist; deleting a time limitation on the validity of certain licensure examination results; conforming provisions to changes made by the act; deleting a requirement that certain applicants for licensure engage in the full-time practice of dentistry inside the geographic boundaries of this state for 1 year after licensure; deleting provisions related to compliance with and enforcement of such requirement; amending s. 466.009, F.S.; conforming a provision to changes made by the act; deleting a board-imposed reexamination fee; amending s. 466.0135, F.S.; revising continuing education requirements for dentists; providing an effective date.

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

Section 1. Paragraph (b) of subsection (1), subsection (2), paragraph (b) of subsection (4), and subsections (5) and (6) of section 466.006, Florida Statutes, are amended to read:

466.006 Examination of dentists.—

(1)

(b) Any person desiring to be licensed as a dentist must ~~shall~~ apply to the department ~~to take the licensure examinations and shall verify the information required on the application by oath. The application shall include two recent photographs~~. There is ~~shall be~~ an application fee set by the board which may not ~~to~~ exceed $100 and is ~~which shall be~~ nonrefundable. ~~There shall also be an examination fee set by the board, which shall not exceed $425 plus the actual per applicant cost to the department for purchase of some or all of the examination from the American Board of Dental Examiners or its successor entity, if any, provided the board finds the successor entity's clinical examination complies with the provisions of this section. The examination fee may be refundable if the applicant is found ineligible to take the examinations.~~

(2) The department shall license an applicant who the board certifies meets all of the following criteria ~~shall be entitled to take the examinations required in this section to practice dentistry in this state if the applicant~~:

(a) Is 18 years of age or older.

(b)1. Is a graduate of a dental school accredited by the American Dental Association Commission on Dental Accreditation or its successor entity, if any, or any other dental accrediting entity recognized by the United States Department of Education;

or

2. Is a dental student ~~in the final year of a program~~ at ~~such~~ an accredited dental school who has completed all the coursework necessary to prepare the student to perform the clinical and diagnostic procedures required to pass the licensure examinations. ~~With respect to a dental student in the final year of a program at a dental school, a passing score on the examinations is valid for 365 days after the date the examinations were completed.~~ A dental school student who takes the licensure examinations during the student's final year of an approved dental school must graduate ~~have graduated~~ before being certified for licensure pursuant to s. 466.011.

(c)~~1.~~ Has successfully completed the examination administered by the Joint Commission on National Dental Examinations or its successor organization ~~National Board of Dental Examiners dental examination; or~~

~~2. Has an active health access dental license in this state; and~~

~~a. The applicant has at least 5,000 hours within 4 consecutive years of clinical practice experience providing direct patient care in a health access setting as defined in s. 466.003; the applicant is a retired veteran dentist of any branch of the United States Armed Services who has practiced dentistry while on active duty and has at least 3,000 hours within 3 consecutive years of clinical practice experience~~

~~providing direct patient care in a health access setting as defined in s. 466.003; or the applicant has provided a portion of his or her salaried time teaching health profession students in any public education setting, including, but not limited to, a community college, college, or university, and has at least 3,000 hours within 3 consecutive years of clinical practice experience providing direct patient care in a health access setting as defined in s. 466.003;~~

~~b. The applicant has not been disciplined by the board, except for citation offenses or minor violations;~~

~~c. The applicant has not filed a report pursuant to s. 456.049; and~~

~~d. The applicant has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession~~.

(4) Notwithstanding any other provision of law in chapter 456 pertaining to the clinical dental licensure examination or national examinations, to be licensed as a dentist in this state, an applicant must successfully complete both of the following:

(b) A practical or clinical examination, which must be the American Dental Licensing Examination produced by the American Board of Dental Examiners, Inc., or its successor entity, if any, which ~~that~~ is administered in this state, provided that the board has attained, and continues to maintain thereafter,

representation on the board of directors of the American Board of Dental Examiners, the examination development committee of the American Board of Dental Examiners, and such other committees of the American Board of Dental Examiners as the board deems appropriate by rule to assure that the standards established herein are maintained organizationally. ~~A passing score on the American Dental Licensing Examination administered in this state is valid for 365 days after the date the official examination results are published.~~

1. As an alternative to such practical or clinical examination, an applicant may submit scores from an American Dental Licensing Examination previously administered in a jurisdiction other than this state after October 1, 2011, and such examination results are ~~shall be~~ recognized as valid for the purpose of licensure in this state. A passing score on the American Dental Licensing Examination administered out of state is ~~shall be~~ the same as the passing score for the American Dental Licensing Examination administered in this state. ~~The examination results are valid for 365 days after the date the official examination results are published.~~ The applicant must have completed the examination after October 1, 2011. This subparagraph may not be given retroactive application.

2. If the date of an applicant's passing American Dental Licensing Examination scores from an examination previously administered in a jurisdiction other than this state under

subparagraph 1. is older than 365 days, such scores are nevertheless valid for the purpose of licensure in this state, but only if the applicant demonstrates that all of the following additional standards have been met:

a. The applicant completed the American Dental Licensing Examination after October 1, 2011. This sub-subparagraph may not be given retroactive application.~~;~~

b. The applicant graduated from a dental school accredited by the American Dental Association Commission on Dental Accreditation or its successor entity, if any, or any other dental accrediting organization recognized by the United States Department of Education. Provided, however, if the applicant did not graduate from such a dental school, the applicant may submit proof of having successfully completed a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation of at least 2 consecutive academic years at such accredited sponsoring institution. Such program must provide didactic and clinical education at the level of a D.D.S. or D.M.D. program accredited by the American Dental Association Commission on Dental Accreditation. For purposes of this sub-subparagraph, a supplemental general dentistry program does not include an advanced education program in a dental specialty.~~;~~

c. The applicant currently possesses a valid and active dental license in good standing, with no restriction, which has

never been revoked, suspended, restricted, or otherwise disciplined, from another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico.~~;~~

d. The applicant must disclose to the board during the application process if ~~submits proof that~~ he or she has ~~never~~ been reported to the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, or the American Association of Dental Boards Clearinghouse. This sub-subparagraph does not apply if the applicant successfully appealed to have his or her name removed from the data banks of these agencies.~~;~~

e.(I)(A) The applicant submits proof of having been consecutively engaged in the full-time practice of dentistry in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico in the 5 years immediately preceding the date of application for licensure in this state; or

(B) If the applicant has been licensed in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico for less than 5 years, the applicant submits proof of having been engaged in the full-time practice of dentistry since the date of his or her initial licensure.

(II) As used in this section, "full-time practice" is defined as a minimum of 1,200 hours per year for each ~~and every~~

year in the consecutive 5-year period or, when applicable, the period since initial licensure, and must include any combination of the following:

(A) Active clinical practice of dentistry providing direct patient care.

(B) Full-time practice as a faculty member employed by a dental or dental hygiene school approved by the board or accredited by the American Dental Association Commission on Dental Accreditation.

(C) Full-time practice as a student at a postgraduate dental education program approved by the board or accredited by the American Dental Association Commission on Dental Accreditation.

(III) The board shall develop rules to determine what type of proof of full-time practice is required and to recoup the cost to the board of verifying full-time practice under this section. Such proof must, at a minimum, be:

(A) Admissible as evidence in an administrative proceeding;

(B) Submitted in writing;

(C) ~~Submitted by the applicant under oath with penalties of perjury attached;~~

~~(D)~~ Further documented by an applicant's annual income tax return filed with the Internal Revenue Service for each year in the preceding 5-year period or, if the applicant has been

practicing for less than 5 years, the period since initial licensure ~~affidavit of someone unrelated to the applicant who is familiar with the applicant's practice and testifies with particularity that the applicant has been engaged in full-time practice~~; and

(D)~~(E)~~ Specifically found by the board to be both credible and admissible.

(IV) The board may excuse applicants from the 1,200-hour requirement in the event of hardship, as defined by the board. ~~An affidavit of only the applicant is not acceptable proof of full-time practice unless it is further attested to by someone unrelated to the applicant who has personal knowledge of the applicant's practice. If the board deems it necessary to assess credibility or accuracy, the board may require the applicant or the applicant's witnesses to appear before the board and give oral testimony under oath;~~

f. The applicant submits documentation that he or she has completed, or will complete before he or she is licensed in this state, continuing education equivalent to this state's requirements for the last full reporting biennium.~~;~~

g. The applicant proves that he or she has never been convicted of, or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession in any jurisdiction.~~;~~

h. The applicant has successfully passed a written

examination on the laws and rules of this state regulating the practice of dentistry and the computer-based diagnostic skills examination.~~; and~~

i. The applicant submits documentation that he or she has successfully completed the applicable examination administered by the Joint Commission on National Dental Examinations or its successor organization.

(5)(a) The practical examination required under subsection (4) is the American Dental Licensing Examination developed by the American Board of Dental Examiners, Inc., or its successor entity, if any, provided the board finds that the successor entity's clinical examination complies with the provisions of this section, and must include, at a minimum, all of the following:

1. A comprehensive diagnostic skills examination covering the full scope of dentistry and an examination on applied clinical diagnosis and treatment planning in dentistry for dental candidates.~~;~~

2. Two restorations on a manikin that has typodont teeth with simulated caries as approved by the Commission on Dental Competency Assessments. The board by rule shall determine the class of such restorations.~~;~~

3. A demonstration of periodontal skills on a manikin that has typodont teeth with simulated calculus as approved by the Commission on Dental Competency Assessments.~~;~~

4. A demonstration of prosthetics and restorative skills in complete and partial dentures and crowns and bridges and the utilization of practical methods of evaluation, specifically including the evaluation by the candidate of completed laboratory products such as, but not limited to, crowns and inlays filled to prepared model teeth.~~;~~

5. A demonstration of restorative skills on a manikin which requires the candidate to complete procedures performed in preparation for a cast restoration.~~;~~

6. A demonstration of endodontic skills.~~; and~~

7. A diagnostic skills examination demonstrating ability to diagnose conditions within the human oral cavity and its adjacent tissues and structures from photographs, slides, radiographs, or models pursuant to rules of the board. If an applicant fails to pass the diagnostic skills examination in three attempts, the applicant is not eligible for reexamination unless she or he completes additional educational requirements established by the board.

(b) ~~The department shall consult with the board in planning the times, places, physical facilities, training of personnel, and other arrangements concerning the administration of the examination. The board or a duly designated committee thereof shall approve the final plans for the administration of the examination;~~

~~(c)~~ If the applicant fails to pass the clinical

examination in three attempts, the applicant is ~~shall~~ not ~~be~~ eligible for reexamination unless she or he completes additional educational requirements established by the board.~~; and~~

(c)~~(d)~~ The board may by rule provide for additional procedures that ~~which~~ are to be tested, provided such procedures are ~~shall be~~ common to the practice of general dentistry. The board by rule shall determine the passing grade for each procedure and the acceptable variation for examiners. ~~No~~ Such rules may not ~~rule shall~~ apply retroactively.

~~The department shall require a mandatory standardization exercise for all examiners prior to each practical or clinical examination and shall retain for employment only those dentists who have substantially adhered to the standard of grading established at such exercise.~~

~~(6)(a) It is the finding of the Legislature that absent a threat to the health, safety, and welfare of the public, the relocation of applicants to practice dentistry within the geographic boundaries of this state, who are lawfully and currently practicing dentistry in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico, based on their scores from the American Dental Licensing Examination administered in a state other than this state, is substantially related to achieving the important state interest of improving access to dental care for underserved~~

~~citizens of this state and furthering the economic development goals of the state. Therefore, in order to maintain valid active licensure in this state, all applicants for licensure who are relocating to this state based on scores from the American Dental Licensing Examination administered in a state other than this state must actually engage in the full-time practice of dentistry inside the geographic boundaries of this state within 1 year of receiving such licensure in this state. The Legislature finds that, if such applicants do not actually engage in the full-time practice of dentistry within the geographic boundaries of this state within 1 year of receiving such a license in this state, access to dental care for the public will not significantly increase, patients' continuity of care will not be attained, and the economic development goals of the state will not be significantly met.~~

~~(b)1. As used in this section, "full-time practice of dentistry within the geographic boundaries of this state within 1 year" is defined as a minimum of 1,200 hours in the initial year of licensure, which must include any combination of the following:~~

~~a. Active clinical practice of dentistry providing direct patient care within the geographic boundaries of this state.~~

~~b. Full-time practice as a faculty member employed by a dental or dental hygiene school approved by the board or accredited by the American Dental Association Commission on~~

~~Dental Accreditation and located within the geographic boundaries of this state.~~

~~c. Full-time practice as a student at a postgraduate dental education program approved by the board or accredited by the American Dental Association Commission on Dental Accreditation and located within the geographic boundaries of this state.~~

~~2. The board shall develop rules to determine what type of proof of full-time practice of dentistry within the geographic boundaries of this state for 1 year is required in order to maintain active licensure and shall develop rules to recoup the cost to the board of verifying maintenance of such full-time practice under this section. Such proof must, at a minimum:~~

~~a. Be admissible as evidence in an administrative proceeding;~~

~~b. Be submitted in writing;~~

~~c. Be submitted by the applicant under oath with penalties of perjury attached;~~

~~d. Be further documented by an affidavit of someone unrelated to the applicant who is familiar with the applicant's practice and testifies with particularity that the applicant has been engaged in full-time practice of dentistry within the geographic boundaries of this state within the last 365 days;~~ ~~and~~

~~e. Include such additional proof as specifically found by~~

~~the board to be both credible and admissible.~~

~~3. An affidavit of only the applicant is not acceptable proof of full-time practice of dentistry within the geographic boundaries of this state within 1 year, unless it is further attested to by someone unrelated to the applicant who has personal knowledge of the applicant's practice within the last 365 days. If the board deems it necessary to assess credibility or accuracy, the board may require the applicant or the applicant's witnesses to appear before the board and give oral testimony under oath.~~

~~(c) It is the further intent of the Legislature that a license issued pursuant to paragraph (a) shall expire in the event the board finds that it did not receive acceptable proof of full-time practice within the geographic boundaries of this state within 1 year after the initial issuance of the license. The board shall make reasonable attempts within 30 days prior to the expiration of such a license to notify the licensee in writing at his or her last known address of the need for proof of full-time practice in order to continue licensure. If the board has not received a satisfactory response from the licensee within the 30-day period, the licensee must be served with actual or constructive notice of the pending expiration of licensure and be given 20 days in which to submit proof required in order to continue licensure. If the 20-day period expires and the board finds it has not received acceptable proof of full-~~

~~time practice within the geographic boundaries of this state within 1 year after the initial issuance of the license, then the board must issue an administrative order finding that the license has expired. Such an order may be appealed by the former licensee in accordance with the provisions of chapter 120. In the event of expiration, the licensee shall immediately cease and desist from practicing dentistry and shall immediately surrender to the board the wallet-size identification card and wall card. A person who uses or attempts to use a license issued pursuant to this section which has expired commits unlicensed practice of dentistry, a felony of the third degree pursuant to s. 466.026(1)(b), punishable as provided in s. 775.082, s. 775.083, or s. 775.084.~~

Section 2. Subsection (1) of section 466.009, Florida Statutes, is amended to read:

466.009 Reexamination.—

(1) ~~The department shall permit~~ Any person who fails an examination that ~~which~~ is required under s. 466.006 or s. 466.007 may ~~to~~ retake the examination. ~~If the examination to be retaken is a practical or clinical examination, the applicant shall pay a reexamination fee set by rule of the board in an amount not to exceed the original examination fee.~~

Section 3. Paragraph (c) of subsection (1) of section 466.0135, Florida Statutes, is amended to read:

466.0135 Continuing education; dentists.—

(1) In addition to the other requirements for renewal set out in this chapter, each licensed dentist shall be required to complete biennially not less than 30 hours of continuing professional education in dental subjects, with a minimum of 2 hours of continuing education on the safe and effective prescribing of controlled substances. Programs of continuing education shall be programs of learning that contribute directly to the dental education of the dentist and may include, but shall not be limited to, attendance at lectures, study clubs, college postgraduate courses, or scientific sessions of conventions; and research, graduate study, teaching, or service as a clinician. Programs of continuing education shall be acceptable when adhering to the following general guidelines:

(c) The board may also authorize up to 3 hours of credit biennially for a practice management course that includes instruction on principles of ethical practice management, ~~provides~~ substance abuse, effective communication with patients, time management, or ~~and~~ burnout prevention ~~instruction~~.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 563 Persons with Lived Experience
SPONSOR(S): Children, Families & Seniors Subcommittee, Campbell
TIED BILLS: **IDEN./SIM. BILLS:** SB 558

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	14 Y, 0 N, As CS	Osborne	Brazzell
2) Health Care Appropriations Subcommittee		Fontaine	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Homelessness can be defined in several different ways. Generally, a person is considered to be experiencing homelessness if they stay in a shelter live in transitional housing, or sleep in a place not meant for human habitation or outdoors.

The State Office on Homelessness within the Department of Children and Families (DCF) was established in 2001 as a central point of contact within state government on issues relating to homelessness. The State Office on Homelessness coordinates resources and programs across all levels of government and with private providers that serve the homeless pursuant to policies set by the Council on Homelessness and available funding. Continuums of Care (CoCs) coordinate local efforts to prevent and end homelessness at the local level. CoCs operate within catchment areas designated by the State Office on Homelessness, and receiving state and federal funding to implement programs and provide services.

Florida provides standard procedures for screening a prospective employee where the Legislature has determined it is necessary to conduct a criminal history background check to protect vulnerable persons.

All individuals subject to background screening must be confirmed to have not been arrested for and waiting final disposition of, been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, or been adjudicated delinquent and the record has not been sealed or expunged for any of 52 disqualifying offenses outlined in current law. For otherwise qualified individuals who would be disqualified from employment due to their criminal history, current law establishes a process through which such individual can be exempt from disqualification.

DCF interprets current law as subjecting contractors and subcontractors to background screening as a condition of their contract with the department. As such, DCF requires employees of CoCs and their subcontractors to undergo level 2 background screening. However, individuals with lived experience of homelessness, who can be helpful in delivering homelessness services, may have crimes that raise difficulties in passing a background screening.

CS/HB 563 defines a “person with lived experience” and establishes a modified background screening process for such persons applying for positions with the State Office on Homelessness or a CoC. The bill allows for an applicant meeting certain requirements to be certified as a “person with lived experience,” and considered a qualified applicant eligible for the modified screening process. The bill requires DCF to accept or reject a request for exemption from disqualification within 90 days of receiving the application.

The bill has an indeterminate, insignificant fiscal impact on state government, and no fiscal 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

Homelessness

Homelessness can be defined in several different ways. Generally, a person is considered to be experiencing homelessness if that person stays in a shelter, lives in transitional housing, or sleeps in a place not meant for human habitation or outdoors.[1] To receive federally funded homelessness services, a person is considered homeless if he or she:[2]

- Is living in a place not meant for human habitation, in emergency shelter, in transitional housing, or exiting an institution where the person temporarily resided;[3]
- Will imminently lose a primary nighttime residence within 14 days and lacks resources or support networks to remain in permanent housing;[4]
- Is part of a family with children or an unaccompanied youth who is unstably housed and likely to continue in that state; or
- Is fleeing or attempting to flee from domestic violence, has no other residence, and lacks the resources or support networks to obtain permanent housing.

Annually, the United States Department of Housing and Urban Development (HUD) releases what is known as a point-in-time snapshot (PIT) or a count of the number of individuals who experience homeless on a single night. Based on the 2023 PIT, roughly 653,100 people in America experienced homelessness on a single night. Sixty percent experienced sheltered homelessness (i.e., living in emergency shelter, transitional housing, or a safe haven program) whereas 40 percent were unsheltered. From 2022 to 2023, the number of individuals experiencing homelessness increased by 12 percent, or roughly 70,650 additional individuals. This is the highest PIT count of persons experiencing homelessness since reporting began in 2007.[5]

Experiencing homelessness negatively effects a person's mental and physical health. Rates of mortality, mental illness, communicable diseases, sexually transmitted diseases, and substance abuse are higher among homeless populations.[6] Services and programs at the state and federal level provide support to individuals experiencing homelessness that attempt to address the associated effects of homelessness.[7]

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[1] Centers for Disease Control and Prevention, *About Homelessness* (2022). Available at https://www.cdc.gov/orr/science/homelessness/about.html (Last visited January 25, 2024).
[2] 24 C.F.R. 578.3
[3] This includes a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; a supervised publicly or privately operated shelter designed to provide temporary living arrangement; or exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.
[4] Provided that the primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; no subsequent residence has been identified; and the individual lacks the resources or support networks.
[5] U.S. Department of Housing and Urban Development, *The 2023 Annual Homelessness Assessment Report* (AHAR) to Congress (2023). Available at https://www.huduser.gov/portal/sites/default/files/pdf/2023-AHAR-Part-1.pdf (last visited January 25, 2024).
[6] Richards, J. & Kuhn, R., *Unsheltered Homelessness and Health: A Literature Review* (2022). American Journal of Preventative Medicine, 2(1). https://doi.org/10.1016/j.focus.2022.100043
[7] US Department of Health and Human Services, *Homelessness*. Available at https://www.hhs.gov/programs/social-services/homelessness/index.html (last visited January 26, 2024).

Homelessness in Florida

In a 2023 PIT count of Florida's homeless population, an estimated 30,809 individuals were experiencing homelessness, with 15,706 considered unsheltered homeless (i.e., living outside in a car, park, or another place not meant for human habitation). The 2023 PIT count represents a 34 percent increase from the 11,746 individuals who were experiencing homelessness in 2022.[8]

The State Office on Homelessness (Office) within the Department of Children and Families (DCF) was established in 2001 as a central point of contact within state government on issues relating to homelessness.[9] The Office coordinates resources and programs across all levels of government and with private providers that serve the homeless pursuant to policies set by the Council on Homelessness[10] and available funding.[11]

Continuums of Care

A Continuum of Care (CoC) is an entity coordinating community efforts to prevent and end homelessness in a geographic area designated by the Office.[12] CoCs are responsible for organizing and delivering housing and services to meet the needs of people who are homeless as they move to stable housing and self-sufficiency.[13] CoCs are composed of representatives from local organizations including, but not limited to:[14]

- Nonprofit homeless service providers;
- Victim services providers;
- Faith-based organizations;
- Governments;
- Businesses;
- Advocates;
- Public housing agencies;
- School districts;
- Social service providers;
- Mental health agencies;
- Hospitals;
- Universities;
- Affordable housing developers;
- Law enforcement; and
- Organizations that serve homeless and formerly homeless persons.

CoC lead agencies implement policies and provide direct services within their respective catchment areas. There are currently 27 CoC lead agencies distributed across the state.[15]

Each CoC must create a continuum of care plan to implement an effective and efficient housing crisis response system to prevent and end homelessness in its designated catchment area. A continuum of care plan must include all of the following:[16]

[8] Department of Children and Families, *Council on Homelessness Annual Report* (2023). Available at https://www.myflfamilies.com/sites/default/files/2023-07/Florida%27s%20Council%20On%20Homelessness%20Annual%20Report%202023.pdf (last visited January 25, 2024).
[9] Ch. 2001-98, L.O.F.
[10] The Council on Homelessness is an inter-agency body which develops statewide policy and advises the State Office on Homelessness on how to reduce homelessness in the state. See, s. 420.622, F.S.
[11] S. 420.622(3), F.S.
[12] The catchment areas designated by the State Office must be consistent with the federally-recognized catchment areas designated by HUD as a condition for receiving federal homeless assistance grant funding. *See*, s. 420.6225, F.S.
[13] *Supra*, note 8.
[14] S. 420.621(1), F.S.
[15] *Supra*, note 8..
[16] S. 420.6225, F.S.

- Outreach to unsheltered individuals and families to link them with appropriate housing interventions;
- A coordinated entry system that is compliant with federal requirements and is designed to coordinate intake, utilize common assessment tools, prioritize households for housing interventions, and refer households to the appropriate housing intervention;
- Emergency shelter, designed to provide safe temporary shelter while the household is in the process of obtaining permanent housing;
- Supportive services, designed to maximize housing stability once the household is in permanent housing;
- Permanent supportive housing, designed to provide long-term affordable housing and support services to persons with disabilities who are moving out of homelessness;
- Rapid ReHousing, as specified in s. 420.6265, F.S.;
- Permanent housing, including links to affordable housing, subsidized housing, long-term rental assistance, housing vouchers, and mainstream private sector housing; and
- An ongoing planning mechanism to end homelessness for all subpopulations of persons experiencing homelessness

CoCs receive state and federal funding through DCF.[17]

Background Screening

Florida provides standard procedures for screening a prospective employee[18] where the Legislature has determined it is necessary to conduct a criminal history background check to protect vulnerable persons.[19] Chapter 435, F.S., establishes procedures for criminal history background screening of prospective employees and outlines the screening requirements. There are two levels of background screening: level 1 and level 2.

- Level 1: Screening includes, at a minimum, employment history checks and statewide criminal correspondence checks through the Florida Department of Law Enforcement (FDLE) and a check of the Dru Sjodin National Sex Offender Public Website,[20] and may include criminal records checks through local law enforcement agencies. A Level 1 screening may be paid for and conducted through FDLE's website, which provides immediate results.[21]
- Level 2: Screening includes, at a minimum, fingerprinting for statewide criminal history records checks through FDLE and national criminal history checks through the Federal Bureau of Investigation (FBI), and may include local criminal records checks through local law enforcement agencies.[22]

Every person required by law to be screened pursuant to ch. 435, F.S., must submit a complete set of information necessary to conduct a screening to his or her employer.[23] Such information for a level 2 screening includes fingerprints, which are taken by a vendor that submits them electronically to FDLE.[24]
For both level 1 and 2 screenings, the employer must submit the information necessary for screening to FDLE within five working days after receiving it.[25] The person whose background is being checked

[17] *Id*.
[18] S. 435.02, F.S., defines "employee" to mean any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers.
[19] Ch. 435, F.S.
[20] The Dru Sjodin National Sex Offender Public Website is a U.S. government website that links public state, territorial, and tribal sex offender registries in one national search site. Available at www.nsopw.gov (last visited January 25, 2024).
[21] Florida Department of Law Enforcement, *State of Florida Criminal History Records Check*. Available at http://www.fdle.state.fl.us/Criminal-History-Records/Florida-Checks.aspx (last visited January 25, 2024).
[22] S. 435.04, F.S.
[23] S. 435.05(1)(a), F.S.
[24] Ss. 435.03(1) and 435.04(1)(a), F.S.
[25] S. 435.05(1)(b)-(c), F.S.

must supply any missing criminal or other necessary information upon request to the requesting employer or agency within 30 days after receiving the request for the information.[26]

After the background screening is completed, FDLE responds to the employer or agency, and the employer or agency must inform the employee whether screening has revealed disqualifying information.[27] If the employer or agency finds that an individual has a history containing one of these offenses, it must disqualify that individual from employment.

Criminal History Checks

Florida law authorizes and outlines a variety of specific elements required for Level 1 and Level 2 background screening; however, current law only establishes distinct requirements for determining whether an individual "passes" a screening in regard to an individual's criminal history.

All individuals subject to background screening must be confirmed to have not been arrested for and waiting final disposition of, been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, or been adjudicated delinquent and the record has not been sealed or expunged for, any of the following 52 offenses prohibited under Florida law, or similar law of another jurisdiction:[28]

- Section 393.135, F.S., relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.
- Section 394.4593, F.S., relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.
- Section 415.111, F.S., relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
- Section 777.04, F.S., relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
- Section 782.04, F.S., relating to murder.
- Section 782.07, F.S., relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.
- Section 782.071, F.S., relating to vehicular homicide.
- Section 782.09, F.S., relating to killing of an unborn child by injury to the mother.
- Chapter 784, F.S., relating to assault, battery, and culpable negligence, if the offense was a felony.
- Section 784.011, F.S., relating to assault, if the victim of the offense was a minor.
- Section 784.03, F.S., relating to battery, if the victim of the offense was a minor.
- Section 787.01, F.S., relating to kidnapping.
- Section 787.02, F.S., relating to false imprisonment.
- Section 787.025, F.S., relating to luring or enticing a child.
- Section 787.04(2), F.S., relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.
- Section 787.04(3), F.S., relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.
- Section 790.115(1), F.S., relating to exhibiting firearms or weapons within 1,000 feet of a school.
- Section 790.115(2)(b), F.S., relating to possessing an electric weapon or device, destructive device, or other weapon on school property.
- Section 794.011, F.S., relating to sexual battery.
- Former s. 794.041, F.S., relating to prohibited acts of persons in familial or custodial authority.

[26] S. 435.05(1)(d), F.S.
[27] S. 435.05(1)(b), F.S.
[28] S. 435.04(2), F.S.

- Section 794.05, F.S., relating to unlawful sexual activity with certain minors.
- Chapter 796, F.S., relating to prostitution.
- Section 798.02, F.S., relating to lewd and lascivious behavior.
- Chapter 800, F.S., relating to lewdness and indecent exposure.
- Section 806.01, F.S., relating to arson.
- Section 810.02, F.S., relating to burglary.
- Section 810.14, F.S., relating to voyeurism, if the offense is a felony.
- Section 810.145, F.S., relating to video voyeurism, if the offense is a felony.
- Chapter 812, F.S., relating to theft, robbery, and related crimes, if the offense is a felony.
- Section 817.563, F.S., relating to fraudulent sale of controlled substances, only if the offense was a felony.
- Section 825.102, F.S., relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.
- Section 825.1025, F.S., relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.
- Section 825.103, F.S., relating to exploitation of an elderly person or disabled adult, if the offense was a felony.
- Section 826.04, F.S., relating to incest.
- Section 827.03, F.S., relating to child abuse, aggravated child abuse, or neglect of a child.
- Section 827.04, F.S., relating to contributing to the delinquency or dependency of a child.
- Former s. 827.05, F.S., relating to negligent treatment of children.
- Section 827.071, F.S., relating to sexual performance by a child.
- Section 843.01, F.S., relating to resisting arrest with violence.
- Section 843.025, F.S., relating to depriving a law enforcement, correctional, or correctional probation officer of means of protection or communication.
- Section 843.12, F.S., relating to aiding in an escape.
- Section 843.13, F.S., relating to aiding in the escape of juvenile inmates in correctional institutions.
- Chapter 847, F.S., relating to obscene literature.
- Section 874.05, F.S., relating to encouraging or recruiting another to join a criminal gang.
- Chapter 893, F.S., relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.
- Section 916.1075, F.S., relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.
- Section 944.35(3), F.S., relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.
- Section 944.40, F.S., relating to escape.
- Section 944.46, F.S., relating to harboring, concealing, or aiding an escaped prisoner.
- Section 944.47, F.S., relating to introduction of contraband into a correctional facility.
- Section 985.701, F.S., relating to sexual misconduct in juvenile justice programs.
- Section 985.711, F.S., relating to contraband introduced into detention facilities.

Current law required some positions to be screened for additional criminal offenses due to the nature of the position or the populations being served. For example, some positions under the authority of the Agency for Health Care Administration are screened for additional offenses, such as financial crimes like fraud.[29]

The criminal history check process does not limit disqualification based on when an offense was committed. As such, any history of a listed offense is considered disqualifying regardless of when the offense was committed. Only through the exemption process can some offenses be disregarded dependent on when they were committed.

[29] *See*, s. 408.809, F.S.

Exemption from Disqualification

For otherwise qualified individuals who would be disqualified from employment due to their criminal history, there is a process established in current law through which such individual can be exempt from disqualification. Current law allows the Secretary of the appropriate state agency to exempt applicants from disqualification under certain circumstances:[30]

- Three years have elapsed since the individual has completed or been lawfully released from confinement, supervision, or nonmonetary condition imposed by a court for a disqualifying felony; or
- The applicant has completed or been lawfully released from confinement, supervision, or nonmonetary condition imposed by a court for a misdemeanor or an offense that was a felony at the time of commission but is now a misdemeanor.

Receiving an exemption allows that individual to be employed in a profession or workplace where background screening is statutorily required despite the disqualifying offense in that person's past. Certain criminal backgrounds, however, render a person ineligible for an exemption; a person who is considered a sexual predator,[31] career offender,[32] or registered sexual offender[33] is not eligible for exemption.[34]

Exemption Process

To seek exemption from disqualification, an employee must submit a request for an exemption from disqualification within 30 days after being notified of a pending disqualification.[35] The disqualified employee must apply to DCF for an exemption from disqualification. Such application requests information regarding the individual, the facility and role they are applying for, details about their criminal offense, and the status of any court-ordered payments (e.g., fees, fines, costs of prosecution or restitution).[36]

To be exempted from disqualification and thus be able to work, the applicant must demonstrate by clear and convincing evidence that he or she should not be disqualified from employment.[37] Clear and convincing evidence is a heavier burden than the preponderance of the evidence standard but less than beyond a reasonable doubt.[38] This means that the evidence presented is credible and verifiable, and that the memories of witnesses are clear and without confusion. This evidence must create a firm belief and conviction of the truth of the facts presented and, considered as a whole, must convince DCF representatives without hesitancy that the requester will not pose a threat if allowed to hold a position of special trust relative to children, vulnerable adults, or to developmentally disabled individuals. Evidence that may support an exemption includes, but is not limited to:[39]

- Personal references;
- Letters from employers or other professionals;

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[30] S. 435.07, F.S.
[31] S. 775.21, F.S.
[32] S. 775.261, F.S.
[33] S. 943.0435, F.S.
[34] S. 435.07(4)(b), F.S.
[35] S. 397.4073(1)(f), F.S.
[36] Department of Children and Families, *Apply for an Exemption from Disqualification.* Available at https://www.myflfamilies.com/services/background-screening/apply-exemption-disqualification (last visited January 25, 2024).
[37] S. 435.07(3)(a), F.S.
[38] Department of Children and Families, *CF Operating Procedure 60-18, Personnel: Exemption from Disqualification* (2010). Available at https://www.myflfamilies.com/sites/default/files/2022-12/cfop_60-18_exemption_from_disqualification.pdf (last visited January 26, 2024).
[39] *Id.*

- Evidence of rehabilitation, including documentation of successful participation in a rehabilitation program;
- Evidence of further education or training;
- Evidence of community involvement;
- Evidence of special awards or recognition;
- Evidence of military service; and
- Parenting or other caregiver experiences.

After the agency head receives a complete exemption request package from the applicant, the background screening coordinator searches available data, including, but not limited to, a review of records and pertinent court documents including case disposition and the applicant's plea in order to determine the appropriateness of granting the applicant an exemption. These materials, in addition to the information provided by the applicant, form the basis for a recommendation as to whether the exemption should be granted.[40]

After all reasonable evidence is gathered, the background screening coordinator consults with his or her supervisor, and after consultation with the supervisor, the coordinator and the supervisor will recommend whether the exemption should be granted. At DCF, the regional legal counsel's office reviews the recommendation to grant or deny an exemption to determine legal sufficiency; the criminal justice coordinator in the region in which the background screening coordinator is located also reviews the exemption request file and recommendation and makes an initial determination whether to grant or deny the exemption.[41]

If the regional criminal justice coordinator makes an initial determination that the exemption should be granted, the exemption request file and recommendations are forwarded to the regional director, who has delegated authority from the agency head to grant or deny the exemption. After an exemption request decision is final, a written response is provided to the applicant as to whether the request is granted or denied.[42]

If the agency head grants the exemption, the applicant and the facility or employer are notified of the decision by regular mail. However, if the request is denied, notification of the decision is sent by certified mail, return receipt requested, to the applicant, addressed to the last known address and a separate letter of denial is sent by regular mail to the facility or employer. If the application is denied, the denial letter must set forth pertinent facts that the background screening coordinator, the background screening coordinator's supervisor, the criminal justice coordinator, and regional director, where appropriate, used in deciding to deny the exemption request. It must also inform the denied applicant of the availability of an administrative review pursuant to ch. 120, F.S.[43]

Current law does not require agencies to adhere to any specified timeline in their response to requests for exemption from disqualification.[44]

Background Screening for Employees of Homeless Service Providers

People with lived experience of homelessness typically have the best understanding of the reality of the work to prevent and end homelessness. From a programmatic perspective, people with lived experience of homelessness bring insight through a personal familiarity with the barriers people face, the gaps in services, and the interventions that are the most effective.[45] On a person-to-person level,

[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] S. 435.07, F.S.
[45] HUD Exchange, *Centering Lived Experience*. Available at https://www.hudexchange.info/programs/coc/centering-lived-experience/ (last visited January 26, 2024).

people with lived experience are often more easily able to meet people where they are and truly understand their struggle.[46]

People who are experiencing homelessness present with complex needs to be addressed by service providers. This population is more likely to be experiencing mental illness, communicable diseases, sexually transmitted diseases, and substance abuse than the general population.[47] Homelessness is increasingly criminalized,[48] and people experiencing homelessness and extreme poverty may be driven to commit crimes as a means of survival. As a result, homeless individuals have frequent interactions with law enforcement, and more than half of people experiencing homelessness in the US have been previously incarcerated.[49] The existence of a criminal record creates barriers to permanent housing and employment once the underlying causes of a person's homelessness have been addressed.[50]

DCF interprets current law as subjecting contractors and subcontractors to background screening as a condition of their contract with the department. As such, DCF requires employees of CoCs and their subcontractors to undergo Level 2 background screening as a prerequisite to employment.[51] This presents a barrier to CoCs hiring people with lived experience of homelessness who may have a criminal history as a result of their lived experience.

Potential employees who are disqualified through background screening are eligible for exemption through the agency as described above.[52] Obtaining an exemption from disqualification is a lengthy and time-consuming process. Individual exemption requests can take upwards of six months to process and receive final approval through the department; a period of time which an individual is not able to work in the role which they have been hired for. This results in qualified individuals with relevant lived experiences to the population they're seeking to serve being screened out and further limiting the pool of eligible employees.[53]

Effect of the Bill

CS/HB 563 creates a category of "persons with lived experience" who are eligible to apply for employment with the State Office or a CoC (hiring entity) through a modified background screening process. Under the bill, a person who has past or present experience with homelessness pursuant to federal law[54] may qualify as a person with lived experience.

The bill allows the hiring entity to certify that the applicant is a qualified applicant with relevant lived experience if the applicant has received homeless services in the past. The hiring entity must submit documentation to DCF verifying that the applicant has received homeless services when requesting the background check of the applicant.

Under the bill, an applicant who has been certified as a person with lived experience is then subject to a modified background screening. The background screening must ensure that the applicant has not been arrested for and is not awaiting final disposition of, has not been found guilty of, regardless of

[46] United States Interagency Council on Homelessness, *The Value of Lived Experience in the Work to End Homelessness* (2018). Available at https://www.usich.gov/news-events/news/value-lived-experience-work-end-homelessness (last visited January 26, 2024).
[47] *Supra*, note 6.
[48] United States Interagency Council on Homelessness. *Collaborate, Don't Criminalize: How Communities Can Effectively and Humanely Address Homelessness* (2022). Available at https://www.usich.gov/news-events/news/collaborate-dont-criminalize-how-communities-can-effectively-and-humanely-address (last visited January 26, 2024).
[49] US Justice Department, Bureau of Justice Assistance, *Responding to Homelessness: Police-Mental Health Collaboration Toolkit*. Available at https://bja.ojp.gov/program/pmhc/responding-homelessness#3-0 (last visited January 26, 2024).
[50] *Id*.
[51] Department of Children and Families, *Agency Bill Analysis for HB 563* (2024). On file with the Children, Families & Seniors Subcommittee.
[52] *See*, s. 435.07, F.S.
[53] Correspondence with Leeanne Sacino, Executive Director of the Florida Coalition to End Homelessness. On file with the Children, Families & Seniors Subcommittee.
[54] A person who has lacked a fixed, regular, and adequate nighttime residence is generally considered homeless. *See*, 24 C.F.R § 578.3, for all of the situations which constitute being "homeless."

adjudication, or entered a plea of nolo contendere or guilty to, or has not been adjudicated delinquent and the record has been sealed or expunged for:

- Any felony during the previous three years; or
- Any offense prohibited under any of the following laws of Florida or similar laws of another jurisdiction:
    - Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.
    - Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.
    - Section 409.920, relating to Medicaid provider fraud, if the offense was a felony of the first or second degree.
    - Section 415.111, relating to criminal penalties for abuse, neglect, or exploitation of vulnerable adults.
    - Any offense that constitutes domestic violence, as that term is defined in s. 741.28.
    - Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this paragraph.
    - Section 782.04, relating to murder.
    - Section 782.07, relating to manslaughter or aggravated manslaughter of an elderly person, a disabled adult, a child, an officer, a firefighter, an emergency medical technician, or a paramedic.
    - Section 782.071, relating to vehicular homicide.
    - Section 782.09, relating to killing of an unborn child by injury to the mother.
    - Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.
    - Section 787.01, relating to kidnapping.
    - Section 787.02, relating to false imprisonment.
    - Section 787.025, relating to luring or enticing a child.
    - Section 787.04(2), relating to leading, taking, enticing, or removing a child beyond the state limits, or concealing the location of a child, with criminal intent pending custody proceedings.
    - Section 787.04(3), relating to leading, taking, or removing a child beyond the state lines, or concealing the location of a child, with criminal intent pending dependency proceedings or proceedings concerning alleged abuse or neglect of a child.
    - Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.
    - Section 790.115(2)(b), relating to possessing an electric weapon or device, a destructive device, or any other weapon on school property.
    - Section 794.011, relating to sexual battery.
    - Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.
    - Section 794.05, relating to unlawful sexual activity with certain minors.
    - Section 794.08, relating to female genital mutilation.
    - Section 796.07, relating to procuring another to commit prostitution, except for those offenses expunged pursuant to s. 943.0583.
    - Section 798.02, relating to lewd and lascivious behavior.
    - Chapter 800, relating to lewdness and indecent exposure.
    - Section 806.01, relating to arson.
    - Section 810.02, relating to burglary.
    - Section 810.14, relating to voyeurism, if the offense is a felony.
    - Section 810.145, relating to video voyeurism, if the offense is a felony.
    - Section 812.13, relating to robbery.
    - Section 812.131, relating to robbery by sudden snatching.
    - Section 812.133, relating to carjacking.
    - Section 812.135, relating to home-invasion robbery.

- Section 817.034, relating to communications fraud, if the offense is a felony of the first degree.
- Section 817.234, relating to false and fraudulent insurance claims, if the offense is a felony of the first or second degree.
- Section 817.50, relating to fraudulently obtaining goods or services from a health care provider and false reports of a communicable disease.
- Section 817.505, relating to patient brokering.
- Section 817.568, relating to fraudulent use of personal identification, if the offense was a felony of the first or second degree.
- Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.
- Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.
- Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.
- Section 826.04, relating to incest.
- Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.
- Section 827.04, relating to contributing to the delinquency or dependency of a child.
- Former s. 827.05, relating to negligent treatment of children.
- Section 827.071, relating to sexual performance by a child.
- Section 831.30, relating to fraud in obtaining medicinal drugs.
- Section 831.31, relating to the sale, manufacture, delivery, or possession with intent to sell, manufacture, or deliver of any counterfeit controlled substance, if the offense was a felony.
- Section 843.01, relating to resisting arrest with violence.
- Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.
- Section 843.12, relating to aiding in an escape.
- Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.
- Chapter 847, relating to obscenity.
- Section 874.05, relating to encouraging or recruiting another to join a criminal gang.
- Chapter 893, relating to drug abuse prevention and control, if the offense was a felony of the first or second degree or greater severity.
- Section 895.03, relating to racketeering and collection of unlawful debts.
- Section 896.101, relating to the Florida Money Laundering Act.
- Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.
- Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.
- Section 944.40, relating to escape.
- Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.
- Section 944.47, relating to introduction of contraband into a correctional facility.
- Section 985.701, relating to sexual misconduct in juvenile justice programs.
- Section 985.711, relating to contraband introduced into detention facilities.

The bill allows an applicant that is disqualified through the modified background screening process to apply to DCF for an exemption pursuant to s. 435.07, F.S. The bill requires DCF to accept or reject the exemption within 90 days of receiving the application.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 420.621, F.S., relating to definitions.
Section 2: Creates s. 420.6241, F.S., relating to persons with lived experience.

Section 3: 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 will have an insignificant, indeterminant impact on DCF which can be absorbed by 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.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Rule-making authority is not necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 29, 2024, the Children, Families & Seniors Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Aligns the bill with the Senate companion;
- Removes the requirement that the signed attestation that an applicant has lived experience be submitted under penalty of perjury; and
- Adds the definition for “person with lived experience” to the appropriate section of statute.

The analysis is drafted to the committee substitute as approved by the Children, Families & Seniors Subcommittee.

A bill to be entitled

An act relating to persons with lived experience; amending s. 420.621, F.S.; defining the term "person with lived experience"; creating s. 420.6241, F.S.; providing legislative intent; providing qualifications for a person seeking certification as a person with lived experience; requiring continuum of care lead agencies to submit certain information to the Department of Children and Families for purposes of background screening; providing duties of the department; prescribing screening requirements; specifying disqualifying offenses for a person applying for certification; authorizing a person who does not meet background screening requirements to request from the department an exemption from disqualification; providing an effective date.

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

Section 1. Subsection (6) of section 420.621, Florida Statutes, is renumbered as subsection (7), and a new subsection (6) is added to that section, to read:

420.621 Definitions.—As used in ss. 420.621-420.628, the term:

(6) "Person with lived experience" means any person with

current or past experience of homelessness, as defined in 24 C.F.R. s. 578.3, including persons who have accessed or sought homeless services while fleeing domestic violence.

Section 2. Section 420.6241, Florida Statutes, is created to read:

420.6241 Persons with lived experience.—

(1) LEGISLATIVE INTENT.—The Legislature finds that the ability to provide adequate homeless services is limited due to a shortage of professionals and paraprofessionals in the field. Persons with lived experience of homelessness are uniquely qualified to provide effective support services because they share common life experiences with the persons they assist. A person with lived experience may have a criminal history that prevents him or her from meeting background screening requirements.

(2) QUALIFICATIONS.—A person may seek certification as a person with lived experience if he or she has received homeless services. A continuum of care lead agency serving the homeless must include documentation of the homeless services such person received when requesting a background check of the applicant.

(3) DUTIES OF THE DEPARTMENT.—The department shall ensure that an applicant's background screening required to achieve certification is conducted as provided in subsection (4).

(4) BACKGROUND SCREENING.—

(a) The background screening conducted under this

subsection must ensure that the qualified applicant has not, during the preceding 3 years, been arrested for and is not awaiting final disposition of, has not been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, or has not been adjudicated delinquent and the record has been sealed or expunged for, any felony.

(b) The background screening conducted under this subsection must ensure that the qualified applicant has not been arrested for and is not awaiting final disposition of, has not been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, or has not been adjudicated delinquent and the record has been sealed or expunged for, any offense prohibited under any of the following state laws or similar laws of another jurisdiction:

1. Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

2. Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

3. Section 409.920, relating to Medicaid provider fraud, if the offense is a felony of the first or second degree.

4. Section 415.111, relating to criminal penalties for abuse, neglect, or exploitation of vulnerable adults.

5. Any offense that constitutes domestic violence, as

defined in s. 741.28.

6. Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this paragraph.

7. Section 782.04, relating to murder.

8. Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or a disabled adult, aggravated manslaughter of a child, or aggravated manslaughter of an officer, a firefighter, an emergency medical technician, or a paramedic.

9. Section 782.071, relating to vehicular homicide.

10. Section 782.09, relating to killing of an unborn child by injury to the mother.

11. Chapter 784, relating to assault, battery, and culpable negligence, if the offense is a felony.

12. Section 787.01, relating to kidnapping.

13. Section 787.02, relating to false imprisonment.

14. Section 787.025, relating to luring or enticing a child.

15. Section 787.04(2), relating to leading, taking, enticing, or removing a minor beyond the state limits, or concealing the location of a minor, with criminal intent pending custody proceedings.

16. Section 787.04(3), relating to leading, taking, enticing, or removing a minor beyond the state limits, or concealing the location of a minor, with criminal intent pending

dependency proceedings or proceedings concerning alleged abuse or neglect of a minor.

17. Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

18. Section 790.115(2)(b), relating to possessing an electric weapon or device, a destructive device, or any other weapon on school property.

19. Section 794.011, relating to sexual battery.

20. Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

21. Section 794.05, relating to unlawful sexual activity with certain minors.

22. Section 794.08, relating to female genital mutilation.

23. Section 796.07, relating to procuring another to commit prostitution, except for those offenses expunged pursuant to s. 943.0583.

24. Section 798.02, relating to lewd and lascivious behavior.

25. Chapter 800, relating to lewdness and indecent exposure.

26. Section 806.01, relating to arson.

27. Section 810.02, relating to burglary, if the offense is a felony of the first degree.

28. Section 810.14, relating to voyeurism, if the offense is a felony.

29. Section 810.145, relating to video voyeurism, if the offense is a felony.

30. Section 812.13, relating to robbery.

31. Section 812.131, relating to robbery by sudden snatching.

32. Section 812.133, relating to carjacking.

33. Section 812.135, relating to home-invasion robbery.

34. Section 817.034, relating to communications fraud, if the offense is a felony of the first degree.

35. Section 817.234, relating to false and fraudulent insurance claims, if the offense is a felony of the first or second degree.

36. Section 817.50, relating to fraudulently obtaining goods or services from a health care provider and false reports of a communicable disease.

37. Section 817.505, relating to patient brokering.

38. Section 817.568, relating to fraudulent use of personal identification, if the offense is a felony of the first or second degree.

39. Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or a disabled adult.

40. Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or a disabled person.

41. Section 825.103, relating to exploitation of an

elderly person or a disabled adult, if the offense is a felony.

42. Section 826.04, relating to incest.

43. Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.

44. Section 827.04, relating to contributing to the delinquency or dependency of a child.

45. Former s. 827.05, relating to negligent treatment of children.

46. Section 827.071, relating to sexual performance by a child.

47. Section 831.30, relating to fraud in obtaining medicinal drugs.

48. Section 831.31, relating to the sale, manufacture, delivery, or possession with intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense is a felony.

49. Section 843.01, relating to resisting arrest with violence.

50. Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer of the means of protection or communication.

51. Section 843.12, relating to aiding in an escape.

52. Section 843.13, relating to aiding in the escape of juvenile inmates of correctional institutions.

53. Chapter 847, relating to obscenity.

54. Section 874.05, relating to encouraging or recruiting another to join a criminal gang.

55. Chapter 893, relating to drug abuse prevention and control, if the offense is a felony of the second degree or greater severity.

56. Section 895.03, relating to racketeering and collection of unlawful debts.

57. Section 896.101, relating to the Florida Money Laundering Act.

58. Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

59. Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate, resulting in great bodily harm.

60. Section 944.40, relating to escape.

61. Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

62. Section 944.47, relating to introduction of contraband into a correctional institution.

63. Section 985.701, relating to sexual misconduct in juvenile justice programs.

64. Section 985.711, relating to introduction of contraband into a detention facility.

(5) EXEMPTION REQUESTS.—An applicant who desires to become a certified person with lived experience but is disqualified

under subsection (4) may apply to the department for an exemption from disqualification under s. 435.07, as applicable. The department shall accept or reject an application for exemption within 90 days after receiving the application from the applicant.

Section 3. This act shall take effect July 1, 2024.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 783 Medicaid Managed Care Plan Performance Metrics
SPONSOR(S): Select Committee on Health Innovation, Berfield and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 794

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation	11 Y, 0 N, As CS	Lloyd	Calamas
2) Health Care Appropriations Subcommittee		Smith	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Medicaid program is a medical assistance program for low-income people and disabled individuals, funded jointly by the state and federal governments. The Agency for Health Care Administration (AHCA) administers the Medicaid program, primarily through a managed care model under contracts with managed care plans. The Statewide Medicaid Managed Care Program (SMMC) operates under a federal waiver to deliver primary and acute care services as the Managed Medical Assistance (MMA) program, and under a second federal waiver to deliver comprehensive long-term care services.

Current law requires AHCA to monitor plan performance, including requiring the managed care plans to report various data related to provider interactions and provider network administration. AHCA imposes detailed reporting requirements for the plans through their contracts, including data not currently published or analyzed by AHCA in a systematic manner.

CS/HB 783 establishes detailed requirements for analysis and publication of data on managed care plan administrative performance related to providers, including data on provider credentialing, prior authorization processing, claims payment and complaints from providers and recipients. AHCA must contract with a third-party vendor to analyze the data submitted by the plans and develop an online dashboard on the agency's website to publish the data.

AHCA must publish the data on the dashboard quarterly beginning October 1, 2024. AHCA must also produce an annual report on the data beginning January 1, 2026, and submit the report to the Medical Care Advisory Committee, the Governor and the Legislature.

The implementation costs of the bill can be absorbed within existing agency resources. *See* Fiscal Analysis.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Medicaid

The Medicaid program is a medical assistance program funded jointly between the state and federal governments. The program provides health care coverage for over 4.8 million low-income families and individuals, the elderly, and individuals with disabilities in Florida, including 3.4 million recipients who receive their services through a managed care plan.[1] In Florida, two in every five Florida children receive Medicaid, and 45 percent of all births in the state are covered by the program.[2]

The Agency for Health Care Administration (AHCA) administers the Florida Medicaid program authorized under Title XIX of the federal Social Security Act and Ch. 409, F.S. The AHCA administers the program through the managed care model,[3] under contracts with managed care plans. The program operates under two separate federal Medicaid waivers: Section 1115 waiver for primary and acute care services called the Managed Medical Assistance (MMA) program, and Long Term Care (LTC) services waiver under Sections 1915(b) and (c) of the Social Security Act.[4] Currently, the AHCA is conducting its third procurement process under these waivers with the selection of new contracts anticipated at the end of February, 2024.[5] The existing SMMC contracts have been effective for almost seven years and will expire December 31, 2024.

Managed Care Plan Accreditation

Accreditation is a "seal of approval" given to an organization by an independent evaluator, which has reviewed the practices and performances of the managed care plan. An accreditation rating indicates that a plan meets or exceeds certain quality criteria based on the level or rating that a plan has earned. Accreditation status is one of the statutorily-designated quality selection criteria that the AHCA must consider in the selection of eligible plans during the procurement process. Plans must be accredited by the National Committee for Quality Assurance[6], the Joint Commission[7] or another nationally recognized accrediting body, or have initiated the accreditation process, within one year after the contract is executed.

Each accrediting organization has its own standards and assesses those standards against the health plan's performance and organizational structure to determine if its established standards and performance standards meet the accrediting body's requirements. The plan may be reviewed for its provider credentialing processes, prior authorization procedures, and prompt payments of provider claims. Accreditation can be awarded for different lengths of time and then must be renewed.

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[1] Agency for Health Care Administration, *Comprehensive Medicaid Managed Care Enrollment Reports (December 31, 2023)* available at https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-data-analytics/medicaid-monthly-enrollment-report (last visited February 8, 2024).
[2] Kaiser Family Foundation, *Medicaid in Florida (June 2023),* available at https://files.kff.org/attachment/fact-sheet-medicaid-state-FL (last visited February 8, 2024).
[3] The vast majority of Medicaid enrollees receive services through the managed care model; those with limited benefits (such as the family planning program) are not, and some populations (such as enrollees in the home and community-based waiver for persons with developmental disabilities) may choose managed care or the fee-for-services model. S. 409.965, F.S.
[4] S. 409.964, F.S.
[5] *See* AHCA ITN 23/24 010 for Statewide Medicaid Managed Care (MMA and LTC) available at MyFloridaMarket Place Vendor Information Portal (last visited February 8, 2024) and the AHCA ITN for Statewide Medicaid Prepaid Dental Services available at MyFloridaMarket Place Vendor Information Portal (last visited February 8, 2024).
[6] National Committee on Quality Assurance (NCQA), *About NCQA,* Health Care Accreditation, Health Plan Accreditation Organization - NCQA - NCQA (last visited February 8, 2024).
[7] The Joint Commission, *Who We Are, A Trusted Partner in Patient Care | The Joint Commission* (last visited February 8, 2024).

Provider Network Credentialing

Medicaid Provider Identification Number

To deliver health care services to a Medicaid recipient and be paid for that service, an individual provider must be an enrolled provider through AHCA's provider enrollment system. The credentialing process ensures that health care workers and organizations have the proper education, training, qualifications, and licenses to care for patients. The provider enrollment system also reduces improper payments in Medicaid by minimizing the risk of allowing unscrupulous providers to bill the Medicaid program, according to AHCA. [8]

For providers who only need to enroll for a Medicaid Provider Identification Number for billing under a Medicaid managed care contract and will only be paid through the plan and not through FFS, AHCA established a streamlined credentialing process that includes basic credentialing, licensure verification, review of background screening history, and a check with the federal exclusion database checks.[9] If a provider contracts with more than one SMMC plan, the basic credentialing by AHCA reduces the time it takes for a provider to complete each plan's unique or supplemental credentialing requirements.

The limited provider enrollment option is only for those providers participating with the managed care plans and is not a sufficient process for a provider who is reimbursed as an individual provider in the FFS delivery system.[10] Providers credentialed through the limited process do not have access to the necessary web portal tools, including the ability to submit claims, upload or download files, or view reports.[11] A Limited Enrollment Provider can always submit a new application to become an Enrolled Provider later to have his or her access upgraded to direct billing and other options.[12]

Managed Care Plan Network Credentialing

A plan may conduct its own credentialing process or contract with an accreditation credential verification organization(s) to conduct the process on its behalf. While the managed care plan's credentialing process may be conducted concurrently with the Medicaid provider enrollment process, which could shorten the length of the credentialing period, most of the current plans require a prospective provider to obtain its Medicaid provider ID *prior to* submitting its credentialing application to the managed care plan for credentialing.[13]

The *Medicaid Provider Enrollment Application Guide* presents example timeframes for provider application processing based on stages and if there are no deficiencies with the application. The following stages and timeframes would likely apply for a new application:[14]

- In Process: Application is being reviewed for accuracy and compliance with all provider eligibility requirements (*approximately 14 business days*).
- Background Screening: Application processing has been completed. Results of the background screening have not yet been received from the Background Screening Clearinghouse (*approximately 5 business days*)
- Clearinghouse Screening: The application has no deficiencies and is awaiting the results of the background screening (*less than 15 calendar days*). If screening results are not received within 14 days, the provider receives a deficiency letter.

[8] *Supra*, note 5.
[9] Agency for Health Care Administration. *An Overview of Streamlined Credentialing (Limited Enrollment), February 2, 2022,* available at https://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Managed%20Care/Streamlined%20Credentialing%20(Limited%20Enrollment).pdf (last visited February 8, 2024).
[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] Agency for Health Care Administration, *Florida Medicaid Provider Enrollment Application Guide (October 2022)* available at Florida Medicaid Provider Enrollment App Guide.pdf (flmmis.com) (last visited February 8, 2024).

- State Review: Applications pending verification by AHCA will show a status of "State Review." State Review means validating the information on the application, such as certification and expiration dates, search for any prior history with the applicant and Medicaid or any other state agencies, and a review of the applicant's financial history.
- Enrolled: Enrollment approved. A Welcome letter is mailed within 2 business days after the activation of the new provider (*activated within 5 business days*).

The timeframes for activation of a new provider identification number depend on the sufficiency of the application submitted, and if additional documentation becomes necessary as part of the review process. Ensuring that an applicant's name and identification number are clearly marked on items helps with the matching of supplemental materials and the return of documents after the review.

Prior Authorization

Prior authorization is one method of managing health care utilization and quality. Insurers and managed care plans may require providers to obtain coverage and reimbursement authorization prior to providing certain services or prescribing certain drugs. Prior authorization is often used to help identify under- and over- utilization of services, identify clinical risks such as drug-drug interactions, and prevent fraud and abuse. In Medicaid managed care, both federal regulations and AHCA plan contracts establish maximum timelines for plans to resolve both urgent and non-urgent prior authorization requests.

Prior Authorization Timeline Comparison		
	Federal Regulations 42 CFR 438.210(d)	**AHCA Contract**
Standard Request (Non-Urgent)	14 calendar days	7 days
Standard Request Allowable Extension	14 calendar days	4 days
Standard Request Maximum Allowed	28 calendar days	11 days
Urgent Request	72 hours	2 days
Urgent Request - Allowable Extension	14 calendar days	1 day
Urgent Request - Maximum Extension	17 calendar days	3 days

The AHCA reports that when the current SMMC contracts were renewed, a reduced response time for non-urgent and urgent requests was agreed upon by the parties. The non-urgent prior request maximum time was modified from the federal limit of 28 calendar days to the contractual standard of 11 days.[15] For urgent requests, the current contractual standard is two days with an extension period of one additional day, which reduces the length of the maximum possible review time from 17 review days to three days.[16]

The plans currently report monthly on all service authorization requests completed during the previous reporting month. Service authorization requests are categorized as standard, extended standard, expedited, or extended expedited authorizations.[17] Plans are specifically prohibited from requiring prior authorization for emergency services; however, prior authorization for specific Medicaid services or benefits may be applicable for services with higher utilization or higher costs. In some instances, there are procedural limitations in state statute if a prior authorization process is applied, including a requirement that access to the prior authorization system be accessible 24 hours a day, 7 days a week for approval of hospital inpatient services[18], or that responses to authorization requests be initially

[15] *Supra,* note 5.
[16] *Supra,* note 5.
[17] *Id.*
[18] S. 409.905(5), F.S.

made within 24 hours.[19] Other prior authorization directives focus on the entity requesting authorization and the items necessary for a determination such as clinical and medical records, prior use of a treatment or prescription, a recipient's plan of care, and documentation that supports the recipient's diagnosis.[20]

Prompt Payment

Federal Medicaid regulations establish standards for the prompt payment of provider claims for Medicaid beneficiaries.[21] The regulation defines a "claim" to mean a bill for services, a line item of service, or all services for one beneficiary within a bill." A "clean claim" is considered to be a claim that can be processed without obtaining additional information from the provider of the service or from a third party.[22]

State law also requires the plan to have a claims payment system which ensures the timely payment of clean claims within state standards under s. 641.3155, F.S.[23] With the receipt of a clean electronic claim, the plan may either dispute or deny the claim or pay the claim within 20 days after the claim has been received. If requested, a provider must submit additional information and documentation within 35 days of receipt of the request for additional information. The claim must be paid or denied with 90 days of receipt. [24]

For nonelectronic or paper claims, a plan must pay the provider also in accordance with federal and state regulations. Paper claims must be denied or paid within 40 days after receipt of the claim; however, the time can be extended if supplemental documentation is required. If the claim is not denied or paid within 120 days of the original receipt date, the Plan is obligated to pay the claim within 140 days.[25]

Contractually, the AHCA and the MMA plan agreed to tighter prompt payment standards in the renewal of their contracts in 2018. With notice periods significantly less than statutory requirements, AHCA reports that the managed care plans must pay or notify a provider that a claim is denied or contested within 10 business days of receipt of a clean claim from either a nursing home or hospice and within 15 days if received from a non-nursing home/hospice facility. If contested or denied, the claim must be paid or denied within 90 days after receipt, but if the claim is neither denied nor paid, the plan has a maximum time period to pay of 120 days.

For non-electronically submitted claims, the plan must pay the paper claim or notify the provider that the claim is denied or contested within 20 days after receipt of the claim.[26] The chart below shows the existing authorities and standards for Medicaid contracts and prompt payment of claims.

[19] S. 409.912(5)(1)(a), F.S.
[20] *See* ss. 409.905(4) and(5), 409.906(8), (13), (23), and 24 409.912(5)(a), 409.91195(5) and (9), F.S.
[21] 42 CFR 447.45.
[22] *Supra,* note 5.
[23] ss. 409.966(3)(c)(6), F.S. and 641.3155(3), F.S.
[24] *Supra,* note 5.
[25] Agency for Health Care Administration, *Florida Medicaid Provider Enrollment Application Guide (October 2022),* available at Florida Medicaid Provider Enrollment App Guide.pdf (flmmis.com) (last visited February 8, 2024).
[26] *Supra,* note 5.

Comparison of Time Standards – Prompt Payment of Claims Maximum Time Measured from First Receipt of Claim				
	Federal CFR 42.447(d)*	**FL Insurance Code** §641.3155, F.S.	**Medicaid Contract** §409.966(3)(c)6, F.S.	
	**Based on a percentage of claims paid within this standard*		Nursing Home Hospice	Non-Nursing Home Hospice
Electronic Clean Claims				
#Days to acknowledge receipt	NA	NA	Next business day	
#Days to pay, notify denial or contest	30 days	20 days	10 business days	15 business days
#Days to provide additional information > denial	NA	35 days	35 days	35 days
#Days to pay > additional information	NA	NA	90 days	90 days
Paper Claims				
#Days to acknowledge receipt	NA	40 days	20 days	20 days
#Days to pay, notify denial, or contest	30 days	35 days	20 days	20 days
All Claims Types				
#Days to pay or deny claim	90 days	90 days	20 days	20 days
#Days before Plan must pay if no payment, or a denial or contest	90 days	120 days	90 days	90 days
Maximum time to pay any claim	12 months	140 days	120 days	120 days

Quality Strategies

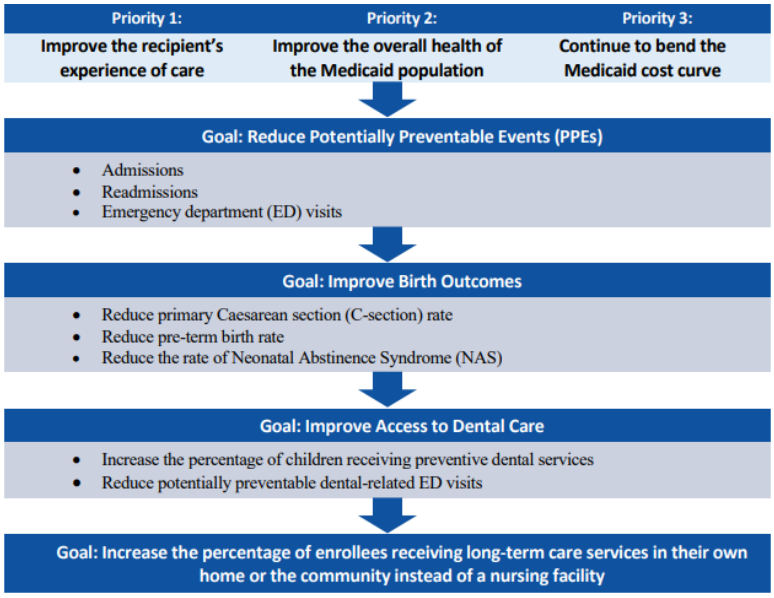
In 2016, the federal Centers for Medicare & Medicaid Services (CMS) re-vamped the Medicaid standards for contracting with managed care plans. States that contract with managed care plans must have a monitoring plan in place which includes:

- Standards for access to care, structure and operations, and quality measurement and improvement;
- Procedures for regularly monitoring and evaluating plan compliance with state standards;
- National performance measures identified and developed by CMS;
- External independent reviews of quality outcomes and access to services;
- Allowance for Intermediate sanctions for plans;
- Operation and review of the state's quality strategy;
- State-defined network adequacy and availability of services standards for managed care;
- Measurable goals and objectives for continuous quality improvement, with consideration of the existing population's health status;
- Performance targets, performance measures, quality measures, and performance outcomes that will be measured and reported;
- Performance improvement projects and other interventions proposed to improve access, quality, or timeliness of care;
- Description of the state's care transition policy;
- Description of the state's plan to address health care disparities; and
- Mechanisms to identify persons who need long-term services and supports or persons with special health care needs.[27]

In addition to these ongoing requirements, the plans must continually demonstrate ongoing compliance with state contractual requirements for being nationally accredited, having experience with the population to be served, offering sufficient primary care and specialty care physicians, and processing of uncontested claims in a timely manner.[28] The plans were required before the federal regulation to maintain accurate and complete databases of their provider network and display data and patient feedback on the provider in such a manner that it allowed patients to easily make provider comparisons.[29]

[27] 42 CFR 438.340.
[28] S. 409.966(3), F.S.
[29] ss. 409.967(2)(c)(1) and 409.967(2)(e), F.S.

The federal regulations[30], also require states to develop and implement a written quality strategy and to re-assess that strategy every three years. The AHCA last updated these goals during the 2019-2020 state fiscal year and identified three priorities tied to four specific program goals.[31]



The state may implement performance improvement projects (PIP) as another quality improvement strategy. A PIP includes four elements:

- Performance measurement;
- Implementation of interventions;
- Evaluation of the interventions' impact using the performance measures; and
- Activities to increase/sustain improvement.[32]

A PIP may be focused on a specific improvement need of a plan or region, or it could be a PIP that is shared among all plans as a systematic goal of the Medicaid program. In a few cases, CMS has mandated a national PIP to see improvements in specific areas of health care, such as a focus on children's oral health. At this time, the MMA plans have three shared PIP topics incorporated into their contracts relating to maternal health, potentially preventable events, administration issues of the transportation benefit. In addition, the contracts require plans to add a PIP of their choosing in behavioral health or integrating behavioral health and primary care.[33]

An External Quality Review Organization (EQRO) is also required for each state's Medicaid program.[34] An EQRO acts to validate the data behind the performance measurements and other mandatory state and federal reporting requirements the state is held accountable for, review of the performance and measurement of the PIPs of the managed care plans, and to assist in the development of the state's quality rating system.

Complaints and Grievances

[30] 42 CFR section 438.340
[31] Agency for Health Care Administration, Health Services Advisory Group, *SFY 2021-2022 External Quality Review Technical Report (April 2023),* available at SFY 2021–2022 External Quality Review Technical Report (myflorida.com) (last visited February 8, 2024).
[32] 42 CFR 438.330(d)
[33] Agency for Health Care Administration, *Medicaid Managed Care, 2018-2024 Model Contracts, Managed Medical Assistance, Attachment II, Exhibit II-A, Section IX (Quality),* available at https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/2018-2024-smmc-plans (last visited February 8, 2021).
[34] Section 1932(c)(1) of the Social Security Act.

The AHCA uses a centralized approach to resolve Medicaid complaints and to determine if Medicaid managed care plans are meeting their contractual obligations. All complaints are recorded whether the complaint is later substantiated or not.[35]

Complaint and grievance are defined in state statute in several places and while sometimes used interchangeably, the two words are statutorily and procedurally different. Federal laws and rules which govern the Medicaid program do not define "complaint", but do define "grievances".[36] By contract, the SMMC contract defines both "complaint" and "grievance." The SMMC contract defines "complaint" as "any oral or written expression of dissatisfaction by an enrollee submitted to the Managed Care Plan or to a State Agency and resolved by close of business the following business day." A complaint is considered to be a subcomponent by a grievance by the AHCA as any unresolved complaint at the end of the following business day becomes a grievance.

A "grievance" is then defined by the federal regulation definition. As a grievance, the managed care plan must provide the beneficiary with a written notice of the resolution within 90 days from the date of the receipt of the grievance. Unresolved grievances can then lead to a plan appeal, the Medicaid fair hearing process, the District Court of Appeal, and ultimately the Florida Supreme Court. The maximum time frames for these processes are established in the Code of Federal Regulations.[37]

Quarterly, the managed care plans submit a report to AHCA on the total number, description, and outcome of the grievances filed by beneficiaries. This internal review process is part of each plan's quality review process.

Effect of Bill

CS/HB 783 creates a new section of statute relating to Medicaid managed care contracts and data analysis related to provider credentialing, prior authorization, and the prompt claims payment. Under the bill, AHCA must contract with a third-party vendor to analyze data reported to AHCA by the plans pursuant to statutory and contract requirements. The data analyses must produce and document performance metrics specified in the bill, as listed below:

- Provider Credentialing volume, including:
  - Percentage and total number of provider applications processed and loaded for provider billing within the last 60 days;
  - Percentage and total number of provider applications processed and loaded for provider billing within the last 90 days
  - Percentage and total number of provider applications processed and loaded for provider billing within the last 120 days.
- Prior authorization requests, including:
  - Percentage and total number of standard prior authorization requests approved by service type;
  - Percentage and total number of standard prior authorization requests denied;
  - Percentage and total number of expedited prior authorization requests approved by service type;
  - Percentage and total number of expedited prior authorization requests denied;
  - For each of the approvals, the standard length of time for an approval;
  - For each of the appeals, the percentage of appeals granted and the length of time from appeal to granting of request;
  - Average and median time between submission of requests and decisions, for standard and expedited authorizations.
- Prompt payment of claims:
  - Percentage and total number of claims that are rejected before review;

[35] *Id.*
[36] 42 CFR 438.400(b) defines grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination.
[37] *Supra,* note 5.

    - Percentage and total number of claims that are rejected before paid;
    - Percentage and total number of claims that are rejected before partially paid;
    - Percentage and total number of claims that are rejected before denied;
    - Percentage and total number of claims that are rejected before suspended;
    - Average length of time to pay clean claims;
    - The percentage of clean claims paid within seven, 10 and 20 days, and in excess of 120 days;
    - Top 10 reasons for claim denial, with the percentage and the total number of claims for each reason cited.
- Managed care plan complaints:
    - Number of managed care recipients enrolled in the statewide Medicaid Managed Medical Assistance program;
    - Number of complaints per 1,000 beneficiaries;
    - By each managed care plan, per 1,000 recipients;
        - Number of complaints by provider category (physicians, hospitals, outpatient services; skilled nursing facilities, assisted living facilities, therapy services, transportation; services, laboratories, home care services, and community based services);
        - Number of complaints received by region;
        - Number of complaints resolved by region;
        - Number of complaints pending for resolution by region;
        - Average length of time to resolve provider complaint by region; and
        - Average length of time to resolve Medicaid recipient complaint by region.

Most of the data required by the bill relating to claims payment, prior authorization, and complaints are already being collected by AHCA; some data would require additional reporting by the managed care plans. Not all of the data *calculations* required by the bill are included in current reporting; however, the agency would be able to perform those calculations.

AHCA must publish the data quarterly on the dashboard developed by the third-party vendor, beginning October 1, 2024. In addition, the bill requires AHCA to create and make publicly available an annual report on the listed metrics beginning January 1, 2026. AHCA must also submit the report to the Medical Care Advisory Committee, the Governor, the President of the Senate, and the Speaker of the House of Representatives.

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

SECTION DIRECTORY:

Section 1: Creates s. 409.9673, relating to managed care plan performance metrics.
Section 2: Provides and effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   AHCA indicates the bill would have an operational and fiscal impact on the Medicaid program. AHCA would be required to contract with a third-party vendor to create a dashboard to display the required reports of plan data. AHCA estimates the bill implementation cost would total $584,241, with $500,000 in nonrecurring costs for the third-party vendor contract, and one FTE position

totaling $84,241, of which $78,685 is recurring. [38] Based on prior year reversions and long term vacant positions, the agency can absorb the implementation costs 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. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The AHCA 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 February 2, 2024, the Select Committee on Health Innovation adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Limited the AHCA data analysis to information already reported by managed care plans pursuant to law or contract.
- Required complaint data published to be based on plan enrollment per 1,000 enrollees.
- Require certain prior authorization data to be analyzed by service type.
- Required quarterly publication on an agency dashboard developed by a third-party vendor, beginning October 1, 2024.
- Required an annual report beginning January 1, 2026.

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

[38] Agency for Health Care Administration, *2024 Agency Legislative Bill Analysis: HB 783* (published December 28, 2023), on file with the House Health Care Appropriations Subcommittee.

A bill to be entitled

An act relating to Medicaid managed care plan performance metrics; creating s. 409.9673, F.S.; requiring the Agency for Health Care Administration to produce certain Medicaid managed care performance data; requiring the agency's reports to include certain data submitted by Medicaid managed care plans; requiring the agency to contract with a third party vendor to publish such data on a dashboard quarterly; requiring the agency to submit an annual report to certain entities; providing requirements for such report; providing an effective date.

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

Section 1. Section 409.9673, Florida Statutes, is created to read:

409.9673 Managed care plan performance metrics.—The agency shall produce managed care plan performance data related to the administration of provider contracts. The agency's reports must include data submitted by the managed care plans to the agency pursuant to statutory and contract requirements related to provider credentialing, service prior authorization, claims payment, and consumer complaints. The agency shall contract with a third party to analyze the data and develop a dashboard on the

agency's website to display the data, and shall publish the data by managed care plan and by region on the dashboard quarterly, beginning October 1, 2024. An annual report of the data analyses, beginning January 1, 2026, shall be submitted to the Medical Care Advisory Committee, the Governor, the President of the Senate, and the Speaker of the House of Representatives and published on the website. The analyses must include the following:

(1) Credentialing.

(a) The percentage and total number of providers for which a submitted provider application has been fully loaded and processed for provider billing within 60 days.

(b) The percentage and total number of providers for which a submitted provider application has not been fully loaded and processed for provider billing in excess of:

1. Sixty days.

2. Ninety days.

3. One hundred twenty days.

(2) Prior authorization.

(a)1. The percentage and total number of standard prior authorizations requests approved by service type.

2. The percentage and total number of standard prior authorizations requests denied.

3. The percentage and total number of standard prior authorization requests approved after appeal and the length of

time of the appeal process, from the beginning of the appeal until the approval.

4. The percentage and total number of expedited prior authorization requests approved and the length of time to receive approval by service type.

(b) The average and median time between submissions of requests and decisions for:

1. Standard prior authorizations.

2. Expedited prior authorizations.

(3) Prompt payment.

(a) The percentage and total number of claims that are:

1. Rejected before review.

2. Paid, partially paid, denied, or suspended.

(b) The average length of time to pay clean claims.

(c) The percentage of clean claims paid within:

1. Seven days.

2. Ten days.

3. Twenty days.

4. In excess of 120 days.

(d) The top 10 reasons for claims denial, with the percentage and total number of claims for each reason cited.

(4) Managed care plan complaints.

(a) The number of Medicaid recipients enrolled in the statewide managed medical assistance program.

(b) The number of complaints per 1,000 Medicaid

recipients.

(c) By each managed care plan, per 1,000 Medicaid recipients:

1. By provider category, the number of complaints received by physicians, hospitals, outpatient services, skilled nursing facilities, assisted living facilities, therapy services, transportation services, laboratories, home care services, and community-based services.

2. The number of Medicaid recipient complaints for each region.

3. The number of Medicaid recipient complaints resolved for each region.

4. By provider category:

a. The number of provider complaints resolved for each region.

b. The number of complaints pending for resolution for each region.

c. The average length of time to resolve provider complaints for each region.

d. The average length of time to resolve Medicaid recipient complaints for each region.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1061 Community-based Child Welfare Agencies
SPONSOR(S): Children, Families & Seniors Subcommittee, McFarland
TIED BILLS: **IDEN./SIM. BILLS:** SB 536

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

SUMMARY ANALYSIS

Florida's model for providing child welfare services is unique in the nation. No other state outsources its child welfare services to private organizations to the extent that Florida does. Accordingly, the performance of those private organizations – community based-care lead agencies (CBCs) and their subcontractors – has a great impact on the health, safety, and well-being of the thousands of children and families served by Florida's child welfare system.

While most CBC's are deemed by DCF to overall meet or exceed performance standards, deficiencies remain, particularly in the well-being of children in care. Additionally, a recent forensic audit of 6 CBC's identified the following financial and managerial concerns with one or more of the 6 CBC's:

- Non-compliant contract procurement for related and non-related entities.
- Receipt of Paycheck Protection Program Loans that were not properly reimbursed to the State.
- Board approval of deficit budgets.
- Allocated officer compensation in excess of mandatory caps.
- Non-compliance with Cost Allocation Plans.

CS/HB 1061 strengthens the child welfare system in the following ways:

- Procurement of CBC's: The bill prohibits renewal of CBC contracts by DCF, though it allows DCF to extend a CBC contract for one year.
- Contractual Obligations: The bill restricts the ability of CBCs to transact with third-party entities that are directly or indirectly related to CBC board members, officers, and directors, and certain relatives. The bill expands the minimum data points that the CBCs must publish on its website every month.
- Actuarially-sound funding model: Gradually transitions the allocation of core service funds for CBCs to an actuarially-based tiered payment model over four state fiscal years, starting with 2024-2025.
- CBC Procurements: The bill requires DCF to establish by contract financial penalties or sanctions that DCF must enforce when a CBC is not compliant with applicable local, state, or federal law for the procurement of commodities or contractual services.
- CBC Receivership: The bill lowers the threshold levels that authorize DCF to petition the court for a receivership of a CBC.
- Remedies for Noncompliance or Inadequate Performance: The bill establishes contractual actions that DCF may enforce against a CBC if the CBC fails to comply with contract terms or experiences performance deficiencies.

The bill has an indeterminate, negative fiscal impact on state government 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's Child Welfare System

Chapter 39, F.S., creates the dependency system charged with protecting child welfare. The Florida Legislature has declared four main purposes of the dependency system:[1]

- to provide for the care, safety, and protection of children in an environment that fosters healthy social, emotional, intellectual, and physical development;
- to ensure secure and safe custody;
- to promote the health and well-being of all children under the state's care; and
- to prevent the occurrence of child abuse, neglect, and abandonment.

Florida's dependency system identifies children and families in need of services through reports to the central abuse hotline and child protective investigations. The Department of Children and Families (DCF) works with those families to address the problems endangering children, if possible. DCF's practice model is based on the safety of the child within the home by using in-home services, such as parenting coaching and counseling, to maintain and strengthen that child's natural supports in his or her environment. If the problems are not addressed, the child welfare system finds safe out-of-home placements for these children.

Community Alliances

DCF is required to establish community alliances to serve as a catalyst for community resource development and promote prevention and early intervention, among other obligations.[2] Each community alliance may encompass more than one county when such arrangement is determined to provide for more effective representation.[3]

Community Alliances include local stakeholders and representatives in each county to encourage and maintain community participation and oversight of community-based care lead agencies (CBCs).[4] Community alliances are composed of representatives from:

- DCF.
- the county government.
- the school district.
- the county United Way.
- the county sheriff's office.
- the circuit court corresponding to the county.
- the county children's board, if one exists.
- a faith-based organization involved in efforts to prevent child maltreatment, strengthen families, and promote adoption.[5]

The community alliance must adopt bylaws and may increase the membership of the alliance if such increase is necessary to adequately represent the diversity.[6] The additional members may include state

[1] S. 39.001(1)(a), F.S.
[2] S. 20.19(5)(b), F.S.
[3] S. 20.19(5)(a), F.S.
[4] *Id*.
[5] S. 20.19(5)(d), F.S.

attorneys, public defenders, their designees, or individuals from funding organizations, community leaders or individuals who have knowledge of community-based service issues.[7]

DCF's procurement team for CBC contracts must include individuals from the community alliance in the area to be served under the contract.[8]

Community-Based Care Lead Agencies

Florida's model for providing child welfare services is unique in the nation. No other state outsources its child welfare services to private organizations to the extent that Florida does. Accordingly, the performance of those private organizations—community based-care lead agencies, or CBCs-- has great impact on the health, safety, and well-being of the thousands of children and families served by Florida's child welfare system. DCF's effective management and oversight of contractors is critical to the successful functioning of the child welfare system.

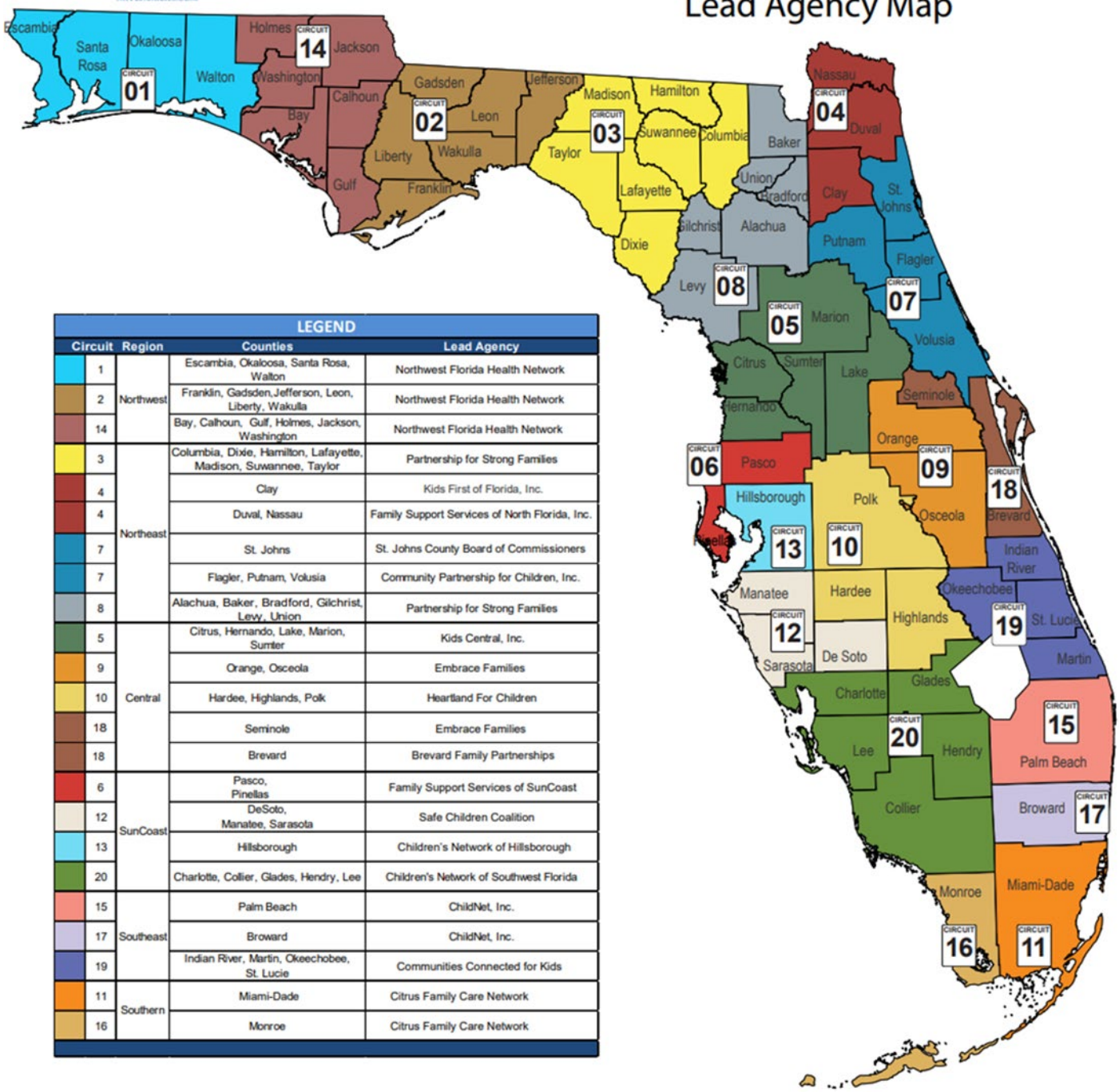
The Department of Children and Families (DCF) competitively contracts with CBCs as required by chapters 287 and 409 to provide child protection and child welfare services to children and families in Florida. These contracts generally cover case management, out-of-home services, and related services. The outsourced provision of child welfare services is intended to increase local community ownership of service delivery and design. CBCs in turn contract with a number of subcontractors for case management and direct care services to children and their families. DCF remains responsible for a number of child welfare functions, including operating the central abuse hotline, performing child protective investigations, and providing children's legal services. Ultimately, DCF is responsible for program oversight and the overall performance of the child welfare system. [9]

At present, there are 18 CBCs that each cover specific geographic areas within the 20 Judicial Circuits in Florida. The geographic size of the CBC's varies widely. While a few serve only one county, ranging from St. Johns County to Broward County, several CBCs cover multiple counties, with one CBC (Partnership for Strong Families) encompassing 13 rural counties. The following map illustrates DCF Regions, Judicial Circuits, and CBC geographic areas.[10]

[6] S. 20.19(5)(e), F.S.
[7] *Id*.
[8] S. 409.987(5), F.S.
[9] S. 409.996, F.S.
[10] Florida Department of Children and Families, *A Comprehensive, Multi-Year Review of the Revenues, Expenditures, and Financial Position of All Community-Based Care Lead Agencies with System of Care Analysis*, p. 2 (Dec. 1, 2023) https://www.myflfamilies.com/services/child-family/lmr (last visited Jan. 6, 2024).

Community-Based Care

Lead Agency Map

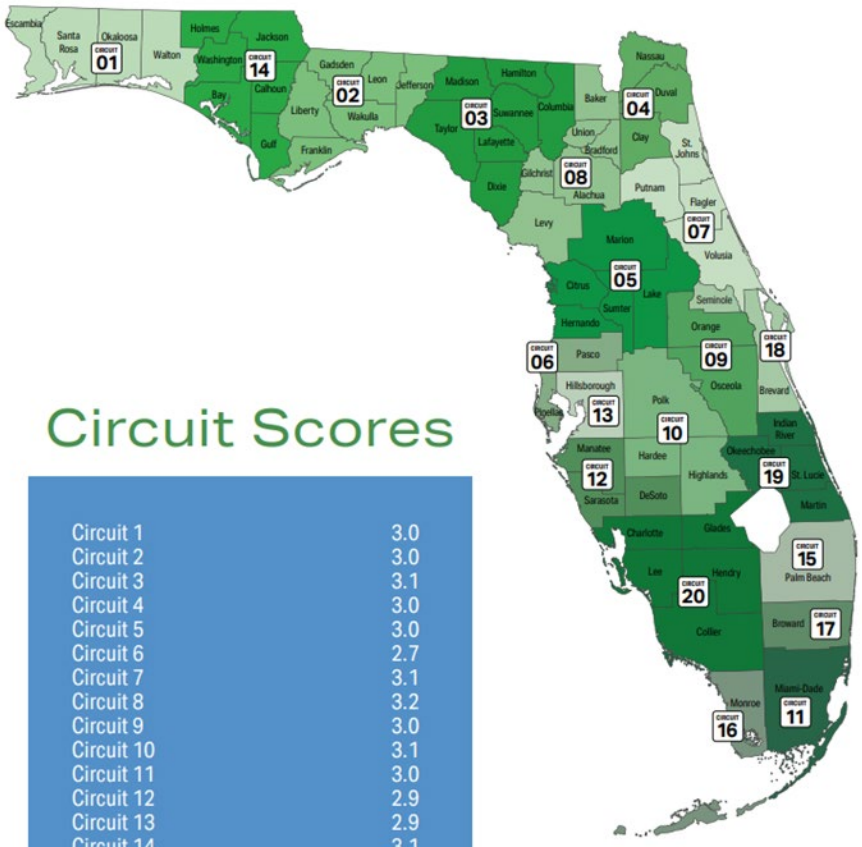


LEGEND				
Circuit		Region	Counties	Lead Agency
1		Northwest	Escambia, Okaloosa, Santa Rosa, Walton	Northwest Florida Health Network
2			Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla	Northwest Florida Health Network
14			Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Northwest Florida Health Network
3		Northeast	Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	Partnership for Strong Families
4			Clay	Kids First of Florida, Inc.
4			Duval, Nassau	Family Support Services of North Florida, Inc.
7			St. Johns	St. Johns County Board of Commissioners
7			Flagler, Putnam, Volusia	Community Partnership for Children, Inc.
8			Alachua, Baker, Bradford, Gilchrist, Levy, Union	Partnership for Strong Families
5		Central	Citrus, Hernando, Lake, Marion, Sumter	Kids Central, Inc.
9			Orange, Osceola	Embrace Families
10			Hardee, Highlands, Polk	Heartland For Children
18			Seminole	Embrace Families
18			Brevard	Brevard Family Partnerships
6		SunCoast	Pasco, Pinellas	Family Support Services of SunCoast
12			DeSoto, Manatee, Sarasota	Safe Children Coalition
13			Hillsborough	Children's Network of Hillsborough
20			Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida
15		Southeast	Palm Beach	ChildNet, Inc.
17			Broward	ChildNet, Inc.
19			Indian River, Martin, Okeechobee, St. Lucie	Communities Connected for Kids
11		Southern	Miami-Dade	Citrus Family Care Network
16			Monroe	Citrus Family Care Network

Accordingly, the child population of the area served by each CBC varies, and the number of children and families served by each CBC varies.

Florida Child Welfare System Performance Serving Children

The DCF infographic below scores the health of Florida's child welfare system at the circuit level.[11] DCF identifies areas with the most significant systemic impact on improving permanency and well-being[12] and evaluates progress toward achieving permanency, safety, and well-being for children in the welfare system. The overall score for each of the 20 circuits aggregates individual circuit performance scores on permanency, safety, and well-being. For FY21-22, the overall median score is 3.1 out of a possible 5, and 85% of circuits earned a 3.0 or higher.[13] A score over 3.50 indicates the circuit's performance exceeds established standards.[14] A score between 3.00-3.349 indicates the circuit's performance meets established standards.[15] A score of 2.00-2.99 indicated the circuit's performance does not meet established standards.[16] In FY 2021-2022, DCF gave 17 of 20 circuits a score of 3 or higher, indicating that the circuit's performance exceeds established standards. However, there were still deficiencies. Every CBC except one was rated below expectations or poor for the well-being of children in care.



[17]

[11] Florida Department of Children and Families, *Annual Accountability Report on the Health of Florida's Child Welfare System: Fiscal Year 2021-2022,* p. 6 (Dec. 12, 2022) https://www.myflfamilies.com/sites/default/files/2022-12/Accountability_System_Report_2022-revision12DEC22.pdf (last visited Nov. 28, 2023).
[12] *Id*. at p. 3.
[13] *Id*. at p. 2.
[14] *Id*. at p. 7.
[15] *Id*.
[16] *Id*.
[17] *Id*. at pg. 6.

CBC Funding

The source of CBC revenues are predominately federal and state funds appropriated by the Florida Legislature. Nearly all federal funding for child welfare purposes comes from the Social Security Act[18] and the Child Abuse Prevention and Treatment Act (CAPTA). Each of these federal sources generally require state matching funds.[19] Historically, CBCs could use Title IV-E funds in a variety of state-specific, innovative ways because the federal government approved a waiver allowing Florida to experiment. However, the federal government terminated the Title IV-E waiver authority it had allowed states on September 30, 2019.[20] This has led to significant change in levels and the mix of federal and state funds over the last five years.

CBC appropriations from federal and state sources grew from $951.9 million in Fiscal Year (FY) 2018-19 to $1.3 billion for FY 2023-24.[21] The Legislature appropriates funds from both state and federal sources to CBC's through DCF.

State law specifies calculation of annual CBC funding. The Legislature first established a CBC funding formula in law in 2011 and has changed over time.[22] Before this statutory formula, the allocation of new state or federal funds to lead agencies was based primarily on the number of children in care with direction to the department through proviso language in the General Appropriations Act, though at the time of the formula's enactment, the Legislature had begun considering additional factors such as those now in the formula.[23]

Under the current formula, 100 percent of the recurring core services funding for each community-based care lead agency are based on the prior year recurring base of core services funds, and any new funds are allocated according to a statutory formula.

Generally, all funds allocated to a CBCs are considered "core service funds", except for:

1. Funds appropriated for independent living.
2. Funds appropriated for maintenance adoption subsidies.
3. Funds allocated by DCF for protective investigations training.
4. Nonrecurring funds (e.g., risk pool appropriations, back of the bill authorizations designed in the General Appropriations Act, Legislative Budget Commission actions, and prior year excess federal earnings).[24]
5. Designated mental health wrap-around services.
6. Funds for special projects for a designated CBC.
7. Funds appropriated for the Guardianship Assistance Program under s. 39.6225, F.S.

Unless otherwise specified in the General Appropriations Act, any new core service funds are allocated according to the equity allocation model on the following weighted basis:

- 70% of new funding must be allocated among all CBCs.

[18] Relevant provisions of the Social Security Act include the Title IV-A Temporary Assistance for Needy Families (TANF) block grant, Title IV-B child welfare services, Title IV-B promoting safe and stable families, Title IV-E funds for foster care, Title IV-E funds for adoption assistance, independent living and education, training and voucher funds, and the Title XX Social Services Block Grant.
[19] In addition, a local match is required for the Title IV-B promoting safe and stable families fund.
[20] Florida Department of Children and Families, *A Comprehensive, Multi-Year Review of the Revenues, Expenditures, and Financial Position of All Community-Based Care Lead Agencies with System of Care Analysis*, p. 3 (Dec. 1, 2023) https://www.myflfamilies.com/services/child-family/lmr (last visited Jan. 6, 2024).
[21] *Supra*, FN 10 at 3.
[22] Ch. 2011-62, L.O.F.
[23] Florida Senate Analysis of 2011 Senate Bill 2146, p. 3 (April 1, 2011) https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?FileName=2011s2146.bc.DOCX&DocumentType=Analysis&BillNumber=2146&Session=2011 (last visited Jan. 26, 2024).
[24] *Supra*, FN 3 at 4-5. At the time of DCF's annual report, the carry-forward balance for FY 2023-24 was not yet determined.

- 30% of new funding must be allocated among the CBCs that are funded below their equitable share.[25]

The equity allocation model weights the proportions of the child population, the child abuse hotline workload, and the children in care according to the following formula:

- The proportion of the child population is weighted at 5% of the total.
- The proportion of the child abuse hotline workload is weighted at 35% of the total.
- The proportion of the children in care is weighted at 60% of the total.[26]

The FY 2023-24 GAA provides the following core service funding amounts to CBC's:

Community-based Care Lead Agency	Core Service Funding for FY 2023-24
Big Bend CBC (Northwest Florida Health Network)-West	$55,032,652
Big Bend CBC (Northwest Florida Health Network)-East	$35,459,931
Partnership for Strong Families	$31,401,300
Kids First of Florida	$12,525,871
Family Support Services of North Florida	$49,018,528
St Johns Board of County Commissioners (Family Integrity Program)	$7,683,739
Community Partnership for Children	$43,440,511
Kids Central	$54,912,909
Embrace Families	$60,761,737
Heartland for Children	$46,721,076
Community-Based Care of Brevard (Brevard Family Partnerships)	$29,292,110
Communities Connected for Kids	$24,247,000
Family Support Services of Suncoast	$87,553,887
Safe Children Coalition	$34,861,493
Children's Network of Hillsborough	$75,448,412
Children's Network of Southwest Florida	$53,746,134
ChildNet (Palm Beach)	$38,086,728
ChildNet (Broward)	$60,952,428
Citrus Family Care Network	$76,440,546

Total state-appropriated funds available for CBC's for FY 2023-24 was $1.331 billion.[27]

In addition, some CBCs receive revenue from local sources such as local government, private businesses, and not-for-profit foundations.[28]

Risk Pool

Total new funding available to CBC's varies by year but is generally a small percentage of the total funding for CBC services. This means that a CBC's funding does not change significantly year to year.

[25] S. 409.991(4), F.S.
[26] S. 409.991(2), F.S.
[27] *Supra,* FN 10, at 5.
[28] *Supra*, FN 10 at 5.

When extenuating circumstances result in increased expenditures for CBC's, the funding through the formula does not change significantly. Thus s. 409.990, F.S., establishes a risk pool for lead agencies. The risk pool is intended to mitigate the financial risk to eligible lead agencies.

CBC's must apply for risk pool funding, and then a DCF secretary-appointed risk pool peer review committee reviews and assesses all risk pool applications. The committee includes both DCF and non-applicant CBC representatives. The peer review committee then reports its findings and recommendations to the secretary, providing, at a minimum:

- Justification for the specific funding amount required by the risk pool applicant based on the current year's service trend data, including validation that the applicant's financial need was caused by circumstances beyond the control of the lead agency management;
- Verification that the proposed use of risk pool funds meets at least one of the purposes specified in paragraph (c); and
- Evidence of technical assistance provided in an effort to avoid the need to access the risk pool and recommendations for technical assistance to the lead agency to ensure that risk pool funds are expended effectively and that the agency's need for future risk pool funding is diminished.

Upon approval by the secretary of a risk pool application, the department may request funds from the risk pool in accordance with s. 216.181(6)(a).

The four purposes for which the community-based care risk pool shall be used include:

- Significant changes in the number or composition of clients eligible to receive services.
- Significant changes in the services that are eligible for reimbursement.
- Continuity of care in the event of failure, discontinuance of service, or financial misconduct by a lead agency.
- Significant changes in the mix of available funds.

The Legislature appropriates funding for the risk pool. The amount appropriated varies by year; for FY 23-24, the Legislature appropriated $3.0 million for the risk pool.[29] In FY 2022-23, two CBC's applied for risk pool funding, and one of the two (Embrace Families) was approved and awarded $3.1 million.[30]

2022 and 2024 Reports on Allocation Options

Current law sets monthly reporting requirements for DCF regarding its case management services or case management services provided by CBCs or their subcontractors. At a minimum, DCF must publish the following data points on its website by the 15th day of each month:[31]

1. The average caseload of case managers, including only filled positions;
2. The total number and percentage of case managers who have 25 or more cases on their caseloads;
3. The turnover rate for case managers and case management supervisors for the previous 12 months;
4. The percentage of required home visits completed; and
5. Performance on outcome measures required pursuant to s. 409.997 for the previous 12 months.

[29] *Supra,* FN 10, at 3.
[30] Department of Children and Families, *Risk Pool Peer Review Committee, Executive Summary Report, Fiscal Year 2022-23*, https://www.myflfamilies.com/sites/default/files/2023-05/Risk_Pool_Executive_Summary_FY22-23.pdf, p. 2.
[31] S. 409.988(1)(k), F.S.

Procurement by CBCs and Civil Penalties

Federal Requirements Governing Procurement by CBCs

The federal government awards federal program funds to DCF as the federal awarding agency or pass-through entity. Current law defines the pass-through entity as a non-federal entity that provides a subaward to a subrecipient to carry out part of a federal program. A non-federal entity means a state, local government, indigenous tribe, institution of higher education, or nonprofit organization that carries out a federal award as a recipient or subrecipient. [32]

CBCs must comply with state and federal statutory requirements and agency rules in the provision of contractual services.[33] To determine which federal rules apply to CBCs, DCF must first determine whether CBCs meet the federal classification of subrecipient or contractor. DCF, as the pass-through entity, must make a case-by-case determination whether each agreement it makes for the disbursement of Federal program funds casts the party receiving the funds in the role of a subrecipient or a contractor. The pass-through entity must use judgment in classifying each agreement as a subaward or a procurement contract. The substance of the relationship is more important the form of the agreement.[34]

The table below describes the criteria that DCF must use to determine whether a CBC is a subrecipient or contractor; CBC's meet the criteria for subrecipients.

The Subrecipient Classification[35]	The Contractor Classification[36]
Determines a person's eligibility for federal assistance	Providers goods and services within normal business operations
Has its performance measured in relation to whether objectives of a federal program were met	Provides similar goods or services to many different purchasers
Has responsibility for programmatic decision-making	Normally operates in a competitive environment
Must adhere to applicable federal program requirements specified in the federal award	Provides goods or services that are ancillary to the operation of the federal program
Uses federal funds to carry out a program for a public purpose authorized in statute (as opposed to providing goods or services for the benefit of a pass-through entity)	Is not subject to compliance requirements of the federal program as a result of the agreement with the pass-through entity.

At the time of DCF's subaward to the subrecipient CBC, the DCF must put the CBC on notice of all federal requirements to ensure the federal award is used in accordance with Federal statutes, regulations, and the terms and conditions of the federal award.[37] DCF must evaluate each CBC's risk of noncompliance with federal statutes, regulations, and terms and conditions of the subaward for purposes of determining the appropriate subrecipient monitoring protocols.[38] The federal government authorizes the DCF to consider taking enforcement action against noncompliant subrecipients.[39]

[32] 2 C.F.R. § 200.1.
[33] S. 409.988(1)(i), F.S.
[34] 2 C.F.R. § 200.331.
[35] 2 C.F.R. § 200.331(a).
[36] 2 C.F.R. § 200.331(b).
[37] 2 C.F.R. § 200.332(a)(2).
[38] 2 C.F.R. § 200.332(b).
[39] 2 C.F.R. § 200.332(h).

The federal government delegates certain federal subaward enforcement responsibilities to DCF. If a CBC fails to comply with federal law or the terms and conditions of a federal award, DCF may impose additional conditions[40] on the subrecipient or contractor. If DCF determines that noncompliance cannot be remedied by imposing additional conditions, DCF may take one of more the following actions:[41]

1. Temporarily withhold cash payments pending correction of the deficiency by the non-federal entity or take more serve enforcement action.
2. Deny all or part of the cost of the activity or action not in compliance.
3. Wholly or partly suspend or terminate the federal award.
4. Initiate suspension or debarment proceedings.
5. Withhold further federal awards for the project or program.
6. Take other remedies that are legally available.

Under federal law, a nonprofit organization that carries out a Federal award as a recipient or subrecipient (i.e., a CBC) must provide for full and open competition in procuring goods and services.[42] When the value of the procurement for property or services under a federal award does not exceed the federal simplified acquisition threshold of $250,000,[43] or a lower threshold established by a non-federal entity, formal procurement methods are not required.[44] When the value of the procurement for property or services under a federal financial assistance award exceed the federal simplified acquisition threshold of $250,000, or a lower threshold established by a non-federal entity, formal procurement methods are required.[45]

A CBC may conduct noncompetitive procurements with federal award dollars if:

1. the acquisition of services does not exceed an established micro-purchase threshold,
2. the item is available only from a single source,
3. there is public exigency or an emergency,
4. the federal awarding agency or pass-through entity expressly authorizes a noncompetitive procurement in response to a written request from the non-Federal entity[46], or
5. competition is deemed inadequate after solicitation of a number of sources.[47]

State Law Governing Procurement by CBC's

In Florida, chapter 287 governs the procurement of commodities and contractual services. Generally, if a procurement request for commodities or contractual services exceeds $35,000, the competitive solicitation process is mandatory.[48] However, purchases of certain contractual services and commodities are exempt from this requirement, such as:

- Health services involving examination, diagnosis, treatment, prevention, medical consultation, or administration.
- Services provided to persons with mental or physical disabilities by nonprofits recognized as 501(c)(3)s by the IRS.
- Medicaid services delivered to Medicaid eligible recipients.
- Family placement services.

[40] Additional conditions include adjusting specific federal award conditions, requiring payments as reimbursements rather than advance payments, requiring more detailed financial reports, requiring additional project monitoring, requiring technical or management assistance, and establishing additional prior approvals. 2 C.F.R. 200.208.
[41] 2 C.F.R. § 200.339.
[42] 2 C.F.R. § 200.318-320.
[43] 48 C.F.R. § 2.101.
[44] 2 C.F.R. § 200.320(a).
[45] 2 C.F.R. § 200.320(b).
[46] e.g., a DCF waiver to bypass competitive procurement requirements that create inefficiencies or inhibit of the performance of the CBC's duties.
[47] 2 C.F.R. § 200.320(c)(1)-(5).
[48] Ss. 287.057(1), 287.017(2), F.S.

- Prevention services related to mental health operated by nonprofits – including drug abuse prevention programs, child abuse prevention programs, and shelters for runaways.[49]

If an agency receives fewer than two responsive bids, proposals, or replies, the procuring agency may negotiate with the vendor on the best terms and conditions.[50] Also, an agency may award a non-competitive government contract if state or federal law prescribes with whom the agency must contract or if the rate of payment or the receipt of funds is established during the appropriations process.[51]

CBCs have additional limitations on their procurement under state law beyond the general requirements in ch. 287, F.S. Specifically, CBC's cannot directly provide more than 35 percent of all child welfare services unless the CBC can demonstrate a need within the CBC's geographic service area to exceed this threshold. Current law requires community alliances[52] to review the CBC's justification for need and to recommend whether DCF should approve or deny the CBC's request for an exemption from the 35 percent threshold.[53] When CBCs outsource contractual services, the subcontracts must specify how the third-party vendor helps the CBC meet established performance standards under the child welfare results-oriented accountability system.[54].

CBC Governance and Expenditures

Organization and Board Responsibilities

Each CBC must be organized as a Florida corporation or a governmental entity and be governed by a board of directors or a board committee composed of by board members.[55] The membership of the board of directors or board committee must be described in the bylaws or articles of incorporation of each lead agency.

- For boards of directors, at least 75% of the membership must consist of Florida residents, and at least 51% of these Florida resident members must reside within the CBC service area. The board of directors must have the power to hire the CBC's executive director.
- For board committees, 100% of its membership must consist of persons residing within the CBC service area. The board committee must have the power to confirm the selection of an executive director.[56]

Regardless of organization, each governing body must approve its CBC budget, set the CBC's operational policy and procedures, and demonstrate financial responsibility through an organized plan for regular fiscal audits and the posting of a performance bond.[57]

Conflict of Interest Requirements

Section 409.987, F.S, addresses conflict of interests in CBC board decisionmaking. A CBC board member or officer must disclose to the board any activity that may reasonably be construed to be a conflict of interest before that activity may be initially considered and approved. This mandatory disclosure also applies to contract renewals.[58] A conflict of interest transaction manifests when a CBC board member or officer, or their relatives within the third degree of consanguinity by blood or marriage, does any of the following acts:

[49] S. 287.057(3)(e), F.S.
[50] S. 287.057(6), F.S.
[51] S. 287.057(11), F.S.
[52] Current law requires DCF to establish community alliances in each county to provide a focal point for community participation and governance of community-based services. s. 20.19(5), F.S.
[53] S. 409.988(1)(j). F.S.
[54] *Id*.
[55] e.g., St. Johns County Board of Commissioners is the CBC serving St. Johns County in Circuit 7.
[56] S. 409.987(4), F.S.
[57] S. 409.987(4), F.S.
[58] S. 409.987,(7)(b) F.S.

- enters into a contract or other transaction with the CBC for goods or services.
- holds a direct or indirect interest in a corporation, limited liability corporation, partnership, limited liability partnership, or other business entity that conducts or proposes business with the CBC.
- knowingly obtains a direct or indirect personal, financial, professional, or other benefit as a result of the relationship of such board member or officer, or their relatives, with the CBC.[59]

A rebuttable presumption of a conflict of interest exists if the board acted on a proposed conflict of interest transaction without prior notice on the board's meeting agenda. The meeting agenda must clearly identify the existence of a potential conflict of interest for the proposed transaction. At the meeting, if an affirmative vote of two-thirds of all other non-interested board members present approve the proposed transaction, only then can the CBC board member or officer engage in the conflict of interest activity.[60] The interested CBC board member or officer must recuse himself or herself from the vote.[61] However, if the proposed transaction is not approved, the CBC board member or officer must decide whether to provide written notice of the board member's or officer's intent to not pursue the proposed transaction or to withdraw from CBC leadership.[62]

If a conflict-of-interest contract entered into between the CBC and a CBC board member or officer (or their relatives) was not properly disclosed, the contract is voidable. The board may terminate the contract with the formal consent of at least 20% of the voting interests of the CBC.

CBC Executive Compensation

A CBC lead agency administrative employee cannot receive a salary, whether in base pay or base pay plus bonus or incentive payments, in excess of 150% of the annual salary paid to the DCF Secretary from state-appropriated funds – including state-appropriated federal funds.[63] Additional federal requirements also apply. In practice, this is currently a maximum of $350,449.71 of combined state and federal funds, of which only $213,000 can be federal funds. According to DCF, during recent audits of CBC spending on executive compensation, some CBCs stated that because they had multiple DCF contracts, they believed they could exceed this cap.[64]

Remedies

As an immediate remedy for failure to comply with contract terms or in the event of performance deficiencies, all contracts between DCF and the CBCs must provide for tiered interventions and graduated penalties. Examples of available interventions and penalties include:

- Enhanced monitoring and reporting.
- Corrective action plans.
- Requirements to accept DCF's technical assistance and consultation.
- Financial penalties requiring a CBC to reallocate funds from administrative costs to direct care for children.
- Early termination of contracts.[65]

In the event that DCF determines health, safety, and welfare of the dependent children currently cared for or supervised by a CBC is in imminent danger, DCF may petition a court of competent jurisdiction

[59] S. 409.987(7)(a), F.S.
[60] S. 409.987(7)(c), F.S.
[61] S. 409.987(e), F.S.
[62] S. 409.987(7)(d), F.S.
[63] S. 409.992(3), F.S.
[64] Florida Department of Children and Families, Agency Analysis of 2024 House Bill 1061, p. 6.
[65] S. 409.996(d), F.S.

for the appointment of a receiver to ensure the continued health, safety, and welfare of the dependent children.[66] According to current law, DCF can make at least two arguments in a receivership petition:

- DCF determines that conditions exist in the CBC which present an imminent danger to the health, safety, or welfare of dependent children under the CBC's care or supervision.
- The CBC cannot meet its current financial obligations to its employees, contractors, or foster parents. The issuance of bad checks or the existence of delinquent obligations for payment of salaries, utilities, or invoices for essential services or commodities constitute prima facie evidence that the CBC lacks the financial ability to meet its financial obligations.[67]

The court may appoint a receiver for up to 90 days. DCF may petition for additional 30-day extensions. Sixty days after the appointment of the receiver, and every 30 days until the receivership is terminated, DCF must submit to the court an assessment of the CBC's ability to ensure the health, safety, and welfare of the dependent children under its supervision.[68]

Forensic Audits of CBCs

In December 2021, the DCF Inspector General (IG) identified 11 CBCs that routinely transferred funds to related parties. The IG expressed concern over this practice because funds transferred to related parties compromises DCF's ability to track further expenditures of state and federal dollars. Current law mandates that CBCs abide by DCF's financial guidelines and allow for a regular independent auditing of its financial activities,[69] and thus DCF procured the services of two auditing firms with the expertise to perform a forensic audit of these CBCs. As of January 2024, these auditing firms completed forensic examination reports for 6 CBCs and submitted them to DCF in August 2023.[70]

In response to the findings of the initial forensic examinations, the Department issued Corrective Action Plans (CAPs) to address key findings which included:

- Non-compliant contract procurement for related and non-related entities.
- Receipt of Paycheck Protection Program Loans that were not properly reimbursed to the State.
- Board approval of deficit budgets.
- Allocated officer compensation in excess of mandatory caps.
- Non-compliance with Cost Allocation Plans.[71]

[66] S. 409.994, F.S.
[67] S. 409.994, F.S.
[68] S. 409.994(2)(d), F.S.
[69] S. 409.988(1)(c), F.S.
[70] The six CBC's were Northwest Florida Health Network, Embrace Families, Partnership for Strong Families, Children's Network of Southwest Florida, Kids First of Florida, and Brevard Family Partnership. The audit reports for the first six CBC's are at https://www.myflfamilies.com/community-based-care-lead-agencies-audit-findings (last visited Jan. 26, 2024).
[71] *Supra*, FN 64.

Effect of the Bill

Contractual Obligations

Contract Term

The bill prohibits DCF from renewing a CBC contract, instead requiring DCF to reprocure it at the end of the five-year term. The bill allows DCF to extend a CBC contract for one year.

General Governance

The bill requires board members to provide fiduciary oversight to prevent conflicts of interest, to promote accountability and transparency for the system of care, and to protect state and federal funding from misuse. The bill requires at least 75 percent of the membership of the board of directors or the board committee be composed of Florida residents. CBCs must ensure that board members participate in annual training related to their responsibilities.

Related Parties and Conflict of Interest Transactions

The bill restricts the ability of CBCs to transact with third-party entities that are directly or indirectly related to the CBC itself by requiring CBCs to competitively procure all contracts with related parties in excess of $35,000.

The bill defines related party as "any entity of which a director or an executive of the entity is also directly or indirectly related to, or has a direct or indirect financial or other material interest in, the lead agency. The term also includes any subsidiary, parent entity, associate firm, or joint venture, or any entity that is controlled, influenced, or managed by another entity or an individual related to such entity, including an individual who is, or was within the immediately preceding 3 years, an executive officer or a board member of the entity."

The bill requires the board to disclose any known or actual conflicts of interest – including with related parties for the provision of management, administrative services, or oversight.

The bill expands the definition of conflict of interest to cover director level positions in the CBCs and the relatives of a board member, director, or officer of the CBCs. The bill prohibits directors and their relatives from knowingly obtaining a direct or indirect personal, financial, professional, or other benefit as a result of the conflict of interest relationship.

The bill requires DCF to assess a civil penalty of $5,000 per occurrence on a CBC for each known and potential conflict of interest that the CBC fails to disclose to DCF. In addition, the bill requires DCF to assess a civil penalty on a CBC when that CBC procures a contract for which a conflict of interest was not disclosed to DCF prior to the execution of the contract. For the first offense, DCF must assess a civil penalty of $50,000. For each subsequent offense, DCF must assess a civil penalty of $100,000. Finally, the bill requires the CBCs to reprocure transactions that involved a conflict of interest.

The bill authorizes DCF to prohibit the execution of a contract for which a conflict of interest exists, or will exist after execution.

CBC Executive Pay

The bill prohibits a CBC administrative employee from receiving a salary, whether base pay or base pay combined with any bonus or incentive payments from the CBC or any related party, in excess of 150 percent of the annual salary paid to the DCF Secretary from state-appropriated funds. The bill applies this limitation regardless of the number of contracts a CBC executes with DCF.

Financial Integrity

The bill requires the CBCs to comply with regular, independent auditing of its financial activities, including any requests for records associated with such financial audits within the timeframe established by DCF or its contracted vendors.

Reporting Requirements

The bill expands the minimum data points that the CBCs must publish on its website by the 15th day of each month. Specifically, the bill requires the CBCs to report four new data points:

1. The number of unlicensed placements for the previous month.
2. The percentages and trends for foster parent and group home recruitment and licensure for the previous month.
3. The percentage of families being served through family support, in-home, and out-home services for the previous month.
4. The percentage of cases that converted from nonjudicial to judicial for the previous month.

Four-Year Implementation of the Actuarially-Based Tiered Payment Model

The bill gradually transitions the allocation of core services funds for CBCs from an equity allocation model and back-of-the-bill funding to an actuarially-based tiered payment model over four state fiscal years, starting with 2024-2025.

The bill creates a three-tiered payment model that adjusts for workload fluctuations and incentivizes prevention, family preservation, and permanency.

The bill establishes fixed payments for Tier 1 operational base expenses and fixed costs that are not sensitive to the number of children and families served. The bill allows Tier 1 expenses to include administrative expenses, lease payments, asset depreciation, utilities, select components of case management, mandated activities such as training, quality, and contract management, and activities performed for children and families which are nonjudicial and who are not candidates for Title IV-E funding. The bill authorizes Tier 1 fixed payments to vary by geographic catchment area and cost of living differences.

The bill establishes variable payments for the Tier 2 per-child, per-month payment. The bill provides a Tier 2 payment rate that blends out-of-home rates and in-home rates specific to each lead agency. This rate incentivizes CBCs to provide services in the least restrictive safe placement.

The bill requires DCF to establish and annually update Tier 1 and Tier 2 payment rates to maintain cost expectations aligned with the population served, the services provided, and the environment.

The bill creates financial incentive payments for Tier 3 and requires DCF to reward CBCs that achieve performance measures aligned with DCF's goals of prevention, family preservation, and permanency.

Pertaining to the four-year implementation of the actuarially-based tiered payment model, the bill sets up a specific timeline framework as shown in the table below:

State Fiscal Year	Allocation of Core Service Funds	Implementation Responsibilities
Year One: 2024-25	**The Hold Harmless Year**: 100% of core service funding for each CBC will remain constant according to the equity allocation model, unless the GAA provides otherwise.	DCF must establish the requisite systems and processes to collect the data necessary to implement the new payment model. DCF must refine model in collaboration with the CBCs. Quarterly Reporting Requirements • Each quarterly report must contain, at a minimum, documentation of DCF's actions, determinations, proposals, and results of implementation. • First Quarter Report: Due October 31, 2024. Must include an implementation plan. Implementation plan must be updated in subsequent reports. • Second Quarter Report: Must provide details about the Tier 3 incentive payments and the corresponding measures, targets, and payment amounts; these details must be updated in subsequent reports. This report must also describe how Tier 3 will relate to DCF's results-oriented accountability program. This report must disclose the proposed funding for state fiscal year 2025-26.
Year Two: 2025-26	**Hybrid Allocation SFY 2025-26**: • 67% under the equity allocation model unless the GAA provides otherwise. • 33% under the actuarially-based tiered payment model.	Quarterly report requirements continue.
Year Three: 2026-27	**Hybrid Allocation SFY 2026-27**: • 33% under the equity allocation model unless the GAA provides otherwise. • 67% under the actuarially-based tiered payment model.	Starting in 2027, DCF must submit an annual report that evaluates the CBCs fiscal performance under the actuarially-based tier payment model and any funding adjustment and tiered payment model adjustment recommendations proposed. The first annual report is due December 1, 2027. Quarterly report requirements continue.
Year Four: 2027-28	**The Full Implementation Year**: 100% of core service funding for each CBC will be provided according to the actuarially-based tiered payment model.	Quarterly report requirements continue. Annual report evaluating CBC fiscal performance, funding adjustments, and model adjustments is due December 1, 2028.

The bill terminates the quarterly reporting requirement on June 30, 2029.

Because the model requires additional refinement as discussed above, it is unknown what the specific impact is on each CBC once it would be fully implemented in FY 27-28.

Procurements by CBCs

The bill requires CBCs to competitively procure all contracts, consistent with the simplified acquisition threshold as specified the Code of Federal Regulations; the simplified acquisition threshold is currently $250,000. The bill requires DCF to establish by contract financial penalties or sanctions that DCF must enforce when a CBC is not compliant with applicable local, state, or federal law for the procurement of commodities or contractual services.

The bill requires CBCs to procure contracts for real property and professionals services according to established purchasing practices. If a CBC sells, transfers, or dispossesses of real property procured during the contract term, the bill requires any resulting funds from the sell, transfer, or dispossession to be returned to DCF. When DCF or a CBC terminates a contract, the bill grants DCF immediate rights to the retention and ownership of all real property that the CBC procured.

When a CBC subcontracts for the provision of services, the bill requires subcontracts in excess of $250,000 to comply with the federal competitive procurement process. The bill prohibits a CBC from subcontracting administrative and management functions.

The bill prevents a CBC from providing more than 35 percent of all child welfare services unless it can demonstrate a need within its geographic service area where there is a lack of viable providers available to perform the necessary services. The bill limits the waiver period to two years. The bill requires CBCs to reprocure each subcontract before the end of the two-year waiver period. If a CBC wishes to extend an active waiver to exceed the 35 percent cap, the bill requires the CBC to submit a new, evidenced-based exemption request to DCF and the community alliance for the geographic service area (if a community alliance serves the area) for approval each time the CBC wishes to extend an active waiver.

CBC Receivership

The bill lowers the threshold level of danger at which DCF can petition the court for a receivership of a CBC. Specifically, the bill allows DCF to file a petition in court for the receivership of a CBC when DCF determines that conditions exist at the CBC which present any danger to the health, safety, or welfare of the dependent children under that CBC's care or supervision.

The bill also lowers the threshold risk of financial insolvency at which DCF can petition the court for a receivership of a CBC. Specifically, the bill allows DCF to file a petition in court the receivership of a CBC when DCF determines a CBC is unlikely to meet its current financial obligations to its employees, contractors, or foster parents.

Remedies for Noncompliance or Inadequate Performance

The bill establishes contractual actions that DCF may enforce against a CBC if the CBC fails to comply with contract terms or experiences performance deficiencies in the opinion of DCF. Specifically, the bill authorizes DCF to reclaim funds from a CBC's administrative costs as a financial penalty when the CBC fails to provide timely, sufficient resolution of deficiencies resulting in a corrective action plan or other performance improvement plan issued by DCF. The bill allows financial penalties to manifest as liquidated damages.

If DCF reclaims funds for a CBC's administrative costs as a financial penalty, the bill requires DCF to spend those funds to support service delivery of quality improvement activities for children in the CBC's care.

The bill requires contracts between DCF and CBCs to include a provision that requires a CBC pay sanctions and disincentives for failure to comply with contractual terms. The bill requires DCF to establish a schedule of daily monetary sanctions or disincentives for CBCs. The bill requires the schedule of daily monetary sanctions or disincentives to be incorporated by reference into the contracts between DCF and CBCs. The bill vests the right to determine the monetary value of liquidated damages with DCF.

The bill obligates DCF to submit two special implementation reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the rules and polices adopted and other actions taken to implement the bill's requirements. The first special implementation report is due September 30, 2024. The second special implementation report is due February 1, 2025.

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

B. SECTION DIRECTORY:

Section 1: Amending s. 409.987, F.S., relating to lead agency procurement; boards; conflicts of interest.
Section 2: Amending s. 409.988, F.S., relating to community-based care lead agency duties; general provisions.
Section 3: Creating s. 409.9913, F.S., relating to actuarially-based tiered model for allocation of funds for community-based care lead agencies.
Section 4: Creating s. 409.9915, F.S., relating to implementation of actuarially-based tiered model for allocation of funds for community-based care lead agencies.
Section 5: Amending s. 409.992, F.S., relating to lead agency expenditures.
Section 6: Amending s. 409.994, F.S., relating to community-based care lead agencies; receivership.
Section 7: Amending s. 409.996, F.S., relating to duties of the department of children and families.
Section 8: Creating an unnumbered section of law relating to reporting requirements.
Section 9: Providing an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill has no fiscal impact for FY 2024-25, but has an indeterminate fiscal impact in future years. The bill provides a new methodology for the allocation of CBC core service funds, and gradually transitions the use of the new methodology over four fiscal years. Beginning with FY 2024-25, the bill requires DCF to develop the new methodology, to report upon the progress, and that each CBC's allocation shall remain the same as FY 2023-24. There is no fiscal impact in the first year of implementation.

   The new tiered methodology is then phased-in over the remaining three fiscal years. It is unknown to what extent the methodology may suggest additional funds are needed for CBC core services in FY 2025-26, FY 2026-27, and FY 2027-28.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The elimination of the equity allocation model and the substitution of an actuarially sound, tiered payment allocation model means individual CBC funding levels may change and fluctuate. The specific impact is indeterminate.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

DCF has sufficient rulemaking authority to carry out the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 29, 2024, the Children, Families, & Seniors Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The amendment:

- Gradually transitions the allocation for funds for CBC lead agencies to an actuarially-based tiered payment model over four state fiscal years, starting with 2024-2025.
    - Year One is a hold harmless year, and DCF must collaborate with the CBC lead agencies to refine the actuarially-based tiered payment model.
    - Years Two and Three blend the current and actuarial payment models.
    - Year Four and beyond sets 100 percent of payments according to the actuarially-based tiered payment model.

- Establishes reporting requirements for DCF on the details of, and CBC lead agency performance under, the actuarially-based tiered payment model:
    - Starting October 31, 2024, DCF must submit quarterly reports to the Governor, President of the Senate, and Speaker of the House of Representatives about the actuarially-based tiered payment model implementation and the Tier 3 incentive payment program.
    - Starting in 2027, DCF must submit an annual report that evaluates the CBC lead agencies' fiscal performance under the actuarially-based tier payment model and any funding adjustment and tiered payment model adjustment recommendations proposed.

- Requires a CBC lead agency with an active waiver to exceed the 35 percent statutory cap on providing child welfare services to submit a new, evidenced-based exemption request to DCF and the community alliance for the geographic service area (if a community alliance serves the area) for approval each time the CBC lead agency wishes to extend an active waiver.

- Requires DCF to submit two reports on the rules adopted, the policies promulgated, and actions implemented to carry out the provisions of the bill; the first report is due September 30, 2024, and the second report is due February 1, 2025.

The analysis is drafted to the amended bill as passed by the Children, Families, & Seniors Subcommittee.

A bill to be entitled

An act relating to community-based child welfare agencies; amending s. 409.987, F.S.; revising requirements for contracts the Department of Children and Families has with community-based care lead agencies; revising requirements for an entity to serve as a lead agency; providing duties for board members of lead agencies; requiring that lead agencies ensure that board members participate in certain annual training; revising the definition of the term "conflict of interest"; defining the term "related party"; requiring the lead agency's board of directors to disclose any known or potential conflicts of interest; prohibiting a lead agency from entering into a contract or being a party to a transaction that creates a conflict of interest; imposing civil penalties on lead agencies for undisclosed conflicts of interest; providing applicability; requiring certain contracts to be reprocured; authorizing the department to prohibit execution of certain contracts; amending s. 409.988, F.S.; revising community-based care lead agency duties; creating s. 409.9913, F.S.; defining the term "core services funds"; providing the purpose of the tiered payment model; providing the tier payments; providing reporting requirements;

creating s. 409.9915, F.S.; providing implementation of the tiered payment model; providing reporting requirements; providing an expiration date; amending s. 409.992, F.S.; revising requirements for lead agency practices in the procurement of commodities and contractual services; requiring the department to impose certain penalties for a lead agency's noncompliance with applicable procurement law; requiring lead agencies to comply with established purchasing practices for the procurement of real property and professional services; requiring the department to retain all rights to and ownership of real property procured upon termination of contracts; requiring certain funds to be returned to the department; providing applicability of certain limitations on the salaries of community-based care lead agency administrative employees; amending s. 409.994, F.S.; revising the conditions under which the department may petition a court for the appointment of a receiver for a community-based care lead agency; amending s. 409.996, F.S.; revising requirements for contracts between the department and lead agencies; revising the actions the department may take under certain circumstances; making a technical change; providing duties of the department; providing

reporting requirements; providing an effective date.

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

Section 1. Subsections (3) and (4) and paragraphs (a) and (b) of subsection (7) of section 409.987, Florida Statutes, are amended, and paragraph (g) is added to subsection (7) of that section, to read:

409.987 Lead agency procurement; boards; conflicts of interest.—

(3) Notwithstanding s. 287.057, the department shall use 5-year contracts with lead agencies. The 5-year contract must be reprocured at the end of each 5-year contract term. The contract may be extended at the discretion of the department for up to 1 year, based on department needs.

(4) In order to serve as a lead agency, an entity must:

(a) Be organized as a Florida corporation or a governmental entity.

(b) Be governed by a board of directors or a board committee composed of board members. Board members shall provide oversight and ensure accountability and transparency for the system of care. The board of directors shall provide fiduciary oversight to prevent conflicts of interest, promote accountability and transparency, and protect state and federal funding from misuse. The board of directors shall act in

accordance with s. 617.0830. The membership of the board of directors or board committee must be described in the bylaws or articles of incorporation of each lead agency, which must provide that at least 75 percent of the membership of the board of directors or board committee must be composed ~~consist~~ of persons residing in this state, and at least 51 percent of the state residents on the board of directors must reside within the service area of the lead agency. The lead agency shall ensure that board members participate in annual training related to their responsibilities. However, for procurements of lead agency contracts initiated on or after July 1, 2014:

1. At least 75 percent of the membership of the board of directors must be composed ~~consist~~ of persons residing in this state, and at least 51 percent of the membership of the board of directors must be composed ~~consist~~ of persons residing within the service area of the lead agency. If a board committee governs the lead agency, 100 percent of its membership must be composed ~~consist~~ of persons residing within the service area of the lead agency.

2. The powers of the board of directors or board committee include, but are not limited to, approving the lead agency's budget and setting the lead agency's operational policy and procedures. A board of directors must additionally have the power to hire the lead agency's executive director, unless a board committee governs the lead agency, in which case the board

committee must have the power to confirm the selection of the lead agency's executive director.

(c) Demonstrate financial responsibility through an organized plan for regular fiscal audits and the posting of a performance bond.

(7)(a) As used in this subsection, the term:

1. "Activity" includes, but is not limited to, a contract for goods and services, a contract for the purchase of any real or tangible property, or an agreement to engage with a lead agency for the benefit of a third party in exchange for an interest in real or tangible property, a monetary benefit, or an in-kind contribution.

2. "Conflict of interest" means when a board member, director, or ~~an~~ officer, or a relative of a board member, director, or ~~an~~ officer, of a lead agency does any of the following:

a. Enters into a contract or other transaction for goods or services with the lead agency.

b. Holds a direct or indirect interest in a corporation, limited liability corporation, partnership, limited liability partnership, or other business entity that conducts business with the lead agency or proposes to enter into a contract or other transaction with the lead agency. For purposes of this paragraph, the term "indirect interest" has the same meaning as in s. 112.312.

c. Knowingly obtains a direct or indirect personal, financial, professional, or other benefit as a result of the relationship of such board member, director, or officer, or relative of the board member, director, or officer, with the lead agency. For purposes of this paragraph, the term "benefit" does not include per diem and travel expenses paid or reimbursed to board members or officers of the lead agency in connection with their service on the board.

3. "Related party" means any entity of which a director or an officer of the entity is also directly or indirectly related to, or has a direct or indirect financial or other material interest in, the lead agency. The term also includes any subsidiary, parent entity, associate firm, or joint venture, or any entity that is controlled, influenced, or managed by another entity or an individual related to such entity, including an individual who is, or was within the immediately preceding 3 years, an executive officer or a board member of the entity.

4.~~3.~~ "Relative" means a relative within the third degree of consanguinity by blood or marriage.

(b)1. For any activity that is presented to the board of a lead agency for its initial consideration and approval ~~after July 1, 2021~~, or any activity that involves a contract that is being considered for renewal ~~on or after July 1, 2021, but before January 1, 2022~~, a board member, a director, or an officer of a lead agency shall disclose to the board any

activity that may reasonably be construed to be a conflict of interest before such activity is initially considered and approved or a contract is renewed by the board. A rebuttable presumption of a conflict of interest exists if the activity was acted on by the board without prior notice as required under paragraph (c). The board shall disclose any known actual or potential conflicts to the department.

2. A lead agency may not enter into a contract or be a party to any transaction that creates a conflict of interest, including with related parties for the provision of management or administrative services or oversight ~~For contracts with a lead agency which are in existence on July 1, 2021, and are not subject to renewal before January 1, 2022, a board member or an officer of the lead agency shall disclose to the board any activity that may reasonably be construed to be a conflict of interest under this section by December 31, 2021~~.

(g)1. Civil penalties in the amount of $5,000 per occurrence shall be imposed for each known and potential conflict of interest, as described in paragraph (b), which is not disclosed to the department. Civil penalties shall be paid by the board and not from any state or federal funds.

2. If a contract is executed for which a conflict of interest was not disclosed to the department before execution of the contract, the following penalties apply:

a. A civil penalty in the amount of $50,000 for a first

offense.

b. A civil penalty in the amount of $100,000 for a second or subsequent offense.

3. The civil penalties for failure to disclose a conflict of interest under subparagraphs 1. and 2. apply to any contract entered into, regardless of the method of procurement, including, but not limited to, formal procurement, single-source contracts, and contracts that do not meet the minimum threshold for formal procurement.

4. A contract procured for which a conflict of interest was not disclosed to the department before execution of the contract shall be reprocured.

5. The department may, at its sole discretion, prohibit execution of a contract for which a conflict of interest exists, or will exist after execution.

Section 2. Paragraphs (c), (j), and (k) of subsection (1) of section 409.988, Florida Statutes, are amended to read:

409.988 Community-based care lead agency duties; general provisions.—

(1) DUTIES.—A lead agency:

(c) Shall follow the financial guidelines developed by the department and shall comply with regular, independent auditing of its financial activities, including any requests for records associated with such financial audits within the timeframe established by the department or its contracted vendors ~~provide~~

~~for a regular independent auditing of its financial activities~~. The results of the financial audit must ~~Such financial information shall~~ be provided to the community alliance established under s. 20.19(5).

(j) May subcontract for the provision of services, excluding management and oversight functions, required by the contract with the lead agency and the department; however, the subcontracts must specify how the provider will contribute to the lead agency meeting the performance standards established pursuant to the child welfare results-oriented accountability system required by s. 409.997. The lead agency shall directly provide no more than 35 percent of all child welfare services provided unless it can demonstrate a need~~,~~ within the lead agency's geographic service area where there is a lack of qualified providers available to perform the necessary services. The approval period to exceed the threshold shall be limited to 2 years. If a lead agency wishes to continue its exemption from the services threshold, it must submit a new request with updated evidence to the department and the community alliance showing its efforts to recruit providers and that conditions have not changed~~, to exceed this threshold~~. The local community alliance in the geographic service area in which the lead agency is seeking to exceed the threshold shall review the lead agency's justification for need and recommend to the department whether the department should approve or deny the lead agency's

request for an exemption from the services threshold. If there is not a community alliance operating in the geographic service area in which the lead agency is seeking to exceed the threshold, such review and approval or denial of the lead agency's request for an exemption from the services threshold must be made by the department and the department must specify the duration of the exemption ~~recommendation shall be made by representatives of local stakeholders, including at least one representative from each of the following:~~

~~1. The department~~.

~~2. The county government.~~

~~3. The school district.~~

~~4. The county United Way.~~

~~5. The county sheriff's office.~~

~~6. The circuit court corresponding to the county.~~

~~7. The county children's board, if one exists.~~

(k) Shall publish on its website by the 15th day of each month at a minimum the data specified in subparagraphs 1.-9. ~~1.-5.~~, calculated using a standard methodology determined by the department, for the preceding calendar month regarding its case management services. The following information must ~~shall~~ be reported by each individual subcontracted case management provider, by the lead agency, if the lead agency provides case management services, and in total for all case management services subcontracted or directly provided by the lead agency:

1. The average caseload of case managers, including only filled positions;

2. The total number and percentage of case managers who have 25 or more cases on their caseloads;

3. The turnover rate for case managers and case management supervisors for the previous 12 months;

4. The percentage of required home visits completed; ~~and~~

5. Performance on outcome measures required pursuant to s. 409.997 for the previous 12 months; ~~.~~

6. The number of unlicensed placements for the previous month;

7. The percentages and trends for foster parent and group home recruitment and licensure for the previous month;

8. The percentage of families being served through family support, in-home, and out-of-home services for the previous month; and

9. The percentage of cases that converted from nonjudicial to judicial for the previous month.

Section 3. Section 409.9913, Florida Statutes, is created to read:

409.9913 Actuarially-based tiered model for allocation of funds for community-based care lead agencies.—

(1) As used in this section, the term "core services funds" means all funds allocated to lead agencies operating under contract with the department pursuant to s. 409.987. The

term does not include any of the following:

(a) Funds appropriated for independent living services.

(b) Funds appropriated for maintenance adoption subsidies.

(c) Funds allocated by the department for child protective investigation service training.

(d) Nonrecurring funds.

(e) Designated mental health wrap-around service funds.

(f) Funds for special projects for a designated lead agency.

(g) Funds appropriated for the Guardianship Assistance Program established under s. 39.6225.

(2) The purpose of the tiered model is to achieve a stable payment model that adjusts to workload and incentivizes prevention, family preservation, and permanency. The tiers are as follows:

(a) Tier 1 provides operational base and fixed costs, which do not vary based on the number of children and families served. Tier 1 payments may vary by geographic catchment area and cost-of-living differences. The department shall establish and annually update Tier 1 payment rates to maintain cost expectations that are aligned with the population served, services provided, and environment. Tier 1 expenses may include:

1. Administrative expenditures.

2. Lease payment.

3. Asset depreciation.

4. Utilities.

5. Select components of case management, including administrative elements.

6. Mandated activities such as training, quality, and contract management.

7. Activities performed for children and families which are nonjudicial and not candidates for Title IV-E funding, including true prevention and community-focused activities.

(b) Tier 2 is a per-child, per-month payment to provide funding for lead agencies' expenses that vary based on the number of children served for a particular month. The payment rate must blend out-of-home rates and in-home rates specific to each lead agency to create a rate that provides a financial incentive to lead agencies to provide services in the least restrictive safe placement. The department shall establish and annually update Tier 2 payment rates to maintain cost expectations that are aligned with the population served, services provided, and environment. Tier 2 rates must be set annually.

(c) Tier 3 provides financial incentives that the department shall establish to reward lead agencies that achieve performance measures aligned with the department's goals of prevention, family preservation, and permanency.

(3) By December 1 of each year, beginning in 2027, the department shall submit a report to the Governor, the President

of the Senate, and the Speaker of the House of Representatives which includes each lead agency's actual performance in attaining the previous fiscal year's targets, recommendations for adjustments to lead agency funding, and adjustments to the tiered payment model, if necessary.

Section 4. Section 409.9915, Florida Statutes, is created to read:

409.9915 Implementation of actuarially-based tiered model for allocation of funds for community-based care lead agencies.—

(1) The model established under s. 409.9913 shall be implemented as follows:

(a) During the 2024-2025 fiscal year, the department shall:

1. Establish the requisite systems and processes to collect data necessary for system implementation.

2. Refine the model in collaboration with the lead agencies.

(b) Funding for lead agencies shall be determined as follows:

1. During the 2024-2025 fiscal year, funding for a lead agency must be as provided under s. 409.991, unless otherwise provided in the General Appropriations Act.

2. During the 2025-2026 fiscal year, funding for a lead agency must be the sum of 67 percent of the funding determined under s. 409.991, unless otherwise provided in the General

Appropriations Act, and 33 percent of the funding determined under s. 409.9913.

3. During the 2026-2027 fiscal year, funding for a lead agency must be the sum of 33 percent of the funding determined under s. 409.991, unless otherwise provided in the General Appropriations Act, and 67 percent of the funding determined under s. 409.9913.

4. During the 2027-2028 fiscal year, funding for a lead agency must be as provided under s. 409.9913.

(2) The department shall submit quarterly reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives, with the first report due October 31, 2024, and subsequent reports submitted every 3 months thereafter. Each report must contain, at a minimum, information regarding the department's actions, determinations, proposals, and results under this section.

(a) The first quarterly report for the 2024-2025 fiscal year must include a plan for implementation under this section, which shall be updated in subsequent reports.

(b) The second quarterly report for the 2024-2025 fiscal year must additionally provide details regarding:

1. Proposed payments under Tier 3, including, but not limited to, the proposed goals and justifications for any incentive payments in the next fiscal year, measures and targets, and correlating payment amounts, which shall be updated

in subsequent reports. The report must describe how the Tier 3 goals and payments relate to the results-oriented accountability program under s. 409.997.

2. Proposed funding for the 2025-2026 fiscal year, as determined under s. 409.993, by lead agency.

(3) This section shall expire on June 30, 2029.

Section 5. Subsections (1) and (3) of section 409.992, Florida Statutes, are amended to read:

409.992 Lead agency expenditures.—

(1) The procurement of commodities or contractual services by lead agencies is ~~shall be~~ governed by the financial guidelines developed by the department and must comply with applicable state and federal law and follow good business practices. Pursuant to s. 11.45, the Auditor General may provide technical advice in the development of the financial guidelines.

(a)1. Lead agencies shall competitively procure all contracts, consistent with the federal simplified acquisition threshold.

2. Lead agencies shall competitively procure all contracts in excess of $35,000 with related parties.

3. Financial penalties or sanctions, as established by the department and incorporated into the contract, shall be imposed by the department for noncompliance with applicable local, state, or federal law for the procurement of commodities or contractual services.

(b) Notwithstanding s. 402.73, for procurement of real property or professional services, lead agencies shall comply with established purchasing practices, including the provisions of s. 287.055, as required, for professional services, including engineering or construction design. Upon termination of the contract, the department shall immediately retain all rights to and ownership of real property procured. Any funds from the sale, transfer, or other dispossession of such property during the contract term shall be returned to the department.

(3) Notwithstanding any other provision of law, a community-based care lead agency administrative employee may not receive a salary, whether base pay or base pay combined with any bonus or incentive payments from the lead agency or any related party, in excess of 150 percent of the annual salary paid to the secretary of the Department of Children and Families from state-appropriated funds, including state-appropriated federal funds. This limitation applies regardless of the number of contracts a community-based care lead agency may execute with the department. This subsection does not prohibit any party from providing cash that is not from appropriated state funds to a community-based care lead agency administrative employee.

Section 6. Paragraphs (c) and (d) of subsection (1) of section 409.994, Florida Statutes, are amended to read:

409.994 Community-based care lead agencies; receivership.—

(1) The Department of Children and Families may petition a

court of competent jurisdiction for the appointment of a receiver for a community-based care lead agency established pursuant to s. 409.987 if any of the following conditions exist:

(c) The department determines that conditions exist in the lead agency which present a ~~an imminent~~ danger to the health, safety, or welfare of the dependent children under that agency's care or supervision. Whenever possible, the department shall make a reasonable effort to facilitate the continued operation of the program.

(d) The lead agency cannot meet, or is unlikely to meet, its current financial obligations to its employees, contractors, or foster parents. Issuance of bad checks or the existence of delinquent obligations for payment of salaries, utilities, or invoices for essential services or commodities constitutes ~~shall constitute~~ prima facie evidence that the lead agency lacks the financial ability to meet its financial obligations.

Section 7. Paragraph (d) of subsection (1) of section 409.996, Florida Statutes, is amended to read:

409.996 Duties of the Department of Children and Families.—The department shall contract for the delivery, administration, or management of care for children in the child protection and child welfare system. In doing so, the department retains responsibility for the quality of contracted services and programs and shall ensure that, at a minimum, services are delivered in accordance with applicable federal and state

statutes and regulations and the performance standards and metrics specified in the strategic plan created under s. 20.19(1).

(1) The department shall enter into contracts with lead agencies for the performance of the duties by the lead agencies established in s. 409.988. At a minimum, the contracts must do all of the following:

(d) Provide for contractual actions ~~tiered interventions and graduated penalties~~ for failure to comply with contract terms or in the event of performance deficiencies, as determined appropriate by the department.

1. Such contractual actions must ~~interventions and penalties shall~~ include, but are not limited to:

a.~~1.~~ Enhanced monitoring and reporting.

b.~~2.~~ Corrective action plans.

c.~~3.~~ Requirements to accept technical assistance and consultation from the department under subsection (6).

d.~~4.~~ Financial penalties, which ~~shall~~ require a lead agency to direct ~~reallocate~~ funds from administrative costs to the department. The department shall use the funds collected to support service delivery of quality improvement activities for children in the lead agency's care ~~to direct care for children~~. These penalties may be imposed for failure to provide timely, sufficient resolution of deficiencies resulting in a corrective action plan or other performance improvement plan issued by the

department. Financial penalties may include liquidated damages.

e.~~5.~~ Early termination of contracts, as provided in s. 402.7305(3)(f) ~~s. 402.1705(3)(f)~~.

2. The department shall include in each lead agency contract executed a provision that requires payment to the department of sanctions or disincentives for failure to comply with contractual obligations. The department shall establish a schedule of daily monetary sanctions or disincentives for lead agencies, which schedule shall be incorporated by reference into the contract. The department is solely responsible for determining the monetary value of liquidated damages.

Section 8. The Department of Children and Families shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on rules and policies adopted and other actions taken to implement the requirements of this act. The first such report must be due September 30, 2024, and the second such report must be due February 1, 2025.

Section 9. 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 McFarland offered the following:

Amendment (with title amendment)

Remove lines 271-381 and insert:

409.9913 Funding methodology to allocate funding to lead agencies.—

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

(a) "Core services funding" means all funds allocated to lead agencies. The term does not include any of the following:

1. Funds appropriated for independent living services.

2. Funds appropriated for maintenance adoption subsidies.

3. Funds allocated by the department for child protective investigation service training.

4. Nonrecurring funds.

5. Designated mental health wrap-around service funds.

6. Funds for special projects for a designated lead agency.

7. Funds appropriated for the Guardianship Assistance Program established under s. 39.6225.

(b) "Operational and fixed costs" means:

1. Administrative expenditures, including, but not limited to, information technology and human resources functions.

2. Lease payments.

3. Asset depreciation.

4. Utilities.

5. Administrative components of case management.

6. Mandated activities such as training, quality improvement, or contract management.

(2) The department shall develop, in collaboration with lead agencies and providers of child welfare services, a funding methodology for allocating core services funding to lead agencies which, at a minimum:

(a) Is actuarially sound.

(b) Is reimbursement based.

(c) Is designed to incentivize efficient and effective lead agency operation, prevention, family preservation, and permanency.

(d) Considers variable costs, including, but not limited to, direct costs for in-home and out-of-home care for children

served by the lead agencies, prevention services, and operational and fixed costs.

(e) Is scaled regionally for cost-of-living factors.

(3) The lead agencies and providers shall submit any detailed cost and expenditure data that the department requests for the development of the funding methodology.

(4) The department shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2024, which, at a minimum:

(a) Describes a proposed funding methodology and formula that will provide for the annual budget of each lead agency, including, but not limited to, how the proposed methodology will meet the criteria in subsection (2).

(b) Describes the data used to develop the methodology, and the data that will be used to annually calculate the proposed lead agency budget.

(c) Specifies proposed rates and total allocations for each lead agency. The allocations shall ensure that the total of all amounts allocated to lead agencies under the funding methodology does not exceed the total amount appropriated to lead agencies in the General Appropriations Act in the 2024-2025 fiscal year.

(d) Provides risk mitigation recommendations that ensure that lead agencies do not experience a reduction in funding that

would be detrimental to operations or result in a reduction in services to children.

(5) By October 31 of each year, beginning in 2025, the department shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which includes recommendations for adjustments to the funding methodology for the next fiscal year, using the criteria in subsection (2) and basing the recommendations on, at a minimum, updated expenditure data, cost-of-living adjustments, market dynamics, or other catchment area variations. The total of all amounts proposed for allocation to lead agencies under the funding methodology for the next fiscal year may not exceed the total amount appropriated for core services funding in the current fiscal year's General Appropriations Act. The funding methodology must include risk mitigation strategies that ensure that no lead agency experiences a reduction in funding that would be detrimental to operations or result in a reduction in services to children.

(6)(a) The requirements of this section do not replace, and must be in addition to, any requirements of chapter 216, including, but not limited to, submission of final legislative budget requests by the department under s. 216.023.

(b) The data and reports required under subsections (4) and (5) may also include proposed rates and total allocations for each lead agency which reflect any additional core services

funding for lead agencies which is requested by the department under s. 216.023.

(7)(a) Beginning with the 2025-2026 fiscal year, the Legislature shall allocate funding to lead agencies through the General Appropriations Act with due consideration of the funding methodology developed under this section.

(b) The department may not change the allocation of funds to a lead agency as provided in the General Appropriations Act without legislative approval. The department may approve additional risk pool funding for a lead agency as provided under s. 409.990.

(8) The department shall provide to the Governor, the President of the Senate, and the Speaker of the House of Representatives monthly reports from July through October 2024 which provide updates on activities and progress in developing the funding methodology.

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

Remove lines 23-28 and insert:

providing definitions; requiring the department, in collaboration with lead agencies and providers of child welfare services, to develop a funding methodology for allocating certain funding to lead agencies; providing requirements for the methodology;

providing reporting requirements; providing construction; providing duties for the Legislature relating to funding for lead agencies; prohibiting the department from changing allocations of funds to lead agencies without legislative approval; authorizing the department to approve certain risk pool funding for lead agencies; amending

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1313 Clinical Laboratory Personnel
SPONSOR(S): Chamberlin
TIED BILLS: **IDEN./SIM. BILLS:** SB 1108

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	14 Y, 0 N	Guzzo	McElroy
2) Health Care Appropriations Subcommittee		Aderibigbe	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The federal Centers for Medicare and Medicaid Services (CMS), within the United States Department of Health and Human Services, regulates all laboratory testing performed on humans in the United States through the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

The Board of Clinical Laboratory Personnel (Board) within the Department of Health (DOH) oversees the licensure and regulation of clinical laboratory personnel, including directors, supervisors, technologists, technicians, and public health personnel. Licensure requirements for clinical laboratory personnel generally include passage of an exam designated by the Board, completion of a medical technology training program, and completion of applicable education requirements.

All applicants for licensure as a technologist must satisfy the CLIA training and education requirements for High Complexity Testing, and all applicants for licensure as a technician must satisfy the CLIA training and education requirements for Moderate Complexity Testing. In addition, Florida law requires an applicant for licensure as a technologist or technician to comply with additional education and training requirements for each specialty category of licensure.

The bill requires applicants for licensure to perform high or moderate complexity testing as a clinical laboratory technician or technologist to comply only with the federal CLIA education and training requirements. As a result, such applicants will not be required to also comply with the education and training requirements for specialty categories of technician and technologist licensure.

The bill repeals s. 483.811, which authorizes the Board of Clinical Laboratory Personnel to approve clinical laboratory personnel training programs. Training programs will be approved by accrediting organizations authorized under the CLIA. To conform with this change, the bill also removes authority for DOH to conduct exams, register trainers, and approve curriculum in schools and colleges, and removes authority for DOH to collect fees for exams and training programs

The bill has no fiscal impact on state or local government.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Clinical Laboratory Personnel

A clinical laboratory is a facility in which human specimen is tested to provide information or materials for use in the diagnosis, prevention, or treatment of a disease or the identification or assessment of a medical or physical condition.[1] Services performed in clinical labs include the examination of:[2]

- Fluids or other materials taken from the human body;
- Tissue taken from the human body; and
- Cells from individual tissues or fluid taken from the human body.

The Board of Clinical Laboratory Personnel (Board) within the Department of Health (DOH) oversees the licensure and regulation of clinical laboratory personnel, including directors, supervisors, technologists, and technicians.[3] Licensure requirements for clinical laboratory personnel include completion of a medical technology training program,[4] completion of applicable education requirements, and passage of an exam designated by the Board.[5] The Board is authorized to collect fees for initial licensure, licensure renewal, examinations and reexaminations, and providers of laboratory training programs and for trainees of laboratory training programs.[6]

The Board is responsible for approving clinical laboratory training programs in hospitals or clinical laboratories.[7] Any person who completes a training program must also pass an examination provided by DOH.[8]

The federal Centers for Medicare & Medicaid Services (CMS), within the United States Department of Health and Human Services, regulates all laboratory testing performed on humans in the United States through the Clinical Laboratory Improvement Amendments of 1988 (CLIA).[9] The CLIA define a clinical laboratory as any facility that examines materials derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings. Any facility that meets this definition must have the

[1] S. 483.803(2), F.S.
[2] *Id.*
[3] S. 483.805, F.S.
[4] S. 483.111, F.S., and rule 64B3-3.001, F.A.C., authorize the Board to approve clinical laboratory training programs and requires approved training programs to: designate space and laboratory equipment for proper training of students; maintain a file on each student which contains a completed application, evidence of high school graduation or completion of college courses, attendance records, grades, instructor evaluations of laboratory practice, the trainee's registration, and a copy of the student's certificate of completion or official transcript; maintain current examinations and laboratory evaluation instruments utilized by the program; provide students with a certificate or letter of graduation or a transcript indicating the degree granted. Certificates or letters of graduation must be signed by the program director; include instruction in human immunodeficiency virus and acquired immunodeficiency syndrome; include instruction on the prevention of medical errors, which shall include root-cause analysis, error reduction and prevention, and patient safety; include course objectives, course descriptions, course outlines, assessment of outcomes, student evaluations, and graduate evaluations in the curriculum; utilize educational resources for teaching the affective, cognitive, and psychomotor domains; employ systematic procedures for assessing learning outcomes in the affective, cognitive, and psychomotor domains; have a practicum in a clinical laboratory where current laboratory procedures, instrumentation, and diversity of specimens are available for a variety of analyses and are in sufficient quantity to provide competent training; and include instruction on Florida laws and rules governing clinical laboratories and clinical laboratory personnel.
[5] S. 483.809, F.S.
[6] S. 483.807, F.S.
[7] S. 483.811(4), F.S.
[8] *Id.*
[9] 42 C.F.R. § 493.

appropriate CLIA certificate to perform laboratory tests. If a facility is only collecting specimens, a CLIA certificate is not required.

Current Florida Law requires applicants for licensure as clinical laboratory personnel to comply with CLIA education and training standards.

Technologists

Clinical laboratory technologists may perform high complexity medical laboratory tests on patient samples including blood, urine, and tissue. Technologists may also interpret clinical laboratory test results.[10] The specialist categories of technologist licensure include: generalist technologist (which includes the specialties of microbiology, serology/immunology, clinical chemistry, hematology, and immunohematology); blood banking specialist; cytology specialist; cytogenetics specialist; molecular pathology specialist; andrology and embryology specialists; histology specialist; and histocompatibility specialist.

All applicants for licensure as a technologist must satisfy the CLIA requirements for High Complexity Testing, which require the applicant to:[11]

- Be a licensed doctor of medicine, osteopathy, or podiatric medicine; or
- Have earned a doctoral, master's, or bachelor's degree in a chemical, physical, biological or clinical laboratory science, or medical technology from an accredited institution; or
- Have earned an associate degree in a laboratory science or medical laboratory technology from an accredited institution, or have education and training that is equivalent and includes:
    - At least 60 semester hours, or equivalent, from an accredited institution that, at a minimum, include either 24 semester hours of medical laboratory technology courses or 24 semester hours of science courses; and
    - Either completion of a clinical laboratory training program approved or accredited by the Accrediting Bureau of Health Education Schools or the Committee on Allied Health Education and Accreditation (CAHEA). Or have at least three months of documented laboratory training in each specialty in which the individual performs high complexity testing.

In addition, Florida law requires an applicant for licensure as a technologist to comply with additional education and training requirements for each specialty category of technologist licensure.[12]

Generalist Technologist License

Licensure as a generalist technologist includes the specialties of microbiology, serology/immunology, clinical chemistry, hematology, and immunohematology. The education, training, and certification requirements for licensure as a generalist technologist include the following:[13]

- A bachelor's degree in clinical laboratory, chemical, or biological science; and
- A clinical laboratory training program approved by the National Accrediting Agency for Clinical Laboratory Science (NAACLS); and
- Certification as a medical laboratory scientist (MLS) or a medical technologist (MT); and
- Pass an examination (the National Registry of Certified Chemists or the national certifying body categorical examinations in a single discipline specialty area.

Or:

[10] Rule 64B3-10.005(2), F.A.C.
[11] Rule 64B3-5.003(2), F.A.C., and 42 C.F.R. § 493.1489.
[12] Rule 64B3-5.003(3), F.A.C.
[13] Rule 64B3-5.003(3)(a), F.A.C.

- A bachelor's degree in clinical laboratory, chemical, biological science, or a bachelor's degree with 24 semester hours of academic science including six semester hours of biological sciences and six semester hours of chemical sciences; and
- A clinical laboratory training program, or three years pertinent clinical laboratory experience with a minimum of six months in each specialty for which licensure is sought; and
- Certification as a MLS or a MT; and
- Pass an examination (the National Registry of Certified Chemists or the national certifying body categorical examinations in a single discipline specialty area.

Or:

- 90 semester hours of college credit with 24 semester hours of academic science, including six semester hours of biological sciences and six semester hours of chemical sciences; and
- A clinical laboratory training program; and
- Certification as a MLS or a MT; and
- Pass a MT examination or a specialist examination in a single discipline specialty area.

Or:

- An associate degree with six semester hours academic biological sciences and six semester hours of academic chemical sciences; and
- A clinical laboratory training program; and
- Certification as a MLS or a MT; and
- Pass a MT examination and a specialist examination in a single discipline specialty area.

Or:

- An associate degree with six semester hours of academic biological sciences and six semester hours of academic chemical sciences; and
- A clinical laboratory training program offered by the Department of Defense; or
    - Five years of pertinent clinical laboratory experience with one year of experience in each specialty area for which licensure is sought; and
- Pass a MT examination and a specialist examination in a single discipline specialty area.

Blood Banking Specialist

A blood banking specialist must:[14]

- Have a bachelor's degree in clinical laboratory, or chemical or biological science; and
- Have a clinical laboratory training program approved by the NAACLS; and
- Be certified in blood banking or as a MLS, MT, or a specialist in blood banking (SBB).

Or:

- Have a bachelor's degree in medical technology with 24 semester hours of academic science, six semester hours of biological science, and six semester hours of chemical science; and
- Be trained as required by the applicable certifying body; and
- Be certified in blood banking or as a MLS, MT, or a SBB.

Or:

[14] Rule 64B3-5.003(3)(b), F.A.C.

- Have a bachelor's degree in clinical laboratory, or chemical or biological science, or a bachelors degree with 24 semester hours of academic science, six semester hours of biological science, and six semester hours of chemical science; and
- Have three years of pertinent clinical laboratory experience; or
    - A clinical laboratory training program; and
- Be certified in blood banking or as a MLS, MT, or a SBB.

Cytology Specialist

A cytology specialist must meet the education and training requirements of the American Society for Clinical Pathology (ASCP).[15]

Cytogenetics Specialist

A cytogenetics specialist must have a bachelor's degree with 30 hours of academic science and complete a board approved training program in cytogenetics at the technologist level or one year of pertinent clinical laboratory experience in cytogenetics. They must also be certified by the ASCP.[16]

Molecular Pathology Specialist

A molecular pathology specialist must:[17]

- Have a bachelor's degree with 16 semester hours of academic science; and
- Complete training as required by the applicable certifying body; and
- Be certified by the ASCP, the American Association of Bioanalysts, the American Board of Histocompatibility and Immunogenetics, or the American Medical Technologists.

Or:

- Meet education standards as required by the applicable certifying body; and
- Have one year of pertinent clinical laboratory experience in molecular pathology; and
- Be certified by the ASCP, the American Association of Bioanalysts (AAB), the American Board of Histocompatibility and Immunogenetics, or the American Medical Technologists.

Andrology and Embryology Specialists

Andrology and embryology specialists must:[18]

- Have a bachelor's degree with 24 semester hours of academic science, six semester hours of academic biological science, and six semester hours of academic chemical science; and
- Complete training as required by the AAB; and
- Be certified by the AAB; and
- Pass the AAB examination.

Or:

- Have an associate degree with six semester hours of academic biological science and six semester hours of academic chemical science; and
- Complete training as required by the AAB; and
- Be certified by the AAB; and

[15] Rule 64B3-5.003(3)(c), F.A.C.
[16] Rule 64B3-5.003(3)(d), F.A.C.
[17] Rule 64B3-5.003(3)(e), F.A.C.
[18] Rule 64B3-5.003(3)(f), F.A.C.

- Pass the AAB examination.

Histology Specialist

A histology specialist must:[19]

- Have an associate degree; and
- Complete a histotechnology training program approved by the NAACLS; and
- Be certified by the ASCP.

Or:

- Meet education standards as required by the ASCP; and
- Complete training as required by the ASCP; and
- Be certified by the ASCP.

Or:

- Have 60 semester hours with 12 hours of chemical or biological science; and
- Complete a board approved training program; and
- Be certified by the ASCP.

Or:

- Meet education standards as required by the ASCP; and
- Have three years of pertinent experience as a Florida licensed histology technician or equivalent; and
- Be certified by the ASCP.

Or:

- Meet education standards a required by the ASCP; and
- Have five years of pertinent experience and 48 contact hours of continuing education in immunohistochemistry or advanced histologic techniques; and
- Be certified by the ASCP.

Or:

- Meet education standards as required by the ASCP; and
- Have five years of pertinent experience, 48 contact hours of continuing education in immunohistochemistry or advanced histologic techniques, and be a Florida licensed technician in the specialty of histology.

Histocompatibility Specialist

A histocompatibility specialist must be certified by the American Board of Histocompatibility and Immunogenetics (ABHI). To become certified, they must meet the education and training/experience standards of the ABHI.[20]

[19] Rule 64B3-5.003(3)(g), F.A.C.
[20] Rule 64B3-5.003(3)(h), F.A.C.

Technicians

Clinical laboratory technicians are similar to technologists but they are not authorized to interpret clinical laboratory test results and may only perform moderate complexity tests, unless they meet the minimum qualifications for high complexity testing. Such a technician may perform high complexity testing only when under the direct supervision of a licensed technologist or the supervisor or director of the clinical laboratory.[21]

The specialist categories of technician licensure include: generalist technician (which includes the specialties of microbiology, serology/immunology, clinical chemistry, hematology, and immunohematology); histology specialist; andrology and embryology specialists; and molecular pathology specialist.

All applicants for licensure as a technician must satisfy the CLIA requirements for Moderate Complexity Testing, which require the applicant to:[22]

- Be a licensed doctor of medicine, osteopathy, or podiatric medicine; or
- Have earned a doctoral, master's, or bachelor's degree in a chemical, physical, biological or clinical laboratory science, or medical technology from an accredited institution;
- Have earned an associate degree in a chemical, physical, or biological science or medical laboratory technology from an accredited institution; or
- Be a high school graduate or equivalent and have successfully completed an official military medical laboratory procedures course of at least 50 weeks, and have held the military enlisted occupational specialty of medical laboratory specialist; or
- Be a high school graduate or equivalent; and
    - Have documentation of training appropriate for the testing performed prior to analyzing patient specimens.[23]

In addition, Florida law requires an applicant for licensure as a technician to comply with additional education and training requirements for each specialty category of technician licensure.[24]

Generalist Technician Licensure

Licensure as a generalist technician includes the specialties of microbiology, serology/immunology, clinical chemistry, hematology, and immunohematology. The education, training, and certification requirements for licensure as a generalist technician include the following:[25]

- Have a bachelor's degree; and
- Have three years of pertinent clinical laboratory experience within the ten years immediately preceding application for licensure; and
- Be certified by the ASCP, the American Medical Technologists (AMT), or the AAB.

Or:

[21] Rule 64B3-13.004, F.A.C.
[22] Rule 64B3-5.004(2), F.A.C., and 42 C.F.R. § 493.1423.
[23] 42 C.F.R. § 493.1423. Such training must ensure that the individual has: the skills required for proper specimen collection, including patient preparation and labeling, handling, preservation, preparation, transportation, and storage of specimens; the skills required for implementing all standard laboratory procedures; the skills required for performing each test method and for proper instrument use; the sills required for performing preventive maintenance, troubleshooting and calibration procedures related to each test performed; the skills required to implement the quality control policies and procedures of the laboratory; the skills required to assess and verify the validity of patient test results through the evaluation of quality control sample values prior to reporting patient test results; a working knowledge of reagent stability and storage; and an awareness of the factors that influence test results.
[24] Rule 64B3-5.004(3), F.A.C.
[25] Rule 64B3-5.004(3)(a), F.A.C.

- Have an associate degree; and
- Have four years of pertinent clinical laboratory experience within the ten years immediately preceding application for licensure; and
- Be certified by the ASCP, the AMT, or the AAB.

Or:

- Meet education standards as required by the ASCP, the AMT or the AAB; and
- Complete an approved clinical/medical laboratory training program or have five years of pertinent clinical laboratory experience within the ten years immediately preceding application for licensure; and
- Be certified by the ASCP, the AMT, or the AAB.

Histology Specialist

A histology specialist must be certified by the ASCP. To become certified, they must meet the education and training/experience standards of the ASCP.[26]

Andrology and Embryology Specialists

Andrology and embryology specialists must:[27]

- Have a bachelor's degree; and
- Have six months of pertinent clinical laboratory experience; and
- Be certified by the AAB.

Or:

- Have an associate degree; and
- Have five years of pertinent clinical laboratory experience; and
- Be certified by the AAB.

Or:

- Meet education standards as required by the AAB;
- Complete an approved clinical/medical laboratory training program; and
- Be certified by the AAB.

Molecular Pathology Specialist

Molecular pathology specialists must:[28]

- Have a high school diploma; and
- Be a licensed clinical laboratory technologist or technician in any specialty area; and
- Pass the molecular diagnostics examination; and
- Be certified by the AAB.

[26] Rule 64B3-5.004(3)(b), F.A.C.
[27] Rule 64B3-5.004(3)(c), F.A.C.
[28] Rule 64B3-5.004(3)(d), F.A.C.

Effect of the Bill

The bill requires applicants for licensure to perform high or moderate complexity testing as a clinical laboratory technician or technologist to comply only with the federal CLIA education and training requirements. As a result, such applicants will not be required to also comply with the education and training requirements for specialty categories of technician and technologist licensure.

The bill repeals s. 483.811, which authorizes the Board of Clinical Laboratory Personnel to approve clinical laboratory personnel training programs. Training programs will be approved by accrediting organizations authorized under the CLIA. To conform with this change, the bill also removes authority for DOH to conduct exams, register trainers, and approve curriculum in schools and colleges, and removes authority for DOH to collect fees for exams and training programs

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

B. SECTION DIRECTORY:

Section 1: Amends s. 483.809, F.S., relating to licensure; examinations; registration of trainees; approval of curricula.
Section 2: Repeals s. 483.811, F.S., relating to approval of laboratory personnel training programs.
Section 3: Amends s. 483.823, F.S., relating to qualifications of clinical laboratory personnel.
Section 4: Amends s. 483.800, F.S., relating to declaration of policy and statement of purpose.
Section 5: Amends s. 483.803, F.S., relating to definitions.
Section 6: Amends s. 483.807, F.S., relating to fees; establishment; disposition.
Section 7: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See fiscal comments.

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:

The bill has no fiscal impact on DOH. The reduction in revenue from the non-collection of fees for exams and training programs will be offset by a reduction in workload for DOH because they will no longer be required to conduct exams, register trainers, or approve curricula.

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 necessitate rule-making.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to clinical laboratory personnel; amending s. 483.809, F.S.; deleting requirements that the Department of Health conduct examinations for clinical laboratory personnel licensure and register clinical laboratory trainees; deleting the requirement that the Board of Clinical Laboratory Personnel approve training curricula for licensure of clinical laboratory personnel; repealing s. 483.811, F.S., relating to approval of laboratory personnel training programs; amending s. 483.823, F.S.; requiring that applicants for licensure as a technologist or technician who meet specified criteria be deemed to have satisfied minimum qualifications for licensure, as applicable; amending ss. 483.800, 483.803, and 483.807, F.S.; conforming provisions to changes made by the act; making technical changes; providing an effective date.

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

Section 1. Section 483.809, Florida Statutes, is amended to read:

483.809 Licensure~~; examinations; registration of trainees; approval of curricula~~.—

~~(1) LICENSING.—~~The department shall provide biennial licensure of all clinical laboratory personnel who the board certifies have met the requirements of this part. The license of any person who fails to pay a required fee or otherwise fails to qualify within 60 days after the date of expiration of such license shall be automatically canceled without notice or further proceedings unless the individual has made application for inactive status pursuant to s. 483.819.

~~(2) EXAMINATIONS.—The department shall conduct examinations required by board rules to determine in part the qualification of clinical laboratory personnel for licensure. The board by rule may designate a national certification examination that may be accepted in lieu of state examination for clinical laboratory personnel or public health scientists.~~

~~(3) REGISTRATION OF TRAINEES.—The department shall provide for registration of clinical laboratory trainees who are enrolled in a training program approved pursuant to s. 483.811, which registration may not be renewed except upon special authorization of the board.~~

~~(4) APPROVAL OF CURRICULUM IN SCHOOLS AND COLLEGES.—The board may approve the curriculum in schools and colleges offering education and training leading toward qualification for licensure under this part.~~

Section 2. Section 483.811, Florida Statutes, is repealed.

Section 3. Subsections (3) and (4) are added to section

483.823, Florida Statutes, to read:

483.823 Qualifications of clinical laboratory personnel.—

(3) Except as otherwise provided in s. 483.812, a technologist or technician applicant for licensure who satisfies the requirements in 42 C.F.R. s. 493.1489 to perform high complexity testing is deemed to have satisfied the minimum qualifications for licensure under this part to perform high complexity testing as a technologist or technician in this state.

(4) Except as otherwise provided in s. 483.812, a technician applicant for licensure who satisfies the requirements in 42 C.F.R. s. 493.1423 to perform moderate complexity testing is deemed to have satisfied the minimum qualifications for licensure under this part to perform moderate complexity testing as a technician in this state.

Section 4. Section 483.800, Florida Statutes, is amended to read:

483.800 Declaration of policy and statement of purpose.—The purpose of this part is to protect the public health, safety, and welfare of the people of this state from the hazards of improper performance by clinical laboratory personnel. Clinical laboratories provide essential services to practitioners of the healing arts by furnishing vital information that is essential to a determination of the nature, cause, and extent of the condition involved. Unreliable and

inaccurate reports may cause unnecessary anxiety, suffering, and financial burdens and may even contribute directly to death. The protection of public and individual health requires the licensure of clinical laboratory personnel who meet minimum requirements for safe practice. ~~The Legislature finds that laboratory testing technology continues to advance rapidly. The Legislature also finds that a hospital training program under the direction of the hospital clinical laboratory director offers an opportunity for individuals already trained in health care professions to expand the scope of their careers. The Legislature further finds that there is an immediate need for properly trained personnel to ensure patient access to testing. Therefore, the Legislature recognizes the patient-focused benefits of hospital-based training for laboratory and nonlaboratory personnel for testing within hospitals and commercial laboratories and recognizes the benefits of a training program approved by the Board of Clinical Laboratory Personnel under the direction of the hospital clinical laboratory director.~~

Section 5. Subsection (5) of section 483.803, Florida Statutes, is amended to read:

483.803 Definitions.—As used in this part, the term:

(5) "Clinical laboratory trainee" means any person having qualifying education who is enrolled in a clinical laboratory training program ~~approved pursuant to s. 483.811~~ and ~~who~~ is

seeking experience required to meet minimum qualifications for licensing in this state. Trainees may perform procedures under direct and responsible supervision of duly licensed clinical laboratory personnel, but they may not report test results.

Section 6. Subsections (1), (3), (8), and (9) of section 483.807, Florida Statutes, are amended to read:

483.807 Fees; establishment; disposition.—

(1) The board shall establish~~,~~ by rule~~, shall establish~~ fees to be paid for application, ~~examination, reexamination,~~ licensing and renewal, ~~registration, laboratory training program application,~~ reinstatement, and recordmaking and recordkeeping. The board may also establish~~,~~ by rule~~,~~ a delinquency fee. The board shall establish fees that are adequate to ensure the continued operation of the board and to fund the proportionate expenses incurred by the department in carrying out its licensure and other related responsibilities under this part. Fees must ~~shall~~ be based on departmental estimates of the revenue required to implement this part and the provisions of law with respect to the regulation of clinical laboratory personnel.

~~(3) The examination fee shall be in an amount which covers the costs of obtaining and administering the examination and shall be refunded if the applicant is found ineligible to sit for the examination. The combined fees for initial application and examination may not exceed $200 plus the actual per~~

~~applicant cost to the department for developing, administering, or procuring the licensure examination.~~

~~(8) The initial application fee for registration of a trainee shall not exceed $20.~~

~~(9) The initial application and renewal fee for approval as a laboratory training program may not exceed $300. The fee for late filing of a renewal application shall be $50.~~

Section 7. This act shall take effect July 1, 2024.