Healthcare Regulation Subcommittee

Thursday, January 11, 2024
11:00 AM
Reed Hall (102 HOB)

Meeting Packet

Paul Renner
Speaker

Michelle Salzman
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Healthcare Regulation Subcommittee

Start Date and Time:	Thursday, January 11, 2024 11:00 am
End Date and Time:	Thursday, January 11, 2024 01:00 pm
Location:	Reed Hall (102 HOB)
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 415 Pregnancy and Parenting Resources Website by Jacques
HB 775 Surrendered Infants by Canady
HB 1501 Health Care Innovation by Gonzalez Pittman

Pursuant to rule 7.11, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m. Wednesday, January 10, 2024.

By request of the Chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Wednesday, January 10, 2024.

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

NOTICE FINALIZED on 01/09/2024 3:37PM by Arnold.Sabrina

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

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

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee		Clenord	McElroy
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

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

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

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

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

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

In 2022, there were 224,611 recorded births in Florida.[1] The transition to parenthood is an overwhelming life event with more than half of parents' report feeling inadequately prepared.[2] Florida provides a variety of resources, private and public, that can help expectant families and new parents to assist with this transition. The Department of Health (DOH), Department of Children and Families (DCF) and Agency for Health Care Administration (AHCA) provide information related to pregnancy and parenting resources on their respective websites. Florida does not currently have a comprehensive state website containing information related to available public and private pregnancy and parenting resources.

Department of Health

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

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

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

Department of Children and Families

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

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

Agency for Health Care Administration

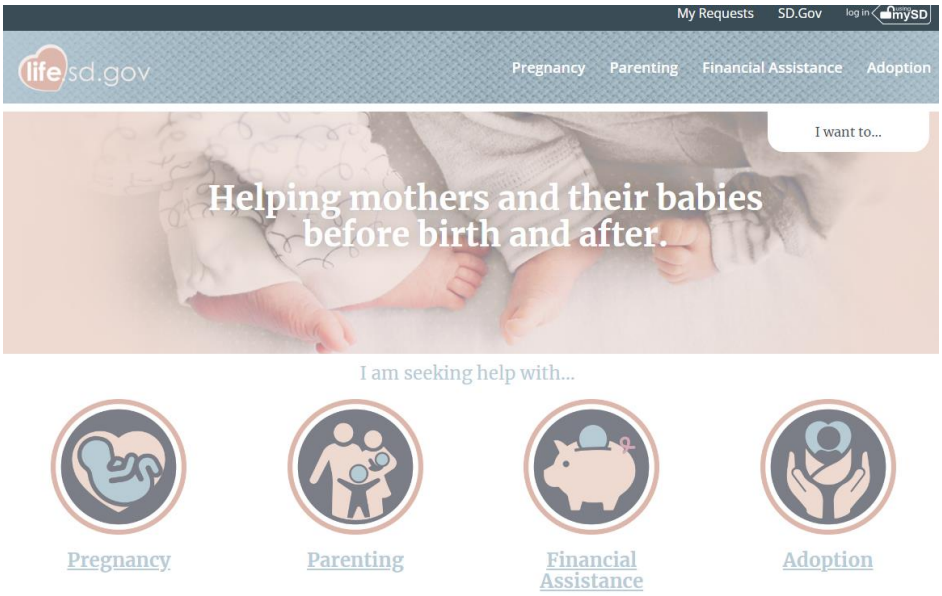
AHCA is the chief health policy and planning entity for the state and is responsible for implementation of the Medicaid program.[6] AHCA's website provides resources on the Medicaid program, including reproductive services available to Medicaid recipients. This includes a list of the procedures Medicaid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

States with Comprehensive Pregnancy and Parenting Resource Websites

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

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

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



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

Comprehensive websites make it easier for expectant and new families to obtain information on all available resources.

Effect of the Bill

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

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

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

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

B. SECTION DIRECTORY:

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

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH estimates the total cost to comply with the bill is $466,200 ($97,000 recurring, $369,200 nonrecurring).[11]

Service	Cost
URL Domain Name	$300 Recurring
Advance Web Designer	$87,300 Recurring / $174,600 Non-Recurring
Project Management	$194,000 Non-Recurring
IT Support	$10,000 Recurring

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

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

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:

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

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

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

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

383.0131 Pregnancy and parenting resources website.—

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

(a) Educational materials on pregnancy and parenting.

(b) Maternal health services.

(c) Prenatal and postnatal services.

(d) Educational and mentorship programs for fathers.

(e) Social services.

(f) Financial assistance.

(g) Adoption services.

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

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

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

HB 775

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 775 Surrendered Infants
SPONSOR(S): Canady
TIED BILLS: **IDEN./SIM. BILLS:** SB 790

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee		Clenord	McElroy
2) Health & Human Services Committee			

SUMMARY ANALYSIS

Florida law allows parents who are unwilling or unable to care for their newborn infants to safely relinquish them at hospitals, fire stations, and emergency medical services stations. This 'safe haven law' currently allows parents to anonymously surrender newborn infants up to 7 days old and grants the parents immunity from criminal prosecution unless there is actual or suspected child abuse or neglect.

HB 775 increases the age that an infant may be surrendered from 7 days old to 30 days old, preventing unsafe abandonment by allowing more time for parents to decide whether to surrender a child.

The bill authorizes a parent, after delivery of a newborn infant in a hospital, to leave the infant with hospital medical staff. The parent of the newborn must notify the staff that the parent is voluntarily surrendering the infant and does not intend to return. The bill also authorizes a parent to call 911 and request that an emergency medical services provider meet the surrendering parent at a specified location.

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

Safe Haven Laws

Safe haven laws allow parents or agents of parents to safely relinquish babies at designated locations while remaining anonymous, and confer immunity from criminal liability and prosecution for child endangerment, abandonment or neglect.[1] The purpose of safe haven laws is to ensure that abandoned infants are left with those who can provide immediate care necessary for the children's safety and well-being.[2]

In 1999, Texas was the first state to enact safe haven legislation.[3] Today, all 50 states, the District of Columbia, and Puerto Rico have variations of safe haven laws which designate the places or personnel authorized to accept an infant.[4]

Policy choices vary among the states. For example, thirty-five states and the District of Columbia expressly allow the person relinquishing an infant to remain anonymous.[5] Eight states and Puerto Rico[6] require infants be 72 hours old or younger to be relinquished at a designate safe haven,[7] while 19 states include infants up to 30 days old.[8] The District of Columbia and 46 states authorize health care providers, such as hospitals or health clinic employees, to accept an infant, and 43 states authorize emergency services personnel, including emergency medical technicians, firefighters and law enforcement officers, to accept an infant or allow relinquishment through the 911 emergency system.[9]

Florida Safe Haven Law

In 2000, Florida enacted safe haven legislation in response to tragedies[10] concerning newborn abandonment at unsafe locations, such as public restrooms or trash receptacles.[11] Current law authorizes parents to surrender a newborn infant up to 7 days old at a hospital, fire station, or emergency medical service station.

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[1] *Infant Safe Haven Laws*, Child Welfare Information Gateway (Sept. 2021), https://cwig-prod-prod-drupal-s3fs-us-east-1.s3.amazonaws.com/public/documents/safehaven.pdf?VersionId=G0IedWIFvcvxOELUST1S5_SUTWdYSclB, (last visited Jan. 3, 2024).
[2] *Id.*
[3] NY Legislative Counsel Bureau, *A Study of Infant Abandonment Legislation*, https://www.leg.state.nv.us/Division/Research/Publications/Bkground/BP01-03.pdf (last visited Jan. 3, 2024).
[4] *supra* note 1
[5] Infant Abandonment, Guttmacher Institute (Sep. 2023), https://www.guttmacher.org/state-policy/explore/infant-abandonment (last visited Jan. 3, 2024)
[6] *supra* note 1
[7] *supra* note 5
[8] *Id.* This data is as of 2023.
[9] *Id.*
[10] The Orlando Sentinel, "*Teen Mom Charged with Attempted Murder*," March 9, 2000, https://www.orlandosentinel.com/news/os-xpm-2000-03-09-0003090076-story.html, (last visited Jan. 3, 2024), *See also*, Meyer , C. L., Oberman , M., White , K., Rone , M., Batra , P., & Proano , T. C. (2001). *Mothers Who Kill Their Children: Understanding the Acts of Moms from Susan Smith to the "Prom Mom"*. New York: New York University Press.
[11] S. 383.50, F.S.

Since 2000, approximately 379 newborns have been surrendered at a safe haven in Florida.[12] In that time, 63 infants are known to have been unsafely abandoned, of which 31 survived and 32 died. [13]

Procedures and Protections for Surrendered Newborn Infants and Parents

The Florida safe haven law outlines procedures and protections concerning what happens after a baby is surrendered. If the parent surrenders a newborn infant born in a hospital, the hospital registrars must complete the infant's birth certificate without naming the mother, if she requests it and expresses an intent to leave without the infant and not return.[14]

The law requires hospitals, fire stations, and emergency medical services stations that are staffed with full-time firefighters or emergency medical technicians to accept any newborn infant left with a firefighter or emergency medical technician so that the newborn infant can receive any necessary immediate medical treatment, including transport to a hospital, if necessary.[15] The law holds emergency medical technicians, paramedics, and fire department staff accountable for criminal and civil liability for treatment and custody of a surrendered newborn infant, except in situations where the individual has acted in good faith concerning the surrendered infant.[16]

The law expressly grants parents surrendering a newborn infant the right to anonymity and to not be pursued, unless the parent seeks to reclaim the infant. The law also grants surrendering parents immunity from criminal prosecution unless there is actual or suspected abuse or neglect of the infant.

Current law creates a presumption that the parent consents to the termination of their parental rights[17] and to transport and medical treatment for the child.[18] A court may not terminate parental rights solely on the basis that the parent left the infant at a hospital, emergency medical services station, or fire station in accordance with Florida's safe haven provisions.[19]

Florida law also has procedures outlining the process for parents to seek to either claim or reclaim a surrendered newborn infant.[20] A parent who leaves a newborn infant at a hospital, emergency medical services station, or fire station under this section may claim his or her newborn infant up until the court enters a judgment terminating his or her parental rights, and a petition for termination of parental rights may not be filed until 30 days after the date the infant was surrendered.[21]

Current law[22] requires DOH to work in conjunction with the Department of Children and Families to prevent the unsafe abandonment of newborns through a media campaign,[23] funded by a $300,000 appropriation of recurring General Revenue.[24]

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[12] A Safe Haven for Newborns, *Safe Haven Statistics*, https://asafehavenfornewborns.com/what-we-do/safe-haven-statistics/ (last visited Jan 3, 2023).
[13] *Id.*
[14] *Id*.
[15] S. 383.50, F.S.
[16] S. 383.50(3), F.S.
[17] S. 63.0423, F.S.
[18] S. 383.50, F.S.
[19] *Id.*
[20] S. 63.0423, F.S.
[21] *Id.*
[22] S. 7, Ch. 2000-188, Laws of Fla.
[23] A Safe Haven for Newborns, *Public Awareness*, https://asafehavenfornewborns.com/what-we-do/public-awareness-2/, (last visited Jan. 3, 2024).
[24] Fiscal Year 2023-2024, HB 5001, *General Appropriations Act*, line 542, http://leagis:8080/sites/2022-2024/2023/Public/Bills/5000-5099/5001/Orig_GAA.pdf, (last visited Jan. 3, 2024).

Effect of Proposed Changes

HB 775 amends Florida's safe haven law to increase the age limit for a parent to surrender an infant from 7 days old to 30 days old. This gives parents more time to make a decision, potentially preventing the unsafe abandonment of infants older than 7 days.

The bill authorizes a parent, after delivery of an infant in a hospital, to leave the infant with medical staff or a licensed health care professional. The parent of the infant must notify the medical staff or a licensed health care professional that the parent is voluntarily surrendering the infant and does not intend to return.

The bill also authorizes a parent to call 911 and request that an emergency medical services provider meet the surrendering parent at a specified location. The bill requires the surrendering parent to stay with the infant until the medical services provider arrives to take custody of the infant.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 383.50, F.S., relating to treatment of surrendered newborn infant.
Section 2: Amends s. 39.01, F.S., relating to definitions.
Section 3: Amends s. 39.201, F.S., relating to required reports of child abuse, abandonment, or neglect, sexual abuse of a child, and juvenile sexual abuse; required reports of death; reports involving a child who has exhibited inappropriate sexual behavior.
Section 4: Amends s. 63.0423, F.S., relating to procedures with respect to surrendered infants.
Section 5: Amends s. 63.167, F.S., relating to state adoption information center.
Section 6: Amends s. 383.51, F.S., relating to confidentiality; identification of parent leaving newborn infant at hospital, emergency medical services station, or fire station.
Section 7: Amends s. 827.035, F.S., relating to newborn infants.
Section 8: Amends s. 827.10, F.S., relating to unlawful desertion of a child.
Section 9: 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:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill does not require the implementation of rules.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to surrendered infants; amending s. 383.50, F.S.; changing the term "newborn infant" to "infant"; increasing the age at which a child is considered an infant; authorizing a parent to leave an infant with medical staff or a licensed health care professional at a hospital after the delivery of the infant, upon the parent giving a certain notification; authorizing a parent to surrender an infant by calling 911 to request that an emergency medical services provider meet the surrendering parent at a specified location; requiring the surrendering parent to stay with the infant until the emergency medical services provider arrives to take custody of the infant; amending ss. 39.01, 39.201, 63.0423, 63.167, 383.51, 827.035, and 827.10, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Section 383.50, Florida Statutes, is amended to read:

383.50 Treatment of surrendered ~~newborn~~ infant.—

(1) As used in this section, the term "~~newborn~~ infant" means a child who a licensed physician reasonably believes is

approximately 30 ~~7~~ days old or younger at the time the child is left at a hospital, an emergency medical services station, or a fire station.

(2) There is a presumption that the parent who leaves the ~~newborn~~ infant in accordance with this section intended to leave the ~~newborn~~ infant and consented to termination of parental rights.

(3) Each emergency medical services station or fire station that is staffed with full-time firefighters, emergency medical technicians, or paramedics shall accept any ~~newborn~~ infant left with a firefighter, an emergency medical technician, or a paramedic. The firefighter, emergency medical technician, or paramedic shall consider these actions as implied consent to and shall:

(a) Provide emergency medical services to the ~~newborn~~ infant to the extent that he or she is trained to provide those services;~~,~~ and

(b) Arrange for the immediate transportation of the ~~newborn~~ infant to the nearest hospital having emergency services.

A licensee as defined in s. 401.23, a fire department, or an employee or agent of a licensee or fire department may treat and transport an ~~a newborn~~ infant pursuant to this section. If an ~~a newborn~~ infant is placed in the physical custody of an employee

or agent of a licensee or fire department, such placement is ~~shall be~~ considered implied consent for treatment and transport. A licensee, a fire department, or an employee or agent of a licensee or fire department is immune from criminal or civil liability for acting in good faith pursuant to this section. ~~Nothing in~~ This subsection does not limit ~~limits~~ liability for negligence.

(4)(a) After the delivery of an infant in a hospital, a parent of the infant may leave the infant with medical staff or a licensed health care professional at the hospital if the parent notifies such medical staff or licensed health care professional that the parent is voluntarily surrendering the infant and does not intend to return.

(b) Each hospital of this state subject to s. 395.1041 shall, and any other hospital may, admit and provide all necessary emergency services and care, as defined in s. 395.002(9), to any ~~newborn~~ infant left with the hospital in accordance with this section. The hospital or any of its medical staff or licensed health care professionals shall consider these actions as implied consent for treatment, and a hospital accepting physical custody of an ~~a newborn~~ infant has implied consent to perform all necessary emergency services and care. The hospital or any of its medical staff or licensed health care professionals are ~~is~~ immune from criminal or civil liability for acting in good faith in accordance with this section. ~~Nothing in~~

This subsection does not limit ~~limits~~ liability for negligence.

(5) Except when there is actual or suspected child abuse or neglect, any parent who leaves an ~~a newborn~~ infant with a firefighter, an emergency medical technician, or a paramedic at a fire station or an emergency medical services station, or brings an ~~a newborn~~ infant to an emergency room of a hospital and expresses an intent to leave the ~~newborn~~ infant and not return, has the absolute right to remain anonymous and to leave at any time and may not be pursued or followed unless the parent seeks to reclaim the ~~newborn~~ infant. When an infant is born in a hospital and the mother expresses intent to leave the infant and not return, upon the mother's request, the hospital or registrar shall complete the infant's birth certificate without naming the mother thereon.

(6) A parent of an ~~a newborn~~ infant left at a hospital, an emergency medical services station, or a fire station under this section may claim his or her ~~newborn~~ infant up until the court enters a judgment terminating his or her parental rights. A claim to the ~~newborn~~ infant must be made to the entity having physical or legal custody of the ~~newborn~~ infant or to the circuit court before whom proceedings involving the ~~newborn~~ infant are pending.

(7) Upon admitting an ~~a newborn~~ infant under this section, the hospital shall immediately contact a local licensed child-placing agency or alternatively contact the statewide central

abuse hotline for the name of a licensed child-placing agency for purposes of transferring physical custody of the ~~newborn~~ infant. The hospital shall notify the licensed child-placing agency that an ~~a newborn~~ infant has been left with the hospital and approximately when the licensed child-placing agency can take physical custody of the infant ~~child~~. In cases where there is actual or suspected child abuse or neglect, the hospital or any of its medical staff or licensed health care professionals shall report the actual or suspected child abuse or neglect in accordance with ss. 39.201 and 395.1023 in lieu of contacting a licensed child-placing agency.

(8) An ~~Any newborn~~ infant admitted to a hospital in accordance with this section is presumed eligible for coverage under Medicaid, subject to federal rules.

(9) An ~~A newborn~~ infant left at a hospital, an emergency medical services station, or a fire station in accordance with this section may ~~shall~~ not be deemed abandoned and subject to reporting and investigation requirements under s. 39.201 unless there is actual or suspected child abuse or until the Department of Health takes physical custody of the infant ~~child~~.

(10) If the parent of an infant is unable to surrender the infant in accordance with this section, the parent may call 911 to request that an emergency medical services provider meet the surrendering parent at a specified location. The surrendering parent must stay with the infant until the emergency medical

services provider arrives to take custody of the infant.

(11) A criminal investigation may ~~shall~~ not be initiated solely because an ~~a newborn~~ infant is surrendered in accordance with ~~left at a hospital under~~ this section unless there is actual or suspected child abuse or neglect.

Section 2. Subsection (1) and paragraph (e) of subsection (34) of section 39.01, Florida Statutes, are amended to read:

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

(1) "Abandoned" or "abandonment" means a situation in which the parent or legal custodian of a child or, in the absence of a parent or legal custodian, the caregiver, while being able, has made no significant contribution to the child's care and maintenance or has failed to establish or maintain a substantial and positive relationship with the child, or both. For purposes of this subsection, "establish or maintain a substantial and positive relationship" includes, but is not limited to, frequent and regular contact with the child through frequent and regular visitation or frequent and regular communication to or with the child, and the exercise of parental rights and responsibilities. Marginal efforts and incidental or token visits or communications are not sufficient to establish or maintain a substantial and positive relationship with a child. A man's acknowledgment of paternity of the child does not limit the period of time considered in determining whether the

child was abandoned. The term does not include a surrendered ~~newborn~~ infant as described in s. 383.50, a "child in need of services" as defined in chapter 984, or a "family in need of services" as defined in chapter 984. The absence of a parent, legal custodian, or caregiver responsible for a child's welfare, who is a servicemember, by reason of deployment or anticipated deployment as defined in 50 U.S.C. s. 3938(e), may not be considered or used as a factor in determining abandonment. The incarceration, repeated incarceration, or extended incarceration of a parent, legal custodian, or caregiver responsible for a child's welfare may support a finding of abandonment.

(34) "Harm" to a child's health or welfare can occur when any person:

(e) Abandons the child. Within the context of the definition of "harm," the term "abandoned the child" or "abandonment of the child" means a situation in which the parent or legal custodian of a child or, in the absence of a parent or legal custodian, the caregiver, while being able, has made no significant contribution to the child's care and maintenance or has failed to establish or maintain a substantial and positive relationship with the child, or both. For purposes of this paragraph, "establish or maintain a substantial and positive relationship" includes, but is not limited to, frequent and regular contact with the child through frequent and regular visitation or frequent and regular communication to or with the

child, and the exercise of parental rights and responsibilities. Marginal efforts and incidental or token visits or communications are not sufficient to establish or maintain a substantial and positive relationship with a child. The term "abandoned" does not include a surrendered ~~newborn~~ infant as described in s. 383.50, a child in need of services as defined in chapter 984, or a family in need of services as defined in chapter 984. The incarceration, repeated incarceration, or extended incarceration of a parent, legal custodian, or caregiver responsible for a child's welfare may support a finding of abandonment.

Section 3. Paragraph (e) of subsection (3) of section 39.201, Florida Statutes, is amended to read:

39.201 Required reports of child abuse, abandonment, or neglect, sexual abuse of a child, and juvenile sexual abuse; required reports of death; reports involving a child who has exhibited inappropriate sexual behavior.—

(3) ADDITIONAL CIRCUMSTANCES RELATED TO REPORTS.—

(e) Surrendered ~~newborn~~ infants.—

1. The central abuse hotline must receive reports involving surrendered ~~newborn~~ infants as described in s. 383.50.

2.a. A report may not be considered a report of child abuse, abandonment, or neglect solely because the infant has been surrendered in accordance with ~~left at a hospital, emergency medical services station, or fire station under~~ s.

383.50.

b. If the report involving a surrendered ~~newborn~~ infant does not include indications of child abuse, abandonment, or neglect other than that necessarily entailed in the infant having been surrendered ~~left at a hospital, emergency medical services station, or fire station~~, the central abuse hotline must provide to the person making the report the name of an eligible licensed child-placing agency that is required to accept physical custody of and to place surrendered ~~newborn~~ infants. The department shall provide names of eligible licensed child-placing agencies on a rotating basis.

3. If the report includes indications of child abuse, abandonment, or neglect beyond that necessarily entailed in the infant having been surrendered ~~left at a hospital, emergency medical services station, or fire station~~, the report must be considered as a report of child abuse, abandonment, or neglect and, notwithstanding chapter 383, is subject to s. 39.395 and all other relevant provisions of this chapter.

Section 4. Subsections (1) and (4), paragraph (c) of subsection (7), and subsection (10) of section 63.0423, Florida Statutes, are amended to read:

63.0423 Procedures with respect to surrendered infants.—

(1) Upon entry of final judgment terminating parental rights, a licensed child-placing agency that takes physical custody of an infant surrendered in accordance with ~~at a~~

~~hospital, emergency medical services station, or fire station pursuant to~~ s. 383.50 assumes responsibility for the medical and other costs associated with the emergency services and care of the surrendered infant from the time the licensed child-placing agency takes physical custody of the surrendered infant.

(4) The parent who surrenders the infant in accordance with s. 383.50 is presumed to have consented to termination of parental rights, and express consent is not required. Except when there is actual or suspected child abuse or neglect, the licensed child-placing agency may ~~shall~~ not attempt to pursue, search for, or notify that parent as provided in s. 63.088 and chapter 49. For purposes of s. 383.50 and this section, a surrendered ~~an~~ infant who tests positive for illegal drugs, narcotic prescription drugs, alcohol, or other substances, but shows no other signs of child abuse or neglect, shall be placed in the custody of a licensed child-placing agency. Such a placement does not eliminate the reporting requirement under s. 383.50(7). When the department is contacted regarding an infant properly surrendered under this section and s. 383.50, the department shall provide instruction to contact a licensed child-placing agency and may not take custody of the infant unless reasonable efforts to contact a licensed child-placing agency to accept the infant have not been successful.

(7) If a claim of parental rights of a surrendered infant is made before the judgment to terminate parental rights is

entered, the circuit court may hold the action for termination of parental rights in abeyance for a period of time not to exceed 60 days.

(c) The court may not terminate parental rights solely on the basis that the parent surrendered ~~left~~ the infant ~~at a hospital, emergency medical services station, or fire station~~ in accordance with s. 383.50.

(10) Except to the extent expressly provided in this section, proceedings initiated by a licensed child-placing agency for the termination of parental rights and subsequent adoption of an infant surrendered ~~a newborn left at a hospital, emergency medical services station, or fire station~~ in accordance with s. 383.50 shall be conducted pursuant to this chapter.

Section 5. Paragraph (f) of subsection (2) of section 63.167, Florida Statutes, is amended to read:

63.167 State adoption information center.—

(2) The functions of the state adoption information center shall include:

(f) Maintaining a list of licensed child-placing agencies eligible and willing to take custody of and place ~~newborn~~ infants surrendered in accordance with ~~left at a hospital, pursuant to~~ s. 383.50. The names and contact information for the licensed child-placing agencies on the list shall be provided on a rotating basis to the statewide central abuse hotline.

Section 6. Section 383.51, Florida Statutes, is amended to read:

383.51 Confidentiality; identification of parent surrendering ~~leaving newborn~~ infant ~~at hospital, emergency medical services station, or fire station~~.—The identity of a parent who surrenders an ~~leaves a newborn~~ infant ~~at a hospital, emergency medical services station, or fire station~~ in accordance with s. 383.50 is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. The identity of a parent surrendering an infant ~~leaving a child~~ shall be disclosed to a person claiming to be a parent of the ~~newborn~~ infant.

Section 7. Section 827.035, Florida Statutes, is amended to read:

827.035 ~~Newborn~~ Infants.—It does ~~shall~~ not constitute neglect of a child pursuant to s. 827.03 or contributing to the dependency of a child pursuant to s. 827.04~~,~~ if a parent surrenders an ~~leaves a newborn~~ infant in accordance ~~at a hospital, emergency medical services station, or fire station or brings a newborn infant to an emergency room and expresses an intent to leave the infant and not return, in compliance~~ with s. 383.50.

Section 8. Subsection (3) of section 827.10, Florida Statutes, is amended to read:

827.10 Unlawful desertion of a child.—

(3) This section does not apply to a person who surrenders an ~~a newborn~~ infant in accordance ~~compliance~~ with s. 383.50.

Section 9. This act shall take effect July 1, 2024.

HB 1501

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1501 Health Care Innovation
SPONSOR(S): Gonzalez Pittman
TIED BILLS: **IDEN./SIM. BILLS:** SB 7018

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee		DesRochers	McElroy

SUMMARY ANALYSIS

HB 1501 creates the Health Care Innovation Council, a 15-member council within the Department of Health (DOH) to facilitate public meetings across the state to lead discussions with innovators, developers, and implementers of technologies, workforce pathways, service delivery models, or other solutions. The bill requires the council to create best practice recommendations and focus areas for the advancement of the delivery of health care in Florida, with an emphasis on:

- Increasing efficiency in the delivery of health care;
- Reducing strain on the health care workforce;
- Increasing public access to health care;
- Improving patient outcomes;
- Reducing unnecessary emergency department visits; and
- Reducing costs for patients and the state without reducing the quality of patient care.

The bill creates a revolving loan program within the DOH to provide low-interest loans to applicants to implement one or more innovative technologies, workforce pathways, or service delivery models in order to:

- Fill a demonstrated need;
- Obtain or upgrade necessary equipment, hardware, and materials;
- Adopt new technologies or systems; or
- A combination thereof to improve the quality and delivery of health care in measurable and sustainable ways that will lower costs and allow that value to be passed onto health care consumer.

The council will review loan applications and submit to the DOH a prioritized list of proposals recommended for funding. Loan recipients enter into agreements with the DOH for loans of up to 10-year terms for up to 50 percent of the proposal costs, or up to 80 percent of the costs for an applicant that is located in a rural or medically underserved area and is either a rural hospital or a nonprofit entity that accepts Medicaid patients.

The bill requires both the council and the DOH to publicly report certain information related to the activities required under the bill and requires the Office of Economic and Demographic Research (EDR) and the Office of Program Policy Analysis and Government Accountability (OPPAGA) to evaluate specified aspects of the revolving loan program every five years.

The bill has an indeterminant, negative impact on state government and no impact on local government.

The bill takes effect upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Challenges of the Health Care System

There are numerous challenges facing the health care system in the United States, including provider shortages, lack of access for certain populations, affordability, and ongoing challenges with health care outcomes for certain populations. Compared with other wealthy nations, Americans have poorer health, lower life expectancy, and less access to health care.[1]

Health Care Professional Shortages

The United States has a current health care professional shortage. The U. S. Department of Health and Human Services designates an area, population group, or facility as a Health Professional Shortage Area (HPSA) if it is experiencing a shortage of professionals.[2] The three types of HPSAs are:

- Geographic HPSAs, which have a shortage of services for the entire population within an established geographic area;
- Populations HPSAs, which have a shortage of services for a particular population subset within an established geographic area, such as low income, migrant farmworker, or Medicaid eligible; and
- Facility HPSAs, which indicate shortages in facilities such as correctional facilities, state or county hospitals with a shortage of psychiatrists, and other public or non-private medical facilities serving a population or geographic area designated as a HPSA with a shortage of health providers.

As of December 3, 2023, there are 8,544 Primary Care HPSAs, 7,651 Dental HPSAs, and 6,822 Mental Health HPSAs nationwide. To eliminate the shortages, an additional 17,637 primary care practitioners, 13,354 dentists, and 8,504 psychiatrists are needed, respectively.[3]

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population.[4] Aging populations create a disproportionately higher health care demand due to seniors having a higher per capita consumption of health care services than younger populations.[5] By 2030, all baby-boomers will be over the age of 65, and by 2034, it is projected that the number of individuals over the age of 65 will surpass the number of children under the age of 18 for the first time in U.S. history.[6] Additionally, as more individuals qualify for health care benefits, there will necessarily be a greater demand for more health care professionals to provide these services.

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[1] Centers for Disease Control and Prevention, *U.S. Health Disadvantage: Causes and Potential Solutions*, available at https://www.cdc.gov/policy/chep/health/index.html (last visited January 9, 2023).
[2] U.S. Department of Health and Human Services, Guidance Portal, *Health Professional Shortage Areas (HPSAs and Medically Underserved Populations (MUA/P) Shortage Designation Types* (Aug. 1, 2019), available at https://www.hhs.gov/guidance/document/hpsa-and-muap-shortage-designation-types (last visited January 9, 2023).
[3] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Health Workforce Shortage Areas*, available at https://data.hrsa.gov/topics/health-workforce/shortage-areas (last visited December 19, 2023).
[4] The U.S. population is projected to increase from almost 336 million in 2023 to nearly 370 million in 2080, before decreasing to 366 million in 2100. *See* U.S. Census Bureau, *U.S. and World Population Clock*, available at https://www.census.gov/popclock/, and U.S. Census Bureau, U.S. Population Projected to Begin Declining in Second Half of Century (Dec. 19, 2023), available at https://www.census.gov/newsroom/press-releases/2023/population-projections.html (both sites last visited January 9, 2023).
[5] *Id*. at 33.
[6] J. Vespa, L. Medina, and D. Armstrong, *Demographic Turning Points for the United States: Population Projections for 2020 to 2060*, United States Census Bureau (Mar. 208, rev. Feb, 2020), available at https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf (last visited January 9, 2023).

Health care workers may experience an extreme amount of stress due to the demanding work conditions, including taxing work, exposure to infectious diseases, long hours, and challenging interactions with coworkers, patients, and their families.[7] Prior to the COVID-19 pandemic, the National Academy of Medicine found that burnout had reached a crisis level, with 35-45 percent of nurses and physicians and 45-60 percent of medical students and residents reporting symptoms of burnout.[8] During the pandemic, the high levels of stress and the increased demands for care led to record numbers of health care workers quitting or planning to quit.[9] In 2022, nearly one half of health care workers reported burnout.[10]

Florida is not immune to the national problem and is also experiencing a health care practitioner shortage. This is evidenced by the fact that as of September 30, 2023, there are 304 primary care HPSAs, 266 dental HPSAs, and 228 mental health HPSAs designated within the state. It would take 1,803 primary care physicians, 1,317 dentists, and 587 psychiatrists to eliminate these shortage areas.[11]

According to data from the DOH, by 2035, Florida will need 17,924 physicians, 50,700 registered nurses, and 4,000 licensed practical nurses to meet the demand in Florida.[12] In the next five years almost 10 percent of Florida physicians are planning to retire, and in nine counties, at least 25 percent of physicians are planning to retire.[13] Nurses make up the largest segment of Florida's health care workforce. Approximately 20 percent of the nursing workforce is over the age of 60 and may leave the workforce in the next five to ten years.[14]

Access to Health Care

Access to health care means the timely use of personal health services to achieve the best possible health outcomes.[15] There are several barriers that limit an individual's access to health care services. Some lack access because they reside in a medically underserved area or are members of a medically underserved population, which means that they lack access to primary health care services.[16] Florida has approximately 130 federally designated medically underserved areas or populations.[17]

Other factors that play a role in access to health care include health care affordability and the lack of health insurance coverage.[18] Studies show that having health insurance is associated with improved access to health services and better health monitoring. Additionally, nonfinancial barriers significantly

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[7] J. Nigam, et. al., *Vital Signs: Health Worker-Perceived Working Conditions and Symptoms of Poor Mental Health – Quality of Worklife Survey, United States, 2018-2022*, MORBIDITY AND MORTALITY WEEKLY REPORT (Oct. 24, 2023), available at https://www.cdc.gov/mmwr/volumes/72/wr/pdfs/mm7244e1-H.pdf (last visited January 9, 2023).
[8] Office of the Surgeon General, *Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce* (2022),, available at https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf (last visited January 9, 2023). "Burnout" is an occupational syndrome characterized by a high degree of emotional exhaustion and depersonalization and a low sense of personal accomplishment at work.
[9] *Id*. at 14.
[10] *Supra*, FN 7.
[11] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, *Designated Health Professional Shortage Areas Statistics, Fourth Quarter of Fiscal Year 2023* (Sept. 30, 2023), available at https://data.hrsa.gov/topics/health-workforce/health-workforce-shortage-areas?hmpgtile=hmpg-hlth-srvcs (last visited January 9, 2023).To generate the report, select "Designated HPSA Quarterly Summary."
[12] Presentation before the Florida Senate Committee on Health Policy by Emma Spencer, Department of Health, *Florida's Physician and Nursing Workforce* (Nov. 14, 2023), available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited January 9, 2023).
[13] *Id*. Those counties are Glades, Gulf, Hamilton, Madison, Union, Calhoun, Hendry, Levy, and Liberty.
[14] *Id*.
[15] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, *Healthy People 2030, Access to Health Services*, available at https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services (last visited January 9, 2023). (Hereinafter "Healthy People 2030").
[16] Health and Resources Services Administration, *What is Shortage Designation?*, available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation (last visited January 9, 2023).
[17] *See*, Heath Resources and Services Administration, *MUA Find*, available at https://data.hrsa.gov/tools/shortage-area/mua-find (last visited January 9, 2023).To generate a list of medically underserved areas and populations, select Florida as the search criteria.
[18] Centers for Disease Control and Prevention, Division of Heart Disease and Stroke Prevention, *Health Care Access*, available at https://www.cdc.gov/dhdsp/health_equity/health-care-access.htm (last visited January 9, 2023).

impact a patient's ability to access care. Among the most prevalent nonfinancial barriers are the ability to get an appointment and inconvenient or unreliable transportation.[19]

Health Care Outcomes

Although the United States spends more on health care per capita than other wealthy nations, it has some of the worst health care outcomes, according to an issue brief published by The Commonwealth Fund. Compared to other wealthy nations, the U.S. has the lowest life expectancy at birth, the highest death rates for avoidable or treatable conditions, the highest maternal and infant mortality, and among the highest suicide rates, according to the issue brief.[20]

Sixty percent of adults in the U.S. have a chronic health condition, and 40 percent have two or more.[21] A chronic condition is a physical or mental health condition that lasts more than one year and causes functional restrictions or requires ongoing monitoring or treatment.[22] Chronic health conditions are the leading drivers of the nation's $4.1 trillion in health care costs, accounting for nearly 75 percent of aggregate health spending.[23] More than two thirds of all deaths are caused by one or more of the five most prevalent chronic health conditions: heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes. Unfortunately, these outcomes are because of the nation's inability to effectively manage chronic conditions, which could be achieved by reducing unhealthy behaviors.[24]

Maternal mortality refers to deaths occurring during pregnancy or within 42 days of the end of pregnancy, regardless of the duration of the pregnancy, from any cause related to or aggravated by the pregnancy, but not from accidental or incidental causes.[25] In 2021, more than 1,200 women died of maternal causes in the United States compared with 861 in 2020 and 754 in 2019. The national maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births. Racial and ethnic gaps exist between non-Hispanic black, non-Hispanic white, and Hispanic women. The maternal mortality rate of these groups is 69.9, 26.6, and 28.0 deaths per 100,000 live births, respectively.[26] The overall number and rate of maternal deaths increased in 2020 and 2021 during the COVID-19 pandemic.[27]

Although Florida's maternal mortality rate is lower than the national rate, it has been increasing in recent years. As of 2021, the maternal mortality rate in Florida is 28.7 deaths per 100,000 live births, an increase from a low of 12.9 deaths per 100,000 live births in 2016.[28] Similar to the national trend, racial and ethnic disparities exist in the maternal mortality rates in Florida.

Infant mortality is the death of an infant before his or her first birthday. The leading causes of infant death are:

- Birth defects;

[19] Healthy People 2030, *supra*, note 156.
[20] M. Gunja, Evan Gumas, and R. Williams, The Commonwealth Fund, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Jan. 31, 2023), available at https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022 (last visited January 9, 2023).Other wealthy nations included in the study are Australia, Canada, France, Germany, Japan, the Netherlands, New Zealand, Norway, South Korea, Sweden, Switzerland, and the United Kingdom.
[21] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, About Chronic Diseases, available at https://www.cdc.gov/chronicdisease/about/index.htm (last visited January 9, 2023).
[22] W. Raghupathi and V. Rahupathi, *An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach to Public Health*, INTERNATIONAL JOURNAL ON ENVIRONMENTAL RESEARCH AND PUBLIC HEALTH, 15(3):431 (Mar. 2018), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5876976/ (last visited January 9, 2023).
[23] *Id*., and CDC, *supra*, note 22.
[24] *Id*.
[25] U.S. Department of Health and Human Services, *The Surgeon General's Call to Action to Improve Maternal Health* (Dec. 2020), available at https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf (last visited January 9, 2023).
[26] Donna L. Hoyert, Ph.D., Division of Vital Statistics, National Center for Health Statistics, *Maternal Mortality Rates in the United States, 2021* (March 2023), available at https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf (last visited January 9, 2023).
[27] United States Government Accountability Office, *Maternal Health Outcomes Worsened and Disparities Persisted During the Pandemic* (Oct. 2022), available at https://www.gao.gov/assets/gao-23-105871.pdf (last visited January 9, 2023).
[28] Presentation before the Florida Senate Committee on Health Policy by Kenneth Scheppke, M.d., F.A.E.M.S., Deputy Secretary for Health, Department of Health, *Telehealth Minority Care Pilot Program* (Nov. 14, 2023), available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited January 9, 2023).

- Preterm birth and low birth weight;
- Sudden infant death syndrome;
- Injuries (i.e. suffocation); and
- Maternal pregnancy complications.[29]

The 2022 infant mortality rate in the U.S. is projected to be 5.6 deaths per 1,000 live births, which is three percent higher than the infant mortality rate in 2021 (5.44).[30] Except for the infants of Asian mothers, mortality rates have increased for all races: American Indian and Alaska native infants from 7.46 to 9.06; white infants from 4.36 to 4.52, black infants from 10.55 to 10.86, native Hawaiian and other Pacific Islander infants from 7.76 to 8.50, and Hispanic infants from 4.79 to 4.88 per 1,000 live births.[31] From 2021 to 2022, Florida's infant mortality rate increased from 5.90 to 5.98 per 1,000 live births. In 2020, the infant mortality rate was more than double the rate for white and Hispanic infants in Florida.[32]

Advancements in Health Care

In the last century, there have been tremendous advances in health care. From the development of vaccines to suppress the spread of diseases that were once considered debilitating or fatal, such as polio,[33] to the first successful organ transplant in 1954, and the development of numerous technologies and medical devices that provide new options for care and treatment.[34] During the last century, there have been numerous clinical innovations, such as the development of medications to make once fatal diseases an almost curable disease, such as AIDS, and the use of genetics to allow for individualized cancer treatments.[35] Despite the many advances in health care technology, the health care delivery system has been slower to change.

Historically, health care primarily involved the prevention and treatment of disease and episodes of acute care; however, health care has evolved to be increasingly occupied with the management of chronic health conditions. Chronic illness is the leading cause of illness, disability, and death in the United States, and accounts for 78 percent of health care expenditures.[36]

Within recent years, and especially during the COVID-19 pandemic, there has been an increase in interest in alternative delivery systems. For example, prior to the pandemic, the use of telehealth was growing; however, during the pandemic, the use of the technology rose by more than 760 percent.[37] As a subset of telehealth, many health care practitioners also adopted the use of remote patient monitoring to manage acute and chronic conditions. Remote patient monitoring may be used to assess high blood pressure, diabetes, weight loss or gain, heart conditions, chronic obstructive pulmonary disease, sleep apnea, or asthma. Using remote patient monitoring may reduce hospitalizations, reduce the length of hospital stays, reduce emergency department visits, and provide better health outcomes, among other things.[38]

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[29] Centers for Disease Control and Prevention, *Infant Mortality*, available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm (last visited December 19, 2023).
[30] D. Ely and K. Driscoll, Centers for Disease Control and Prevention, National Center for Health Statistics, *Infant Mortality in the United States: Provisional Data from the 2022 Period Linked Birth/Infant Death File*, Vital Statistics Rapid Release, Report No. 33 (Nov. 2023), available at https://www.cdc.gov/nchs/data/vsrr/vsrr033.pdf (last visited January 9, 2023).
[31] *Id*.
[32] Department of Health, Infant Mortality in Florida, available at https://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/infant-mortality-FL-.pdf (last visited January 9, 2023).
[33] The vaccine for polio was developed in the early 1950s. *See* World Health Organization, *History of the Polio Vaccine*, available at https://www.who.int/news-room/spotlight/history-of-vaccination/history-of-polio-vaccination (last visited January 9, 2023).
[34] Institute of Medicine, *Evidence-Based Medicine and the Changing Nature of Healthcare: 2007 IOM Annual Meeting Summary*, (2008), available at https://www.ncbi.nlm.nih.gov/books/NBK52825/ (last visited January 9, 2023).
[35] Gary Ahlquist, et. al, Strategy&, *The (R)evolution of Healthcare*, available at https://www.strategyand.pwc.com/gx/en/industries/health/the-revolution-of-healthcare.pdf (last visited January 9, 2023).
[36] Institute of Medicine, *supra*, note 37.
[37] Julia Shaver, M.D., *The State of Telehealth Before and After the COVID-19 Pandemic*, PRIMARY CARE 49(4): 517-530 (Dec. 2022), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9035352/ (last visited January 9, 2023).
[38] Telehealth.HHS.gov, *Telehealth and Remote Patient Monitoring*, available at https://telehealth.hhs.gov/providers/preparing-patients-for-telehealth/telehealth-and-remote-patient-monitoring (last visited January 9, 2023).

Another technological advance that has been widely adopted is the use of an electronic health record (EHR).[39] EHRs offer a number of benefits, such as automating certain tasks, reducing the incidence of medical errors, and making health information more readily available, which reduces duplication of tests, delays in treatment, and enables patients to make better informed decisions.[40]

In addition to advancements in health care technologies and delivery systems, there has also been an evolution in payment models. In recent years, there has been a move to value-based care models. Under these models, providers, such as hospitals and physicians, are paid based on patient outcomes. Providers are rewarded for achievements such as helping the health of their patients to improve and reducing the effects of chronic illness.[41]

Health Care Innovation Initiatives

In recent years, both the state and federal governments have launched or funded programs to examine innovations in health care. Many of the programs were predicated on grants from the Center for Medicare and Medicaid Innovation (CMS Innovation Center).[42]

In 2010, Congress established the CMS Innovation Center to identify ways to improve health care quality and reduce costs in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[43] The CMS Innovation Center's demonstration projects and models measure the effect of potential program changes, while evaluation projects validate research and help to monitor the effectiveness of Medicare, Medicaid, and CHIP.[44]

The Office of Economic and Demographic Research

The Office of Economic and Demographic Research (EDR) is a research arm of the Legislature principally concerned with forecasting economic and social trends that affect policy making, revenues, and appropriations. EDR provides objective information to committee staffs and members of the Legislature in support of the policy making process. EDR publishes all of the official economic, demographic, revenue, and agency workload forecasts that are developed by Consensus Estimating Conferences and makes them available to the Legislature, state agencies, universities, research organizations, and the general public. EDR, through a contract with the University of Florida, arranges for annual estimates of population of each city and county in Florida, which provide the basis for revenue sharing programs.

The Office of Program Policy Analysis and Government Accountability

The Office of Program Policy Analysis and Government Accountability (OPPAGA) is a research arm of the Florida Legislature. OPPAGA was created by the Legislature in 1994 to help improve the performance and accountability of state government. OPPAGA provides data, evaluative research, and objective analyses to assist legislative budget and policy deliberations. OPPAGA conducts research as directed by state law, the presiding officers of the Legislature, or the Joint Legislative Auditing Committee.

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[39] An electronic health record is a digital version of a patient's paper chart. *See* The Office of the National Coordinator for Health Information Technology, HealthIT.gov, *Frequently Asked Questions*, available at https://www.healthit.gov/faq/what-electronic-health-record-ehr (last visited January 9, 2023).
[40] Centers for Medicare and Medicaid Services, *Electronic Health Records*, available at https://www.cms.gov/priorities/key-initiatives/e-health/records (last visited January 9, 2023).
[41] NEJM Catalyst, *What is Value-Based Healthcare?* (Jan. 1, 2017), available at https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558 (last visited January 9, 2023).
[42] For example, see the Delaware Center for Health Innovation, available at https://www.dehealthinnovation.org/; Rhode Island Health Care Innovation Initiative, available at https://eohhs.ri.gov/initiatives/healthcare-innovation; Oklahoma Center for Health Innovation and Effectiveness, available at https://oklahoma.gov/health/about-us/center-for-health-innovation-and-effectiveness.html (all sites last visited January 9, 2023).
[43] Centers for Medicare and Medicaid Services, *About the CMS Innovation Center*, available at https://www.cms.gov/priorities/innovation/About (last visited January 9, 2023).
[44] Centers for Medicare and Medicaid Services, *CMS Innovation Center Programs*, available at https://data.cms.gov/cms-innovation-center-programs (last visited January 9, 2023).

Effect of Proposed Changes

This bill creates s. 381.4015, F.S.,[45] to set forth legislative intent related to health care innovation in this state and create a framework to implement such intent. The intent is to harness the innovation and creativity of entrepreneurs and businesses, in collaboration with the state's health care system and stakeholders, to lead discussion on innovations that will address challenges in the health care system and transform the delivery and strengthen the quality of health care in Florida.

Health Care Innovation Council

The bill creates the Health Care Innovation Council, a 15-member council within the DOH. The Lieutenant Governor serves as the chair of the council and as an ex officio, nonvoting member. The Secretary of Health Care Administration, the Secretary of Children and Families, the director of the Agency for Persons with Disabilities, the State Surgeon General, and the Secretary of Elderly Affairs all serve as ex officio, nonvoting members. The chair of the Council of Florida Medical School Deans serves as a voting member.

The President of the Senate and the Speaker of the House of Representatives each make one appointment to the council. Legislative appointments must be a person from the health care sector who has senior level experience in reducing inefficiencies in health care delivery systems; from the private sector who has senior level experience in cybersecurity or software engineering in the health care sector; who has expertise in emerging technology that can be used in the delivery of health care; or who has experience in finance or investment or in management and operation of early stage companies.

The remainder of the council consists of the following appointments by the Governor:

- A licensed physician;
- An employee of a licensed hospital;
- A licensed nurse;
- A Florida resident to represent the interest of health care patients;
- An employee of a health insurer or health maintenance organization; and
- A representative of the long-term care facility industry.

Appointments must be made by July 1, 2024. Appointees serve two-year terms and may be reappointed for no more than four consecutive terms.[46] Vacancies are filled in the same manner as the appointment, and members whose terms are expired may continue to serve for up to six months until replaced or reappointed. Members serve without compensation but are entitled to per diem and travel expenses. A member may be removed for cause by the appointing entity. Members who are not already required to file a financial disclosure statement must file a disclosure of financial interests.

The bill requires the council to hold its first meeting by September 1, 2024. The council is required to meet at least quarterly at the call of the chair, and in order to provide an opportunity for the broadest public input, must hold a majority of its meetings during the year geographically dispersed across the state. Meetings are encouraged to provide opportunities for demonstrations or presentations of innovative solutions in person. The council is subject to the public records requirements under ch. 119, F.S., and the public meetings requirements of ch. 286, F.S.

A majority of the members represents a quorum, which is required for meetings and can be established by conducting the meeting using teleconference or other electronic means. An affirmative vote by a majority of members present at the meeting is necessary for any official action.

[45] The section expires on July 1, 2043.
[46] The bill provides that the legislative appointees, the physician, and the nurse all serve initial terms of three years in order to create staggered terms.

Council members may not vote or consider any matters which would directly benefit the member or which would benefit a relative or person or entity with which the member has a business relationship.[47]

State agencies and statutorily created state entities are required to assist and cooperate with the council as requested. The DOH is required to administratively support the council, including providing reasonable support staff and maintaining a website for the council.

Council Duties

The bill charges the council with several duties, including adoption of best practices and focus areas. The council is required to adopt a document that sets forth a mission statement, goals, and objectives for the council to function and meet the purposes of the law. This must be adopted by February 1, 2025, and updated as necessary.

The council must facilitate public meetings at which innovators, developers, and implementers of technologies, workforce pathways, service delivery models, and other solutions may present information and lead discussions. The work:

- Must cover concepts that address challenges to the health care system as they develop in real time and concepts that advance the delivery of health care in this state through technology and innovation.
- Must give consideration to how the concepts:
    - Increase efficiency in the health care system in this state;
    - Reduce strain on the state's health care workforce;
    - Improve patient outcomes;
    - Expand public access to health care services in this state; or
    - Reduce costs for patients and the state without reducing the quality of patient care.
- May consider broad community or statewide issues or needs to be addressed.
- May include how concepts can be supported, cross-functional, or scaled to meet the needs of health care consumers, including employers, payers, patients, and the state.
- May include coordination with the Small Business Development Center Network, the Florida Opportunity Fund, the Institute for Commercialization of Florida Technology, and other business incubators, development organizations, or institutions of higher education to include emerging and early stage concepts in the discussions.
- May bring information technology technical experts to lead discussions on recommended structures and integrations of information technology products, services, and solutions.

The bill requires the council to annually distinguish the most impactful concepts, projects, and initiatives. The recognition must be for those that the council finds to have a positive impact in Florida, have huge potential to scale that impact throughout this state through growth or replication, or are cutting-edge advancements, programs, or other innovations that have the capability to accelerate transformation of health care in Florida. The council may develop a logo for awardees to display.

The bill requires the council to use input received to develop and update best practice recommendations. The best practice recommendations must:

- Be made for health care service delivery models and focus on how to explore implementation of innovations and how to implement new technologies and strategies, at a minimum;
- Be distinguished by practice setting and with an emphasis on increasing efficiency in the delivery of health care, reducing strain on the health care workforce, increasing public access to health care, improving patient outcomes, reducing unnecessary emergency department visits, and reducing costs for patients and the state without reducing the quality of patient care; and

[47] "Relative" is defined as a father, mother, son, daughter, husband, wife, brother, sister, grandparent, father-in-law, mother-in-law, son-in-law, or daughter-in-law. "Business relationship" means an ownership or controlling interest, an affiliate or subsidiary relationship, a common parent company, or any mutual interest in any limited partnership, limited liability partnership, limited liability company, or other entity or business association.

- Specifically for information technology, also recommend actions to guide the selection of technologies and innovations, which may include considerations for system-to-system integration, consistent user experiences for health care workers and patients, and patient education and practitioner training.
- Be updated as necessary.

The council must develop and update a list of focus areas for the advancement of the delivery of health care. The council can adopt broad or specific focus areas, and the bill sets forth topics that must be considered at a minimum, including:

- The health care workforce (such as approaches to cultivate interest in the workforce, efforts to improve the workforce, education pathways, and use of technology to reduce workforce burdens).
- The provision of patient care in the most appropriate setting and reduction of unnecessary emergency department visits (such as use of advanced technologies to improve patient outcomes, use of early detection devices, at-home patient monitoring, advanced at-home care, and advanced adaptive equipment).
- The delivery of primary care through methods, practices, or procedures that increase efficiencies.
- The technical aspects of the provision of health care (such as interoperability of electronic health records systems and the protection of health care data and systems).

The council's duties also include identifying and recommending changes to law or administrative changes that are necessary to advance, transform, or innovate health care or to implement the council's duties or recommendations. The DOH is required to incorporate council recommendations into its duties, including updating administrative rules or procedures, as appropriate.

The council must submit an annual report each December 1 on the council's activities, including:

- An update on the status of the delivery of health care in Florida;
- Information on implementation of best practices by Florida health care industry stakeholders; and
- Highlights of exploration, development, or implementation of innovative technologies, workforce pathways, service delivery models, or other solutions by Florida health care industry stakeholders.

Revolving Loan Program

The bill creates a revolving loan program within the DOH to provide funding for applicants seeking to implement innovative solutions. Certain entities licensed, registered, or certified by the Agency for Health Care Administration and educational or clinical training providers in partnership with one of the entities, may apply for a loan.[48]

The bill requires the DOH to establish eligibility criteria that:

- Incorporate recommendations of the council based on input received, focus areas developed, and best practices recommended.
- Determine which proposals are likely to provide the greatest return to the state, taking into consideration the degree to which the proposal would increase efficiency in the health care system in this state, reduce strain on the state's health care workforce, improve patient outcomes, increase public access to health care in this state, or provide cost savings to patients or the state without reducing the quality of patient care.

The bill provides that an applicant that has a conflict of interest relationship with a council member may not receive a loan unless the council member recused herself or himself from consideration of the

[48] Those entities licensed, registered, or certified pursuant to s. 408.802, except for subsections (1), (3), (13), (23), and (25) of that sections, are eligible to apply.

application. If a council member voted to recommend an application for funding with which the member has a conflict of interest, the applicant may not be awarded a loan. A council member may not receive a loan under the program.

The DOH is required under the bill to set application periods to apply for loans and may set up to four application periods in a fiscal year. The DOH must work with the council if application periods include separate priority for current focus areas adopted by the council. The availability of loans will be publicized to stakeholders, education or training providers, and others. The DOH will receive the applications and determine whether the applications are complete and whether the applicant has demonstrated ability to repay the loan. Within 30 days of the close of the application period, the DOH will forward the complete applications to the council.

The council must review submitted applications using the criteria and processes and format adopted by the DOH by rule. The bill requires priority for applicants that are located in a rural or medically underserved area and are either rural hospitals or nonprofit entities that accept Medicaid patients. A loan applicant must demonstrate plans to use the funds to implement one or more innovative technologies, workforce pathways, service delivery models, or other solutions in order to:

- Fill a demonstrated need;
- Obtain or upgrade necessary equipment, hardware, and materials;
- Adopt new technologies or systems; or
- A combination of the above, which will improve the quality and delivery of health care in measurable and sustainable ways and which will lower costs and allow savings to be passed on to health care consumers.

Approved lists of recommended applications for funding, arranged in order of priority and as required by the application period, are to be submitted by the council to the DOH. The DOH is directed under the bill to award the loans based on demonstrated need and availability of funds.

Loans may be made for up to 50 percent of the total projected implementation costs, or up to 80 percent of the total projected implementation costs for an applicant that is located in a rural or medically underserved area and is either a rural hospital or a nonprofit entity that accepts Medicaid patients. However, the DOH may not award more than 10 percent of the total allocated funds for the fiscal year to a single applicant. An applicant may only receive one loan per fiscal year, and if the applicant has an outstanding loan, it may apply for a new loan only if the outstanding loan is in good standing.

The loan term is up to 10 years and may have an interest rate of up to 1 percent. Loan recipients must enter into written agreements with the DOH to receive the loan. At a minimum, the agreement must specify:

- The total amount of the award.
- The performance conditions that must be met, based upon the submitted proposal and the defined category or focus area, as applicable.
- The information to be reported on actual implementation costs, including the share from non-state resources.
- The schedule for payment.
- The data and progress reporting requirements and schedule.[49]
- Any sanctions that would apply for failure to meet performance conditions.

Loan recipients can request the DOH to provide technical assistance, if needed.

The DOH is required to maintain the loan funds in a separate account in its Grants and Donations Trust Fund. All loan repayments of principal must be returned to the revolving loan fund and made available to make loans. Loans appropriated to the program are not subject to reversion.

[49] The DOH is required to develop uniform data reporting requirements in order to evaluate the performance of the implemented proposals. The data collected must be shared with the council.

The DOH is authorized to contract with a third-party administrator to administer the revolving loan program, including loan servicing, and manage the revolving loan fund. A contract for a third-party administrator must, at a minimum, require maintenance of the revolving loan fund to ensure that the program may operate in a revolving manner.

Technical Assistance for Funding Opportunities

The DOH must identify and publish on its website a list of federal, state, and private sources of funding opportunities available to implement innovative technologies and service delivery models in health care. The information must include details and eligibility requirements for each opportunity. The DOH must provide technical assistance to apply for such funding upon request and is encouraged to foster working relationships that will allow the department to refer interested applicants to appropriate contacts for the funding opportunities.

Rulemaking

The bill authorizes the DOH to adopt rules for the revolving loan program, including establishing the loan application process, eligibility criteria, and application requirements. The bill specifies that conditions are deemed met in order for the DOH to adopt emergency rules to implement this bill. The emergency rules are effective for six months after adoption and may be renewed until permanent rules are adopted pursuant to ch. 120, F.S.

Reporting

The bill requires the DOH to publish information on its website related to loan recipients, including the written agreements, the performance conditions and status, and the total amount of funds disbursed to date. Information related to a loan must be updated annually on the award date of the loan.

Each September 1, beginning in 2025, the DOH must post on its website a report on health care innovation which includes all of the following information:

- A summary of the adoption and implementation of recommendations of the council during the previous fiscal year.
- An evaluation of actions and related activities to meet the purposes set forth in the bill.
- Consolidated data based upon the uniform data reporting by funding recipients and an evaluation of how the provision of the loans has met the purposes set forth in the bill.
- The number of applications for loans, the types of proposals received, and an analysis on the relationship between the proposals and the purposes of the bill.
- The amount of funds allocated and awarded for each loan application period, as well as any funds not awarded in that period.
- The amount of funds paid out during the fiscal year and any funds repaid or unused.
- The number of persons assisted and outcomes of any technical assistance requested for loans and any federal, state, or private funding opportunities.

Evaluation

The bill directs EDR and OPPAGA to each evaluate specified aspects of the revolving loan program every five years, as follows.

The first report by EDR is due October 1, 2029, and must be a comprehensive financial and economic evaluation of the innovative solutions undertaken by the revolving loan program. The evaluation must include, but is not limited to, separate calculations of the state's return and the economic value to residents of this state and the identification of any cost savings to patients or the state and the impact on the state's health care workforce.

The first report by OPPAGA is due October 1, 2030, and must be an evaluation of the administration and efficiency of the revolving loan program. The evaluation must include, but is not limited to, the

degree to which the collective proposals increased efficiency in the health care system in this state, improved patient outcomes, increased public access to health care, and achieved the cost savings identified in the EDR evaluation without reducing the quality of patient care.

Each report must include recommendations for consideration by the Legislature.

EDR and OPPAGA must be given access to all data necessary to complete their evaluations, including any confidential data. The offices may collaborate on data collection and analysis. The reports must be sent to the Governor, the President of the Senate, and the Speaker of the House of Representatives.
Effective Date

The bill takes effect upon becoming a law.

B. SECTION DIRECTORY:

Section 1: Creating s. 381.4015, F.S., relating to Florida health care innovation.
Section 2: Creating an unnumbered section of law.
Section 3: Creating an unnumbered section of law.
Section 4: Providing an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Implementation of the revolving loan program is contingent upon an appropriation by the Legislature. The program can be implemented on scale with the appropriation.

   If the program is implemented, the DOH will incur costs to administratively support the council, including travel and per diem expenses of members and website hosting, and to implement and administer the revolving loan program. OPPAGA will incur costs in 2030 and EDR will incur costs in 2029, and every five years thereafter, respectively, to conduct their evaluations of the program.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

If the program is implemented, eligible applicants will be able to apply to receive a loan to implement innovative health care solutions.

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to health care innovation; creating s. 381.4015, F.S.; defining terms; providing legislative intent; creating the Health Care Innovation Council within the Department of Health for a specified purpose; providing for membership, meetings, and conflicts of interest of the council; specifying conflicts of interest with respect to the revolving loan program established under the act; defining the terms "business relationship" and "relative"; specifying duties of the council; requiring the council, by a specified date, to adopt, and update as necessary, a certain document; requiring the council to submit annual reports to the Governor and the Legislature; requiring state agencies and statutorily created state entities to assist and cooperate with the council as requested; requiring the department to provide administrative support to the council; requiring the department to maintain a link to specified information on the homepage of its website; requiring the department to publish specified information on its website; requiring the department to provide technical assistance to certain applicants upon request; requiring the department to establish and administer a revolving loan program for applicants

seeking to implement certain health care innovations in this state; providing for administration of the program; requiring the department to adopt certain rules; specifying eligibility and application requirements; specifying terms, authorized uses, and repayment options for loans; requiring the department to create and maintain a separate account in the Grants and Donations Trust Fund within the department to fund the revolving loan program; providing that funds for the program are not subject to reversion; authorizing the department to contract with a third party to administer the program, including loan servicing, and manage the revolving loan fund; specifying requirements for the contract; requiring the department to publish and update specified information and reports on its website annually; requiring the Office of Economic and Demographic Research and the Office of Program Policy Analysis and Government Accountability to each develop and present an evaluation of the program to the Governor and the Legislature every 5 years beginning on specified dates; specifying requirements for the evaluations; requiring that the offices be given access to all data necessary to complete the evaluation, including confidential data; authorizing the offices to

collaborate on data collection and analysis; requiring the department to adopt rules; providing for future expiration; authorizing the department to adopt emergency rules to implement the act; providing that implementation of the revolving loan fund is contingent upon appropriation by the Legislature; authorizing the department to use a specified percentage of appropriated funds for administrative costs to implement the revolving loan program; providing an effective date.

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

Section 1. Section 381.4015, Florida Statutes, is created to read:

381.4015 Florida health care innovation.—

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

(a) "Council" means the Health Care Innovation Council.

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

(c) "Health care provider" means any person or entity licensed, certified, registered, or otherwise authorized by law to provide health care services in this state.

(2) LEGISLATIVE INTENT.—The Legislature intends to harness the innovation and creativity of entrepreneurs and businesses, together with the state's health care system and stakeholders,

to lead the discussion and highlight advances and innovations that will address challenges in the health care system as they develop in real time and transform the delivery and strengthen the quality of health care in Florida. Innovative technologies, workforce pathways, service delivery models, or other solutions that improve the quality of care in measurable and sustainable ways, that can be replicated, and that will lower costs and allow that value to be passed on to health care consumers shall be highlighted for adoption across all neighborhoods and communities in this state.

(3) HEALTH CARE INNOVATION COUNCIL.—The Health Care Innovation Council, a council as defined in s. 20.03, is created within the department to tap into the best knowledge and experience available by regularly bringing together subject matter experts in a public forum to explore and discuss innovations in technology, workforce, and service delivery models that can be exhibited as best practices, implemented, or scaled in order to improve the quality and delivery of health care in this state in measurable, sustainable, and reproducible ways.

(a) *Membership.*—

1. The Lieutenant Governor shall serve as an ex officio, nonvoting member and shall act as the council chair.

2. The council shall be composed of the following voting members, to be appointed by July 1, 2024:

a. One member appointed by the President of the Senate and one member appointed by the Speaker of the House of Representatives. The appointing officers shall make appointments prioritizing members who have the following experience:

(I) A representative of the health care sector who has senior-level experience in reducing inefficiencies in health care delivery systems;

(II) A representative of the private sector who has senior-level experience in cybersecurity or software engineering in the health care sector;

(III) A representative who has expertise in emerging technology that can be used in the delivery of health care; or

(IV) A representative who has experience in finance or investment or in management and operation of early stage companies.

b. A physician licensed under chapter 458 or chapter 459, appointed by the Governor.

c. A nurse licensed under chapter 464, appointed by the Governor.

d. An employee of a hospital licensed under chapter 395 who has executive-level experience, appointed by the Governor.

e. A representative of the long-term care facility industry, appointed by the Governor.

f. An employee of a health insurer or health maintenance organization who has executive-level experience, appointed by

the Governor.

g. A resident of this state who can represent the interest of health care patients in this state, appointed by the Governor.

3. The chair of the Council of Florida Medical School Deans shall serve as a voting member of the council.

4. The council shall be composed of the following ex officio, nonvoting members:

a. The State Surgeon General.

b. The Secretary of Health Care Administration.

c. The Secretary of Children and Families.

d. The director of the Agency for Persons with Disabilities.

e. The Secretary of Elderly Affairs.

5. Except for ex officio, nonvoting members, the term of all appointees shall be for 2 years unless otherwise specified. However, to achieve staggered terms, the appointees in sub-subparagraphs 2.a.-c. shall serve initial terms of 3 years. The appointees may be reappointed for no more than four consecutive terms.

6. Any vacancy occurring on the council must be filled in the same manner as the original appointment. Any member who is appointed to fill a vacancy occurring because of death, resignation, or ineligibility for membership shall serve only for the unexpired term of the member's predecessor.

7. Members whose terms have expired may continue to serve until replaced or reappointed. However, members whose terms have expired may not serve longer than 6 months after the expiration of their terms.

8. Members shall serve without compensation but are entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061.

9. Members may be removed for cause by the appointing entity.

10. Each member of the council who is not otherwise required to file a financial disclosure statement pursuant to s. 8, Art. II of the State Constitution or s. 112.3144 must file a disclosure of financial interests pursuant to s. 112.3145.

(b) *Meetings.*—The council shall convene its first organizational meeting by September 1, 2024. Thereafter, the council shall meet as necessary, but at least quarterly, at the call of the chair. In order to provide an opportunity for the broadest public input, the chair shall ensure that a majority of the meetings held in a year are geographically dispersed within this state. As feasible, meetings are encouraged to provide an opportunity for presentation or demonstration of innovative solutions in person. A majority of the members of the council constitutes a quorum, and a meeting may not be held with less than a quorum present. In order to establish a quorum, the council may conduct its meetings through teleconference or other

electronic means. The affirmative vote of a majority of the members of the council present is necessary for any official action by the council.

(c) *Conflicts of interest.*—

1. A council member may not vote on any matter that would provide:

a. Direct financial benefit to the member;

b. Financial benefit to a relative of the member, including an entity of which a relative is an officer, partner, director, or proprietor or in which the relative has a material interest; or

c. Financial benefit to a person or entity with whom the member has a business relationship.

2. With respect to the revolving loan program established in subsection (7):

a. Council members may not receive loans under the program.

b. A person or entity that has a conflict-of-interest relationship with a council member as described in sub-subparagraph 1.b. or sub-subparagraph 1.c. may not receive a loan under the program unless that council member recused himself or herself from consideration of the person's or entity's application.

3. For purposes of this paragraph, the term:

a. "Business relationship" means an ownership or

controlling interest, an affiliate or subsidiary relationship, a common parent company, or any mutual interest in any limited partnership, limited liability partnership, limited liability company, or other entity or business association.

b. "Relative" means a father, mother, son, daughter, husband, wife, brother, sister, grandparent, father-in-law, mother-in-law, son-in-law, or daughter-in-law of a person.

(d) *Public meetings and records.*—The council and any subcommittees it forms are subject to the provisions of chapter 119 relating to public records and the provisions of chapter 286 relating to public meetings.

(4) HEALTH CARE INNOVATION COUNCIL DUTIES.—In order to facilitate and implement this section, the council shall:

(a) By February 1, 2025, adopt and update as necessary a document that sets forth and describes a mission statement, goals, and objectives for the council to function and meet the purposes of this section.

(b) Facilitate public meetings across this state at which innovators, developers, and implementers of technologies, workforce pathways, service delivery models, and other solutions may present information and lead discussions on concepts that address challenges to the health care system as they develop in real time and advance the delivery of health care in this state through technology and innovation.

1. Consideration must be given to how such concepts

increase efficiency in the health care system in this state, reduce strain on the state's health care workforce, improve patient outcomes, expand public access to health care services in this state, or reduce costs for patients and the state without reducing the quality of patient care.

2. Exploration and discussion of concepts may include how concepts can be supported, cross-functional, or scaled to meet the needs of health care consumers, including employers, payors, patients, and the state.

3. The council may coordinate with the Florida Small Business Development Center Network, the Florida Opportunity Fund, the Institute for Commercialization of Florida Technology, and other business incubators, development organizations, or institutions of higher education to include emerging and early stage innovators, developers, and implementers of technology, models, or solutions in health care in the exploration and discussion of concepts and breakthrough innovations.

4. To support adoption and implementation of innovations and advancements, specific meetings may be held which bring together technical experts, such as those in system integration, cloud computing, artificial intelligence, and cybersecurity, to lead discussions on recommended structures and integrations of information technology products and services and propose solutions that can make adoption and implementation efficient, effective, and economical.

5. The council may also highlight broad community or statewide issues or needs of providers and users of health care delivery and may facilitate public forums in order to explore and discuss the range of effective, efficient, and economical technology and innovative solutions that can be implemented.

(c) Annually distinguish the most impactful concepts by recognizing the innovators, developers, and implementers whose work is helping Floridians live brighter and healthier lives. In seeking out projects, initiatives, and concepts that are having a positive impact in Florida, have huge potential to scale that impact throughout this state through growth or replication, or are cutting-edge advancements, programs, or other innovations that have the capability to accelerate transformation of health care in this state, the council may issue awards to recognize these strategic and innovative thinkers who are helping Floridians live brighter and healthier lives. The council may develop a logo for the award for use by awardees to advertise their achievements and recognition.

(d) Consult with and solicit input from health care experts, health care providers, and technology and manufacturing experts in the health care or related fields, users of such innovations or systems, and the public to develop and update:

1. Best practice recommendations that will lead to the continuous modernization of the health care system in this state and make the Florida system a nationwide leader in innovation,

technology, and service. At a minimum, recommendations must be made for how to explore implementation of innovations, how to implement new technologies and strategies, and health care service delivery models. As applicable, best practices must be distinguished by practice setting and with an emphasis on increasing efficiency in the delivery of health care, reducing strain on the health care workforce, increasing public access to health care, improving patient outcomes, reducing unnecessary emergency room visits, and reducing costs for patients and the state without reducing the quality of patient care. Specifically for information technology, best practices must also recommend actions to guide the selection of technologies and innovations, which may include, but need not be limited to, considerations for system-to-system integration, consistent user experiences for health care workers and patients, and patient education and practitioner training.

2. A list of focus areas in which to advance the delivery of health care in this state through innovative technologies, workforce pathways, or service delivery models. The focus areas may be broad or specific, but must, at a minimum, consider all of the following topics:

a. The health care workforce. This topic includes, but is not limited to, all of the following:

(I) Approaches to cultivate interest and growth in the workforce, including concepts resulting in increases in the

number of providers.

(II) Efforts to improve the use of the workforce, whether through techniques, training, or devices to increase effectiveness or efficiency.

(III) Educational pathways that connect students with employers or result in attainment of cost-efficient and timely degrees or credentials.

(IV) Use of technology to reduce the burden on the workforce during decisionmaking processes such as triage, but which leaves all final decisions to the health care practitioner.

b. The provision of patient care in the most appropriate setting and reduction of unnecessary emergency room visits. These topics include, but are not limited to, all of the following:

(I) Use of advanced technologies to improve patient outcomes, provide patient care, or improve patient quality of life.

(II) The use of early detection devices, including remote communications devices and diagnostic tools engineered for early detection and patient engagement.

(III) At-home patient monitoring devices and measures.

(IV) Advanced at-home health care.

(V) Advanced adaptive equipment.

c. The delivery of primary care through methods,

practices, or procedures that increase efficiencies.

d. The technical aspects of the provision of health care. These aspects include, but are not limited to, all of the following:

(I) Interoperability of electronic health records systems and the impact on patient care coordination and administrative costs for health care systems.

(II) Cybersecurity and the protection of health care data and systems.

(e) Identify and recommend any changes to Florida law or changes that can be implemented without legislative action which are necessary to:

1. Advance, transform, or innovate in the delivery and strengthen the quality of health care in Florida, including removal or update of any regulatory barriers or governmental inefficiencies.

2. Implement the council's duties or recommendations.

(f) Recommend criteria for awarding loans as provided in subsection (7) to the department and review loan applications.

(g) Annually submit by December 1 a report of council activities and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives. At a minimum, the report must include an update on the status of the delivery of health care in this state; information on implementation of best practices by health care industry

stakeholders in this state; and highlights of exploration, development, or implementation of innovative technologies, workforce pathways, service delivery models, or other solutions by health care industry stakeholders in this state.

(5) AGENCY COOPERATION.—All state agencies and statutorily created state entities shall assist and cooperate with the council as requested.

(6) DEPARTMENT DUTIES.—The department shall, at a minimum, do all of the following to facilitate implementation of this section:

(a) Provide reasonable and necessary support staff and materials to assist the council in the performance of its duties.

(b) Maintain on the homepage of the department a link to a website dedicated to the council on which the department shall post information related to the council, including the outcomes of the duties of the council and annual reports as described in subsection (4).

(c) Identify and publish on its website a list of any sources of federal, state, or private funding available for implementation of innovative technologies and service delivery models in health care, including the details and eligibility requirements for each funding opportunity. Upon request, the department shall provide technical assistance to any person wanting to apply for such funding. If the entity with oversight

of the funding opportunity provides technical assistance, the department may foster working relationships that allow the department to refer the person seeking funding to the appropriate contact for such assistance.

(d) Incorporate recommendations of the council into the department's duties or as part of the administration of this section, or update administrative rules or procedures as appropriate based upon council recommendations.

(7) REVOLVING LOAN PROGRAM.—The department shall establish and administer a revolving loan program for applicants seeking to implement innovative solutions in this state.

(a) *Administration.*—The council may make recommendations to the department for the administration of the loans. The department shall adopt rules:

1. Establishing an application process to submit and review funding proposals for loans. Such rules must also include the process for the council to review applications to ensure compliance with applicable laws, including those related to discrimination and conflicts of interest. If a council member participated in the vote of the council recommending an award for a proposal with which the council member has a conflict of interest, the division may not award the loan to that entity.

2. Establishing eligibility criteria to be applied by the council in recommending applications for the award of loans which:

a. Incorporate the recommendations of the council. The council shall recommend to the department criteria based upon input received and the focus areas developed. The council may recommend updated criteria as necessary, based upon the most recent input, best practice recommendations, or focus areas list.

b. Determine which proposals are likely to provide the greatest return to the state if funded, taking into consideration, at a minimum, the degree to which the proposal would increase efficiency in the health care system in this state, reduce strain on the state's health care workforce, improve patient outcomes, increase public access to health care in this state, or provide cost savings to patients or the state without reducing the quality of patient care.

3. It deems necessary to administer the program, including, but not limited to, rules for application requirements, the ability of the applicant to properly administer funds, the professional excellence of the applicant, the fiscal stability of the applicant, the state or regional impact of the proposal, matching requirements for the proposal, and other requirements to further the purposes of the program.

(b) *Eligibility.*—

1. The following entities may apply for a revolving loan:

a. Entities licensed, registered, or certified by the Agency for Health Care Administration as provided under s.

408.802, except for those specified in s. 408.802(1), (3), (13), (23), or (25).

b. An education or clinical training provider in partnership with an entity under sub-subparagraph a.

2.a. Council members may not receive loans under the program.

b. An entity that has a conflict-of-interest relationship with a council member as described in sub-subparagraph (3)(c)1.b. or sub-subparagraph (3)(c)1.c. may not receive a loan under the program unless that council member recused himself or herself from consideration of the entity's application.

3. Priority must be given to applicants located in a rural or medically underserved area as designated by the department which are:

a. Rural hospitals as defined in s. 395.602(2).

b. Nonprofit entities that accept Medicaid patients.

4. The department may award a loan for up to 50 percent of the total projected implementation costs, or up to 80 percent of the total projected implementation costs for an applicant under subparagraph 3. The applicant must demonstrate the source of funding it will use to cover the remainder of the total projected implementation costs, which funding must be from nonstate sources.

(c) *Applications.*—

1. The department shall set application periods to apply

for loans. The department may set multiple application periods in a fiscal year, with up to four periods per year. The department shall coordinate with the council when establishing application periods to establish separate priority, in addition to eligibility, within the loan applications for defined categories based on the current focus area list. The department shall publicize the availability of loans under the program to stakeholders, education or training providers, and others.

2. Upon receipt of an application, the department shall determine whether the application is complete and the applicant has demonstrated the ability to repay the loan. Within 30 days after the close of the application period, the department shall forward all completed applications to the council for consideration.

3. The council shall review applications for loans under the criteria and pursuant to the processes and format adopted by the department. The council shall submit to the department for approval lists of applicants that it recommends for funding, arranged in order of priority and as required for the application period.

4. A loan applicant must demonstrate plans to use the funds to implement one or more innovative technologies, workforce pathways, service delivery models, or other solutions in order to fill a demonstrated need; obtain or upgrade necessary equipment, hardware, and materials; adopt new

technologies or systems; or a combination thereof which will improve the quality and delivery of health care in measurable and sustainable ways and which will lower costs and allow savings to be passed on to health care consumers.

(d) *Awards.*—

1. The amount of each loan must be based upon demonstrated need and availability of funds. The department may not award more than 10 percent of the total allocated funds for the fiscal year to a single loan applicant.

2. The interest rate for each loan may not exceed 1 percent.

3. The term of each loan is up to 10 years.

4. In order to equitably distribute limited state funding, applicants may apply for and be awarded only one loan per fiscal year. If a loan recipient has one or more outstanding loans at any time, the recipient may apply for funding for a new loan if the current loans are in good standing.

(e) *Written agreement.*—

1. Each loan recipient must enter into a written agreement with the department to receive the loan. At a minimum, the agreement with the applicant must specify all of the following:

a. The total amount of the award.

b. The performance conditions that must be met, based upon the submitted proposal and the defined category or focus area, as applicable.

c. The information to be reported on actual implementation costs, including the share from nonstate resources.

d. The schedule for payment.

e. The data and progress reporting requirements and schedule.

f. Any sanctions that would apply for failure to meet performance conditions.

2. The department shall develop uniform data reporting requirements for loan recipients to evaluate the performance of the implemented proposals. Such data must be shared with the council.

3. If requested, the department shall provide technical assistance to loan recipients under the program.

(f) *Loan repayment.*—Loans become due and payable in accordance with the terms of the written agreement. All repayments of principal received by the department in a fiscal year shall be returned to the revolving loan fund and made available for loans to other applicants.

(g) *Revolving loan fund.*—The department shall create and maintain a separate account in the Grants and Donations Trust Fund within the department as a fund for the program. All repayments of principal must be returned to the revolving loan fund and made available as provided in this section. Notwithstanding s. 216.301, funds appropriated for the revolving loan program are not subject to reversion. The department may

contract with a third-party administrator to administer the program, including loan servicing, and manage the revolving loan fund. A contract for a third-party administrator which includes management of the revolving loan fund must, at a minimum, require maintenance of the revolving loan fund to ensure that the program may operate in a revolving manner.

(8) REPORTING.—The department shall publish on its website information related to loan recipients, including the written agreements, performance conditions and their status, and the total amount of loan funds disbursed to date. The department shall update the information annually on the award date. The department shall, beginning on September 1, 2025, and annually thereafter, post on its website a report on this section for the previous fiscal year which must include all of the following information:

(a) A summary of the adoption and implementation of recommendations of the council during the previous fiscal year.

(b) An evaluation of actions and related activities to meet the purposes set forth in this section.

(c) Consolidated data based upon the uniform data reporting by funding recipients and an evaluation of how the provision of the loans has met the purposes set forth in this section.

(d) The number of applications for loans, the types of proposals received, and an analysis on the relationship between

the proposals and the purposes of this section.

(e) The amount of funds allocated and awarded for each loan application period, as well as any funds not awarded in that period.

(f) The amount of funds paid out during the fiscal year and any funds repaid or unused.

(g) The number of persons assisted and outcomes of any technical assistance requested for loans and any federal, state, or private funding opportunities.

(9) EVALUATION.—

(a) Beginning October 1, 2029, and every 5 years thereafter, the Office of Economic and Demographic Research (EDR) shall develop and present to the Governor, the President of the Senate, and the Speaker of the House of Representatives a comprehensive financial and economic evaluation of the innovative solutions undertaken by the revolving loan program administered under this section. The evaluation must include, but need not be limited to, separate calculations of the state's return and the economic value to residents of this state, as well as the identification of any cost savings to patients or the state and the impact on the state's health care workforce.

(b) Beginning October 1, 2030, and every 5 years thereafter, the Office of Program Policy Analysis and Government Accountability (OPPAGA) shall develop and present to the Governor, the President of the Senate, and the Speaker of the

House of Representatives an evaluation of the administration and efficiency of the revolving loan program administered under this section. The evaluation must include, but need not be limited to, the degree to which the collective proposals increased efficiency in the health care system in this state, improved patient outcomes, increased public access to health care, and achieved the cost savings identified in paragraph (a) without reducing the quality of patient care.

(c) Both the EDR and OPPAGA shall include recommendations for consideration by the Legislature. The EDR and OPPAGA must be given access to all data necessary to complete the evaluation, including any confidential data. The offices may collaborate on data collection and analysis.

(10) RULES.—The department shall adopt rules to implement this section.

(11) EXPIRATION.—This section expires July 1, 2043.

Section 2. The Department of Health shall, and all conditions are deemed met to, adopt emergency rules pursuant to s. 120.54(4), Florida Statutes, for the purpose of implementing s. 381.4015, Florida Statutes. Notwithstanding any other law, emergency rules adopted pursuant to this section are effective for 6 months after adoption and may be renewed during the pendency of the procedure to adopt permanent rules addressing the subject of the emergency rules.

Section 3. (1) Implementation of the revolving loan fund

created in s. 381.4015, Florida Statutes, is contingent upon appropriation by the Legislature.

(2) The Department of Health may use up to 3 percent of the appropriated funds for administrative costs to implement the revolving loan program.

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