The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	SB 1400
INTRODUCER:	Senator Grimsley
SUBJECT:	Child Welfare
DATE:	March 20, 2017
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Hendon	CF	**Favorable**
2.			AHS	
3.			AP	
4.			RC	

I. Summary:

SB 1400 creates a Hormonal Long Acting Reversible Contraception (HLARC) program at the Department of Health (DOH). The bill provides for program components, requires an annual report to the Governor, the President of the Senate and the Speaker of the House of Representatives and specifies what is to be included in the report.

The bill codifies federal requirements in the Child Abuse Prevention and Treatment Act (CAPTA), related to plans of safe care for substance exposed newborns and creates a pilot program for newborns and their caregivers based on the Shared Family Care model.

The bill provides a $750,000 appropriation to the Department of Health to implement an HLARC program and has an indeterminate fiscal impact on the Department of Children and Families.

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

II. Present Situation:

Long-acting Reversible Contraception (LARC)

Unintended pregnancies are a difficult public health problem for both clinicians and policy makers. Unintended pregnancies are associated with an increased risk of adverse reproductive outcomes and sociodemographic[1] challenges. While there was almost three decades of minimal

[1] The term "sociodemographic" refers to a group defined by its sociological and demographic characteristics. It looks at the life around individuals and characteristics such as age, gender, sexual orientation, race, religion, income, marital status, birth rate, death rate, average size of family, heritage, education, medical history. Sociodemographic groups are typically used for analyses in the social sciences.

change in the rate of unintended pregnancies in the United States, the rate has decreased in recent years – from 54 unintended pregnancies per 1,000 adolescents and women 15 to 44 years of age in 2008 to 45 cases per 1,000 adolescents and women in 2011. Nonetheless, the most recent data still indicate that 45% of all pregnancies in the United States are unintended.[2]

Unintended pregnancy in the United States results in 1.2 million abortions per year, has negative effects on women's health and education and the health of newborns, and imposes a considerable personal burden as well as a financial burden on families and society.[3] Women with unintended pregnancies, including those resulting in live births, are also at greater risk of death and morbidity, adverse behaviors (e.g. smoking and drinking) and physical violence by their partners. Evidence supports a relationship between unintended pregnancy and insufficient participation in prenatal care, as well as low birthweight. Children born as a result of mistimed or unwanted conceptions may suffer from deficits in developmental skills and be at higher risk for abuse or neglect. In addition, unplanned pregnancies often disrupt parents' life plans, including educational or professional ambitions, limit the resources available for previously born children and compromise the family's current and future financial security.[4]

Long-acting reversible contraceptives (LARC) are methods of birth control that provide effective contraception for an extended period without requiring user action. They include intrauterine devices (IUDs), both hormonal IUDs and nonhormonal copper containing IUDs and subdermal hormonal implants. They are the most effective reversible methods of contraception because they do not depend on patient compliance. So their 'typical use' failure rates, at less than 1% per year.[5]

In addition to being long-lasting, convenient, and well-liked by users, they are very cost effective. Typically, LARC users can save thousands of dollars over a five-year period compared to the use of condoms and birth control pills. Despite their safety and effectiveness LARCs are underutilized: only 15.5% of women worldwide use IUDs, and only 3.4% use subdermal implants. Women considering using LARCs should obtain contraceptive counseling from reproductive health professionals because those who do are more satisfied with them and use them for longer periods of time.[6]

In 2009, LARC methods became first-line options when the American College of Obstetricians and Gynecologists (ACOG) recommended LARC methods for the majority of women. Since then the growing support had been clear and wide-spread. The American Academy of Pediatrics recommends LARC methods for adolescents as “prevention is the cornerstone of pediatric practice.” In 2012, the ACOG revised one their practice guidelines on LARCs. The new

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[2] Curtis, K. and Peipert, J., *Long-Acting Reversible Contraception*, New England Journal of Medicine 2017, 376: 461-468, February 2, 2017.
[3] Winner, B., Madden, T., et al, *Effectiveness of Long-Acting Reversible Contraception*, New England Journal of Medicine, 2012; 366:1998-2007 May 24, 2012.
[4] Blumenthal, P., Voedisch, A., and Gemzell-Danielsson, K., *Strategies to prevent unintended pregnancy: increasing use of long-acting reversible contraception*, Human Reproduction Update (2011) 17 (1): 121-137, July 15, 2010. Published: 15 July 2010
[5] Curtis, K. and Peipert, J., *Long-Acting Reversible Contraception*, New England Journal of Medicine 2017, 376: 461-468, February 2, 2017.
[6] Donna Shoupe, *LARC methods: entering a new age of contraception and reproductive health*, Contraception and Reproductive Medicine 2016, 1:4, February 23, 2016, *available at*: https://contraceptionmedicine.biomedcentral.com/articles/10.1186/s40834-016-0011-8. (last visited March 17, 2017).

guidelines recommended that sexually active adolescents at high risk for unintended pregnancy should be encouraged to consider LARCs. In its Family Planning Handbook for Providers, the World Health Organization (WHO) recommends the implants and IUDs for women with or without children of any age, including adolescents and women over 40.[7]

All County Health Departments in Florida provide LARC methods. The Department of Health Family Planning Program Office requires that each health department have a trained provider for LARC methods. The DOH has used existing financial resources to purchase LARCs. No additional recurring funding has been appropriated for LARC purchase by the Legislature.

Fiscal Year	Total LARC Expenditures by DOH[8]
2013-14	$1,874,625
2014-15	$1,437,282
2015-16	$3,110,688
2016-17	Approximately $3,000,000 has been allocated to purchase LARC products

In addition, Florida Medicaid expenditures for LARCs for FY 2015-16 totaled $11,293,557.

Substance Exposed Newborns

Statewide Task Force on Prescription Drug Abuse and Newborns

Abuse of drugs or alcohol by parents and other caregivers can have negative effects on the health, safety, and well-being of children either through the harm caused by prenatal drug exposure or the harm caused to children of any age by exposure to drug activity in their homes or environment.

The 2012 Florida Legislature created the Statewide Task Force on Prescription Drug Abuse and Newborns[9] to begin addressing the growing problem of neonatal abstinence syndrome (NAS).[10] The 15-member Task Force was composed of medical professionals, law enforcement, prevention experts and state legislators. The Task Force was charged by the Legislature with examining the scope of NAS in Florida, its long-term effects and the costs associated with caring for drug exposed babies, and which drug prevention and intervention strategies work best with pregnant mothers.

The Task Force adopted eight specific objectives that include:
- Collecting and organizing data concerning the nature and extent of neonatal withdrawal syndrome from prescription drugs in Florida;
- Collecting and organizing data concerning the costs associated with treating expectant mothers and newborns suffering from withdrawal from prescription drugs;

[7] *Id*.
[8] Data provided by Senate Appropriations Committee professional staff.
[9] Chapter 2012-120, Laws of Florida.
[10] NAS is a drug withdrawal syndrome in newborns following birth characterized by such symptoms as increased irritability, hypertonia, tremors, feeding intolerance and respiratory distress.

- Identifying available federal, state, and local programs that provide services to mothers who abuse prescription drugs and newborns with neonatal withdrawal syndrome;
- Evaluating methods to increase public awareness of the dangers associated with prescription drug abuse, particularly to women, expectant mothers, and newborns;
- Examining barriers to reporting neonatal withdrawal syndrome by medical practitioners while balancing a mother's privacy interests;
- Assessing evidence-based methods for caring for a newborn withdrawing from prescription drugs and how nurses can assist the mother in caring for their child;
- Developing a compendium of best practices for treating both prescription drug addicted mothers and infants withdrawing, both prenatal and postnatal; and
- Assessing the current state of substance abuse treatment for expectant mothers and determine what best practices should be used to treat drug addicted mothers.[11]

According to hospital discharge data provided by the Agency for Health Care Administration (AHCA), the number of babies born in Florida addicted to opiates has been on the rise every year in the past decade from 338 in 2005 up to 2,487 in 2015. Babies born addicted to opioids commonly remain hospitalized for weeks after they are delivered so doctors can gradually wean them off the drugs in their systems, usually by giving them diminishing amounts of morphine, phenobarbital (a relaxant) and other drugs to combat withdrawal symptoms.[12]

A recent state report on NAS noted that hospital charges for such patients average more than $53,000, a bill commonly sent to taxpayer-supported Medicaid plans. Medicaid typically pays only a fraction of that cost. The average cost, including prenatal and post-delivery care, runs roughly $9,000. Babies in drug withdrawal stay an average 20 days in the hospital, though some require months in a neonatal intensive care unit to fully recover.[13]

Child Abuse Prevention and Treatment Act (CAPTA)

The Child Abuse Prevention and Treatment Act (CAPTA) requires states to have policies and procedures in place to notify child protective services agencies of substance-exposed newborns and to establish a plan of safe care for newborns identified as being affected by substance abuse or having withdrawal symptoms resulting from prenatal drug exposure.[14]

CAPTA was further amended in 2016 by the Comprehensive Addiction and Recovery Act (CARA)[15] to add requirements for states to ensure the safety and well-being of infants following the release from the care of healthcare providers, by:

- Addressing the health and substance use disorder treatment needs of the infant and affected family members or caregivers;

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[11] Florida Office of the Attorney General, *Statewide Task Force On Prescription Drug Abuse & Newborns Final Rep*ort, February 2013, *available at*: http://myfloridalegal.com/webfiles.nsf/WF/RMAS-94LJPF/$file/Statewide_Task_Force_on_Prescription_Drug_Abuse_and_Newborns_Final_Report.pdf. (last visited March 19, 2017).

[12] Gluck, F., *Born High: Florida battles rising cases of addicted newborns*, *available at*: http://www.news-press.com/story/news/investigations/2016/07/16/born-high-florida-battles-rising-cases-addicted-newborns/87025868/. (last visited March 19, 2017).

[13] *Id*.

[14] U.S.C. s.5106a(b), as amended by the CAPTA Reauthorization Act of 2010 (P.L. 111-320).

[15] P.L. 114-198.

- Monitoring these plans of safe care to determine whether and how local entities are making referrals and delivering appropriate services to the infant and affected family or caregiver in accordance with state requirements; and
- Developing plans of safe care for infants affected by all substance abuse, not just illegal substance abuse, as was the requirement prior to this change.

Florida law includes exposure to controlled substances or alcohol in the definition of harm:

- Exposes a child to a controlled substance or alcohol. Exposure to a controlled substance or alcohol is established by:
  - A test, administered at birth, which indicated that the child's blood, urine, or meconium contained any amount of alcohol or a controlled substance or metabolites of such substances, the presence of which was not the result of medical treatment administered to the mother or the newborn infant; or
  - Evidence of extensive, abusive, and chronic use of a controlled substance or alcohol by a parent when the child is demonstrably adversely affected by such usage.[16]

There is currently no requirement that the parents of substance exposed newborns undergo an assessment or evaluation or complete treatment for substance abuse. The courts presently have the sole discretion to determine whether a parent is required to undergo such treatment.

Shared Family Care

In Shared Family Care (SFC), parent(s) and children are placed together in the home of a family who is trained to mentor and support the parents as they develop the skills and supports necessary to care for their children independently. SFC can also be used to prevent out-of-home placement, to provide a safe environment for the reunification of a family that has been separated, or to help parents consider other permanency options, including relinquishment of parental rights.[17]

SFC recognizes that many parents involved in the child welfare system do not intentionally harm their children but lack the skills and/or resources to adequately care for them. SFC addresses this issue by temporarily placing whole families in the homes of community mentors who, along with a team of professionals, help the families to obtain the skills and resources they need to move toward self-sufficiency and adequately care for their children.[18]

As an alternative to traditional in-home and out-of-home child welfare services, SFC is based on the following premises:

- Families are more likely to become stable and self-sufficient if their basic needs are met and a mentor helps them to establish a positive network of community resources and support;

[16] Section 39.01(30)(g), F.S. As used in this paragraph, the term "controlled substance" means prescription drugs not prescribed for the parent or not administered as prescribed and controlled substances as outlined in Schedule I or Schedule II of s. 893.03.
[17] Child Welfare Information Gateway, Shared Family Care, *available at*: https://www.childwelfare.gov/topics/supporting/support-services/familycare/. (last visited March 15, 2017).
[18] Price, A. and Wichterman, L., *Shared Family Care: Fostering the Whole Family to Promote Safety and Stability*, Journal of Family Social Work, Vol. 7(2) 2003.

- By nurturing and "reparenting" parents, and modeling and teaching them appropriate parenting and home management skills, SFC helps parents better protect and care for their children and helps families interact in a healthier manner; and
- If SFC is successful at keeping families together and preventing subsequent out-of-home placements, the long-term cost of the program will be less than traditional foster care.[19]

III. Effect of proposed Changes:

Section 1 amends s. 30.521, F.S., relating to dependency disposition hearings, to provide that adjudication of a child as dependent based upon evidence of harm as a result of exposing a child to a controlled substance or alcohol demonstrates good cause, and requires the parent whose actions caused the harm to submit to a substance abuse disorder assessment or evaluation and to participate in and comply with treatment and services identified as necessary.

Section 2 creates s. 39.6001, F.S., relating to substance exposed newborns, to require the department, in partnership with the Department of Health, the Agency for Health Care Administration, other state agencies and community partners to develop a strategy for providing coordinated services to help ensure the safety and well-being of substance exposed newborns that includes the development and implementation of safe care plans. The department is also required to monitor the plans to ensure that referrals are being made and services are being delivered.

Section 3 amends s. 39.6012, F.S., relating to case plan tasks and services, to provide that adjudication of a child as dependent based upon evidence of harm as a result of exposing a child to a controlled substance or alcohol demonstrates good cause, and requires the parent whose actions caused the harm to submit to a substance abuse disorder assessment or evaluation and to participate in and comply with treatment and services identified as necessary.

Section 4 creates s. 381.00515, F.S., relating to hormonal long-acting reversible contraception program, to require the Department of Health to:

- Establish a hormonal long-acting reversible contraception program;
- Contract with eligible family planning and health care providers for statewide implementation. Each contract must include provision of intrauterine devices and implants, training for providers and staff, technical assistance, general support to expand the capacity of family planning clinics, marketing and outreach, and any additional services DOH considers necessary.
- Seek grants from federal agencies and other sources; and
- Submit an annual report to the Governor, the President of the Senate and the Speaker of the House of Representatives, on the effectiveness of the HLARC program. The bill also specifies the information that is to be included in the report.

Section 5 creates s. 409.16741, F.S., relating to substance exposed newborns, to provide legislative findings and intent and require the department to:

[19] *Id*.

- Develop or adopt one or more screening and assessment instruments. Any assessment must include not only the needs of the infant, but also, the behaviors of the mother or father that may indicate a risk of harm to the child;
- Conduct multidisciplinary staffings that include individuals involved in the child's care;
- Assess, with the community-based care lead agencies, local service capacity and design a plan to develop the necessary capacity; and
- Ensure that cases involving substance exposed newborns are assigned to child protective investigators and case managers with specialized training in working with these infants and their families.

Section 6 creates s. 409.16742, F.S., relating to a shared family care residential services program for substance exposed newborns, to provide legislative findings and intent, to require the department to establish a pilot program based on the shared family care model to serve substance exposed newborns and their families in the Fourth Judicial Circuit. The department may contract with either the community-based care lead agency or a private entity with the capacity to provide residential care and required to specify services that should be available for newborns and their families through the pilot program.

Section 7 provides for an appropriation for the 2017-2018 state fiscal year of $750,000 in recurring funds from the General Revenue Fund to the Department of Health for the purpose of implementing the HLARC program.

Section 8 provides a statement of public necessity.

Section 9 provides an effective date of July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill provides a $750,000 appropriation from the General Revenue Fund to the Department of Health to implement an HLARC program. The fiscal impact on the Department of Children and Families to establish the pilot program for families of substance exposed newborns is unknown and may need an appropriation.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 39.521 and 39.6012 of the Florida Statutes.
This bill creates sections 39.6001, 381.00515, 409.16741, and 409.16742 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.