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| **Tab 1** | **CS/SB 768** by **HP, Rodriguez**; (Similar to CS/CS/H 00693) Department of Health |

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| ~~513362~~ | A | S | L | WD | AHS, Book | btw L.1122 - 1123: | 02/15 06:53 PM |

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| **Tab 2** | **CS/SB 1120** by **CF, Rodriguez**; (Similar to CS/CS/H 00893) Child Welfare |

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| **Tab 3** | **CS/SB 1262** by **CF, Burgess (CO-INTRODUCERS) Rouson**; (Similar to CS/CS/H 01277) Mental Health and Substance Abuse |

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| 814364 | A | S | RCS | AHS, Burgess | Delete L.332 - 384: | 02/16 12:56 PM |

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| **Tab 4** | **CS/SB 1436** by **CF, Garcia**; (Similar to CS/1ST ENG/H 00615) Human Trafficking |

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| **Tab 5** | **CS/SB 1600** by **CF, Bradley**; (Compare to CS/H 01249) Treatment of Defendants Adjudicated Incompetent to Stand Trial |

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| 774274 | A | S | RCS | AHS, Bradley | Delete L.20 - 43: | 02/16 12:56 PM |
| ~~118168~~ | AA | S | WD | AHS, Farmer | btw L.15 - 16: | 02/16 12:56 PM |
| ~~735792~~ | A | S | WD | AHS, Farmer | btw L.29 - 30: | 02/16 12:56 PM |

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| **Tab 6** | **SB 1712** by **Burgess (CO-INTRODUCERS) Rodrigues**; (Similar to CS/H 01315) Veteran Suicide Prevention Training Pilot Program |

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| **Tab 7** | **SB 1770** by **Book (CO-INTRODUCERS) Stewart**; (Similar to CS/H 01333) Donor Human Milk Bank Services |

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| 272010 | A | S | RCS | AHS, Book | Delete L.41 - 56: | 02/16 12:56 PM |

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| **Tab 8** | **CS/SB 1950** by **HP, Brodeur**; (Compare to H 00607) Statewide Medicaid Managed Care Program |

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| 702460 | A | S | RCS | AHS, Brodeur | Delete L.503 - 629. | 02/16 12:56 PM |

**The Florida Senate**

# COMMITTEE MEETING EXPANDED AGENDA

**APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES**
**Senator Bean, Chair**
**Senator Rodriguez, Vice Chair**

**MEETING DATE:** Wednesday, February 16, 2022
**TIME:** 10:00 a.m.—12:00 noon
**PLACE:** *Pat Thomas Committee Room,* 412 Knott Building

**MEMBERS:** Senator Bean, Chair; Senator Rodriguez, Vice Chair; Senators Book, Brodeur, Burgess, Diaz, Farmer, Harrell, Jones, Rodrigues, and Rouson

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 1 | **CS/SB 768**<br>Health Policy / Rodriguez<br>(Similar CS/H 693, Compare CS/CS/H 343, H 679, CS/S 566, S 1268) | Department of Health; Revising the purpose of the department's targeted outreach program for certain pregnant women; requiring the department to encourage high-risk pregnant women of unknown status to be tested for sexually transmissible diseases; removing the Children's Medical Services office from parties required to coordinate in the development of local emergency management plans for special needs shelters; deleting a requirement that certain nursing program graduates complete a specified preparatory course; defining the terms "doctoral degree from an American Psychological Association accredited program" and "doctoral degree in psychology", etc.<br><br>HP 01/26/2022 Fav/CS<br>AHS 02/16/2022 Favorable<br>AP | Favorable<br>Yeas 11 Nays 0 |
| 2 | **CS/SB 1120**<br>Children, Families, and Elder Affairs / Rodriguez<br>(Identical CS/H 893) | Child Welfare; Authorizing the Department of Children and Families, under certain circumstances, to place children in its custody in therapeutic group homes for residential mental health treatment without prior court approval; providing that the department, rather than the Agency for Health Care Administration, shall appoint qualified evaluators to conduct suitability assessments of certain children in the department's custody; revising requirements for suitability assessments, etc.<br><br>CF 01/25/2022 Fav/CS<br>AHS 02/16/2022 Favorable<br>AP | Favorable<br>Yeas 11 Nays 0 |

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 3 | **CS/SB 1262**<br>Children, Families, and Elder Affairs / Burgess<br>(Similar CS/H 1277) | Mental Health and Substance Abuse; Revising the conditions under which a patient's communication with persons outside of a receiving facility may be restricted; requiring a receiving facility to notify specified emergency contacts of individuals who are being involuntarily held for examination; requiring receiving facilities to document that an option to authorize the release of specified information has been provided, within a specified timeframe, to individuals admitted on a voluntary basis; requiring that reports issued by law enforcement officers when delivering a person to a receiving facility contain certain information related to emergency contacts, etc.<br><br>CF 01/25/2022 Fav/CS<br>AHS 02/16/2022 Fav/CS<br>AP | Fav/CS<br>Yeas 11 Nays 0 |
| 4 | **CS/SB 1436**<br>Children, Families, and Elder Affairs / Garcia<br>(Compare CS/H 615) | Human Trafficking; Providing the Statewide Council on Human Trafficking with an additional duty; requiring the direct support organization of the Statewide Council on Human Trafficking to develop certain training for firesafety inspectors; requiring foster parents and agency staff to complete preservice and inservice training related to human trafficking, etc.<br><br>CF 02/01/2022 Fav/CS<br>AHS 02/16/2022 Favorable<br>AP | Favorable<br>Yeas 11 Nays 0 |
| 5 | **CS/SB 1600**<br>Children, Families, and Elder Affairs / Bradley<br>(Compare CS/H 1249) | Treatment of Defendants Adjudicated Incompetent to Stand Trial; Providing that a forensic client who is being held in a jail awaiting admission to a Department of Children and Families facility and who is likely to regain competence to proceed may receive treatment at any facility designated by the department, etc.<br><br>CF 02/01/2022 Fav/CS<br>AHS 02/16/2022 Fav/CS<br>AP | Fav/CS<br>Yeas 11 Nays 0 |
| 6 | **SB 1712**<br>Burgess<br>(Similar CS/H 1315) | Veteran Suicide Prevention Training Pilot Program; Requiring the Department of Veterans' Affairs to establish the pilot program; requiring pilot program participants to receive certain training; requiring the department to contract with an organization to develop the curriculum for such training; requiring the department to submit an annual report to the Legislature by a specified date, etc.<br><br>MS 01/25/2022 Favorable<br>AHS 02/16/2022 Favorable<br>AP | Favorable<br>Yeas 11 Nays 0 |

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 7 | **SB 1770**<br>Book<br>(Similar CS/H 1333) | Donor Human Milk Bank Services; Authorizing the Agency for Health Care Administration to pay for donor human milk bank services as an optional Medicaid service if certain conditions are met; adding donor human milk bank services to the list of Medicaid services authorized for reimbursement on a fee-for-service basis; adding donor human milk bank services to the list of minimum benefits required to be covered by Medicaid managed care plans, etc.<br><br>HP 01/26/2022 Favorable<br>AHS 02/16/2022 Fav/CS<br>AP | Fav/CS<br>Yeas 11 Nays 0 |
| 8 | **CS/SB 1950**<br>Health Policy / Brodeur<br>(Similar H 7047, Compare H 607, CS/S 1080) | Statewide Medicaid Managed Care Program; Requiring, rather than authorizing, that the reimbursement method for provider service networks be on a prepaid basis; deleting a requirement that the Agency for Health Care Administration provide the opportunity for public feedback on a certain waiver application; revising requirements relating to the databook published by the agency consisting of Medicaid utilization and spending data; revising provisions relating to agency-defined quality measures under the achieved savings rebate program for Medicaid prepaid plans; providing that cancer hospitals meeting certain criteria are statewide essential providers, etc.<br><br>HP 01/26/2022 Fav/CS<br>AHS 02/16/2022 Fav/CS<br>AP | Fav/CS<br>Yeas 11 Nays 0 |

Other Related Meeting Documents

**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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 768 |
| INTRODUCER: | Health Policy Committee and Senator Rodriguez |
| SUBJECT: | Department of Health |
| DATE: | February 15, 2022 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Rossitto-Vanwinkle and Looke | Brown | HP | **Fav/CS** |
| 2. | Howard | Money | AHS | **Recommend: Favorable** |
| 3. | | | AP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:


CS/SB 768 addresses numerous health care-related issues regulated by the Department of Health (DOH). The bill:

- Updates the "Targeted Outreach for Pregnant Women Act of 1998";
- Amends section 381.0303, Florida Statutes., to specify that for pediatric special needs shelters, the DOH is the lead agency to coordinate local medical and health care providers for the staffing and management of the shelters and is the decision-making authority for determining the medical supervision in each special needs shelter;
- Allows the DOH to collect samples of marijuana and marijuana delivery devices, in general, from a medical marijuana treatment center (MMTC) for specified testing, rather than only samples of edibles;
- Expands MMTC recall requirements to all marijuana products and delivery devices, rather than only edibles;
- Provides an exception from criminal laws for the DOH employees to acquire, possess, test, transport, and lawfully dispose of marijuana and marijuana delivery devices;
- Amends statutes regulating several types of health care professions, including allopathic and osteopathic physicians, nurses, midwives, psychologists, orthotists, prosthetists, clinical lab personnel, chiropractors, mental health counselors, clinical social workers, and marriage and family therapists;
- Amends sections 460.406, 468.803, 483.824, and 490.005, Florida Statutes, to delete references to the term "regional" and replace it with the term "institutional" to conform with

the U.S. Department of Education accreditation nomenclature for approving health care-related educational institutions; and

- Amends section 766.314, Florida Statutes, authorizing the Florida Birth-Related Neurological Injury Compensation Association (NICA) to collect and enforce physician assessments in circuit court, if necessary, and requires the NICA to notify the DOH and the appropriate board of any unpaid final judgments against a physician within a specific timeframe.

The bill is projected to have an insignificant negative fiscal impact on the DOH, however, the agency can absorb this impact within existing resources.

The bill provides an effective date of July 1, 2022, except as otherwise provided.

## II. Present Situation:

### Targeted Outreach for Pregnant Women

The Targeted Outreach for Pregnant Women Act (TOPWA) was enacted by the Florida Legislature in 1998. The TOPWA program is designed to establish targeted outreach to high-risk pregnant women who may not be receiving proper prenatal care, who suffer from substance abuse problems, or who may be infected with the human immunodeficiency virus (HIV). The goal of the program is to provide these high-risk pregnant women with referrals for information and services.

In 2019, there were 453 HIV-exposed births in Florida. While there were no known perinatal HIV transmissions in 2019, the Department of Health (DOH) does not have a definitive status on roughly 25 percent of the 453 HIV-exposed births.

Without proper care for both mother and newborn, each of these births risks vertical transmission. The TOPWA supports outreach programs aimed at preventing vertical HIV transmission and other health issues by linking high-risk pregnant women with services that can help them have healthier pregnancies and deliveries and can aid them in ensuring their newborn gets a healthy start.[1]

Many of the women targeted by TOPWA programs may not otherwise receive prenatal care or know their HIV status. In 2021, there were eight TOPWA programs in Florida.[2] The TOPWA programs, which are funded through General Revenue (GR) dollars and grant funds from the federal Centers for Disease Control and Prevention (CDC), provided services to 7,703 women from January 2016 to July 2020. Women living with HIV made up just under 10 percent of TOPWA program enrollments.[3]

[1] Section 381.0045(2), F.S.
[2] Florida Department of Health, Diseases and Conditions, AIDS, Prevention, *TOWPA Map*, available at http://www.floridahealth.gov/diseases-and-conditions/aids/prevention/_documents/topwa/TOPWAProviderMap2021.pdf (last visited Nov. 2, 2021).
[3] Department of Health, *Senate Bill 768 2022 Agency Legislative Bill Analysis* (July 23, 2021) (on file with the Senate Committee on Health Policy).

If a pregnant woman tests positive for HIV, medical interventions and prevention, such as the following, can greatly reduce her risk of transmitting the virus to her baby during childbirth:

- Antiretroviral medication to the mother;
- Delivery by caesarian section;
- Avoiding breastfeeding; and
- Antiretroviral medication to the newborn.

The DOH has developed a GR-funded program, Baby Rxpress, which provides a six-week course of antiretroviral (ARV) medication to HIV-exposed newborns at no cost to the mother. In 2019, this program filled 304 prescriptions to 264 HIV-exposed newborns at a cost of $10,801.96, or $40.92 per baby.[4]

**Special Needs Shelter Program**

Section 381.0303, F.S., was enacted in 2000 to create the Special Needs Shelter Program to provide for the operation and closure of special needs shelters (shelters). The shelters are designed for persons with a physical impairment, mental impairment, cognitive impairment, or sensory disability who, during periods of evacuation or emergency, require sheltering assistance to have a safe and secure place to go during an emergency or disaster. In s. 381.0303(1), F.S., the Legislature designates the DOH, through its county health departments, as the lead agency for coordinating and recruiting health care practitioners to staff the shelters during emergencies or disasters.[5]

In s. 381.0303(2), F.S., the Legislature delineates the responsibilities for the shelters as follows:

- The DOH has the lead responsibility for coordinating local medical and health care providers, the American Red Cross, and other interested parties and in developing a plan for the staffing and medical management of the shelters;
- The DOH's local Children's Medical Services (CMS) offices have responsibility for the coordination of local medical and health care providers, the American Red Cross, and other interested parties in developing a plan for the staffing and medical management of the shelters;
- The county health departments, in conjunction with the local emergency management agencies, have lead responsibility for the coordination and recruitment of the health care practitioners to staff local shelters;
- Local emergency management agencies have responsibility for the designation and operation of the shelters during an emergency or disaster and the closure of the facilities following the event; and
- The local county health department, local CMS office, and local emergency management agency are jointly responsible for deciding who is responsible for the medical supervision in each shelter.[6]

According to the DOH, this shared lead responsibility between the DOH, through its local county health departments, and CMS, through its local offices was, in large part, due to the large local

[4] *Id.*
[5] Section 381.0303(1), F.S.
[6] Section 381.0303(2), F.S.

CMS workforce of health care practitioners with specialized training and experience in the provision of services for children with special needs. Through a series of program and organizational changes at the DOH, toward a more effective operation and cost savings, the CMS workforce has been reduced by more than 70 percent since 2018. Due to this change in the CMS workforce, the DOH advises that the CMS is unable to fulfill its responsibilities under s. 381.3030, F.S.[7]

**Medical Marijuana**

***Amendment 2***

On November 4, 2016, Amendment 2 was approved by the statewide electorate and established Article X, section 29 of the Florida Constitution. This section of the constitution became effective on January 3, 2017, and created several exemptions from criminal and civil liability for:

- Qualifying patients who medically use marijuana in compliance with the amendment;
- Physicians, solely for issuing physician certifications with reasonable care and in compliance with the amendment; and
- MMTCs and their agents and employees for actions or conduct under the amendment and in compliance with rules promulgated by the DOH.

***Implementation***

Subsequently, the Legislature passed SB 8-A in Special Session A of 2017.[8] The bill revised the Compassionate Medical Cannabis Act of 2014[9] in s. 381.986, F.S., to implement Article X, section 29 of the State Constitution.

***Testing Marijuana and Exemption from Criminal Offenses***

Pursuant to s. 381.986(8)(11)d., F.S., the DOH may select a random sample from edibles available for purchase in an MMTC's DOH-approved dispensing facility for testing. The DOH must test the random samples for potency, safety for human consumption, and accuracy of Tetrahydrocannabinol (THC) and Cannabidiol (CBD) labeling.

MMTCs are required to recall all edibles, including all edibles made from the same batch of marijuana, which fail to meet potency requirements, which are unsafe for human consumption, or for which the labeling of the THC and CBD concentration is inaccurate.

Presently, the DOH and its employees are not expressly exempt from criminal prosecution under ss. 893.13, 893.135, and 893.147, F.S., when acquiring, possessing, testing, transporting, and disposing of marijuana and delivery devices under certain circumstances when acting within the scope of their duties.[10]

[7] Department of Health, 2022 *Senate Bill 768 Fiscal Analysis* (July 23, 2021) (on file with the Senate Committee on Health Policy).
[8] Chapter 2017-232, Laws of Fla.
[9] Chapter 2014-157, Laws of Fla.
[10] Department of Health, *Senate Bill 1568 Fiscal Analysis* (Mar. 12, 2021) (on file with the Senate Committee on Health Policy).

**Additional Disclosure for Physician Licensure and Renewal**

Section 456,039, F.S., requires each physician,[11] chiropractor, and podiatrist seeking initial licensure, or license renewal, in Florida, in addition to normal required licensure information, to submit the following to the DOH:

- Name of each medical school attended, including dates of attendance, graduation, and a description of all graduate medical education completed, except continuing education (CE) requirements;
- Name of each hospital where the applicant has privileges;
- Primary practice address;
- Specialty board certifications, if any;
- Date applicant began practicing medicine;
- Medical school faculty appointments currently held and whether the applicant has had the responsibility for graduate medical education within the past 10 years;
- Any criminal offenses, felony or misdemeanor, of which the applicant has been found guilty, regardless of whether adjudication was withheld, or to which the applicant has pled guilty or nolo contendere, including those committed in another jurisdiction which would constitute a felony or misdemeanor in Florida;
- Any final professional disciplinary action within the previous 10 years in Florida or any other jurisdiction, or by any specialty board, similar national organization, licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home;
- Any claim or action for damages in Florida, in another jurisdiction or in a foreign country, for personal injury alleged to have been caused by error, omission, or negligence in the performance of licensee's professional services; and
- Fingerprints.

Any change in the above information must be updated within 45 days after the occurrence of an event or change in status that is required to be reported. The DOH compiles this information and submits it to the practitioner profile of the applicant.[12]

**Educational Institution Accreditation**

Each profession includes the requirement of completion of a program from a "regionally accredited" institution. The U.S. Department of Education issued a letter of guidance on February 26, 2020, specifying that final regulations published that year omit references to "regional" and "national" accreditation. The letter specifies, "Because the Department holds all accrediting agencies to the same standards, distinctions between regional and national accrediting agencies are unfounded." Provisions implemented in 34 C.F.R. § 602.32(d), relating to the recognition of accrediting agencies, will become effective January 1, 2021.[13]

[11] *See* ss. 458.345 and 459 021, F.S., Registered medical and osteopathic, residents are exempt from the requirement of 456.039, F.S.
[12] Section 456.041, F.S.
[13] U.S. Department of Education, Office of the Under Secretary, *Final Accreditation and State Authorization Regulations,* February 26, 2020, (on file with the Senate Committee on Health Policy).

**Nursing**

***Licensure by Examination***

Part I of ch. 464, F.S., the Nurse Practice Act, governs the licensure and regulation of nurses in Florida. Nurses are licensed by the DOH[14] and are regulated by the Board of Nursing (BON).[15] Currently, a person desiring to practice nursing in the state of Florida must obtain a Florida license by examination, endorsement[16]or have a multistate license.[17]

Applicants for licensure by examination as a registered nurse (RN) or licensed practical nurse (LPN) must, among other requirements:

- Graduate from an approved program or its equivalent as determined by the BON;[18]
- Submit an application to the DOH;
- Pay a fee;
- Submit information for a criminal background check;[19] and
- Pass the National Council Licensure Examination (NCLEX).[20]

Any applicant who fails the NCLEX three consecutive times, regardless of the jurisdiction where the examination is taken, must complete a board-approved remedial course before the applicant will be approved to re-take the NCLEX. After taking the remedial course, the applicant may be approved to retake the examination up to three additional times before the applicant must retake remediation. The applicant must apply for reexamination within six months after completion of remediation.[21]

If an applicant who graduates from an approved program does not take the licensure examination within six months after graduation, he or she must enroll in and successfully complete a BON-approved licensure examination preparatory course. The applicant is responsible for all costs associated with the course and may not use state or federal financial aid for such costs. The BON is directed to, by rule, establish guidelines for licensure examination preparatory courses.[22]

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[14] Section 464.008, F.S.

[15] The BON is composed of 13 members appointed by the Governor and confirmed by the Senate who serve four-year terms. All members must be residents of the state. Seven members must be registered nurses who are representative of the diverse areas of practice within the nursing profession. Three members must be licensed practical nurses and three members must be laypersons. At least one member of the board must be 60 years of age or older. *See* Section 464.004, F.S.

[16] Section 464.009, F.S., provides the requirements for licensure by endorsement, and requires an applicant to submit an application and fee, passing a criminal background screening, and 1) Hold a valid license to practice professional or practical nursing in another state or territory of the United States which, when issued, met or exceeded those in Florida at that time; 2) Meet the requirements for licensure in Florida and having successfully completed an examination in another state which is substantially equivalent to the examination in Florida; or 3) Have actively practiced nursing in another state, jurisdiction, or territory of the United States for two of the preceding three years without having his or her license acted against by the licensing authority of any jurisdiction.

[17] Section 464.0095, F.S., A "Multistate license" is a license to practice as a registered nurse (RN) or a licensed practical/vocational nurse (LPN/VN) issued by another Nurse Licensure Compact state's licensing board which authorizes the licensed nurse to practice in all party states under a multistate licensure privilege.

[18] Section 464.008(1)(c), F.S.

[19] Section 464.008(1)(b), F.S.

[20] Section 464.008(2), F.S.

[21] Section 464.008(3), F.S.

[22] Section 464.008 (4), F.S.

***Disciplinary Actions***

Once an individual is licensed to practice nursing in Florida, he or she has a professional responsibility to practice nursing at a minimum level of competency to ensure the safety of the public. The safe practice of nursing also requires that a nurse not commit any of the hundreds of acts that would constitute grounds for the denial of a license, disciplinary action, or even criminal prosecution, as set out under ss. 456.072(2), 464.0095, and 464.018, F.S.

Section 464.018(1)(c)-(e), F.S., as currently written, uses the modifying phrase, "regardless of adjudication;" but where the phrase is placed in subsections (c) and (d) verses subsection (e) has a significant impact on its application in law.

In s. 464.018(1)(e), F.S., the placement of the phrase, "regardless of adjudication," only applies to licensees "having been found guilty of," offenses listed in s. 435.04, F.S., or an offense of domestic violence under s. 741.20, F.S. "Regardless of adjudication" does not apply to those "entering a plea of guilty or nolo contendere to" listed offenses. This interpretation could result in those licensees entering a plea of nolo contendere or guilty and not being found guilty (i.e. adjudication is withheld), therefore not being subject to professional disciplinary action.

**Midwifery**

"Midwifery" is the practice of supervising the conduct of a normal labor and childbirth, with the informed consent of the parent; the practice of advising the parents as to the progress of the childbirth; and the practice of rendering prenatal and postpartal care.[23]

Chapter 467, F.S., is the Midwifery Practice Act. Any person who seeks to practice midwifery in Florida must be at least 21 years of age and be:

- Licensed under s. 464.012, F.S., as an Advanced Practice Registered Nurse (APRN) nurse midwife; or
- Licensed as a midwife under ch. 467, F.S.

Section 467.009, F.S., governs midwifery programs and education and training requirements which are a minimum of three years in an approved program. An applicant must have:

- A high school diploma or the equivalent.
- Taken at least three college-level credits such as math and English.

It is unclear under current law whether both a high school diploma and three college level credits are required for admission, or whether one or the other will satisfy the admission requirement.

Section 467.009, F.S., also requires a student midwife, during training, to undertake the care of 50 women in each of the prenatal, intrapartal, and postpartal periods, and observe an additional 25 women in the intrapartal period under the supervision of a preceptor, but the same women need not be seen through all periods. Prenatal, intrapartal, and postpartal periods are not defined, and the statute is unclear as to whether this requires 150 patients prenatal, intrapartal, and postpartal periods, or just 50 patients in any one of the three phases of pregnancy and delivery.

[23] Section 467.003(8), F.S.

The statute is also unclear as to whether the two references to intrapartal care and observation may be the same patient or require different patient contacts.

Section 467.009, F.S., uses the terms, "applicant" and "student midwife" interchangeably, which is inaccurate. These sections frame standards for admission, education, and clinical training in the context of student requirements. Preceptors direct, teach, supervise, and evaluate the learning experiences of the student midwife and may be physicians, licensed midwives, or a certified nurse midwife, who have a minimum of three years professional experience.[24] Persons with previous midwifery education, RNs, and LPNs may have a reduced training period, but in no case less than two years.

Chapter 467.009, F.S., does not include any provisions explicitly allowing a new midwifery program to be provisionally approved nor does it provide guidance to schools regarding the circumstances under which the DOH may rescind the approval of program.

Section 467.011, F.S., licensure by examination, requires the DOH to:
- Administer the licensure examination to test the proficiency of applicants in the core competencies required to practice midwifery as specified in s. 467.009, F.S.;
- Develop, publish, and make available to interested parties at a reasonable cost a bibliography and guide for the examination; and
- Issue a license to practice midwifery to an applicant who has graduated from an approved midwifery program, successfully completed the examination, and paid a licensure fee.

The DOH no longer administers midwifery examinations, and, pursuant to s. 456.017(c), F.S., the DOH has approved the use of a national examination for midwives seeking to become licensed.[25]

In lieu of examination, an applicant may apply for a license by endorsement based on verification that the applicant holds a current valid license to practice midwifery in another jurisdiction that has equivalent or more stringent licensure requirements than those in Florida.[26]

A midwife may accept and provide care only for those women who are expected to have a normal pregnancy, labor, and delivery and must ensure that:
- The patient has signed an informed consent form; and
- If the patient is delivering at home, the home is safe and hygienic.

The statute does not define "normal delivery," "low risk pregnancy," or "high risk pregnancy."

A midwife licensed under ch. 467, F.S., may administer the following:
- Prophylactic ophthalmic medication;
- Oxygen;
- Postpartum oxytocin;

[24] Section 467.003(12), F.S.
[25] Department of Health, *Senate Bill 678 2022 Agency Legislative Bill Analysis -Midwifery* (July 23, 2021) (on file with the Senate Committee on Health Policy).
[26] Section 467.0125, F.S.

- Vitamin K;
- Rho immune globulin (human); and
- Local anesthetic and other medications prescribed by a practitioner.[27]

A midwife's care of mothers and infants throughout the prenatal, intrapartal, and postpartal periods must be in conformity with the DOH rules and the health laws of Florida. The midwife must:

- Prepare a written plan of action with the family to ensure continuity of medical care throughout labor and delivery and to provide for immediate medical care if an emergency arises;
- Instruct the patient and family regarding the preparation of the environment and ensure availability of equipment and supplies needed for delivery and infant care;
- Instruct the patient in the hygiene of pregnancy and nutrition as it relates to prenatal care;
- Maintain equipment and supplies;
- Determine the progress of labor and, when birth is imminent, be immediately available until delivery is accomplished, and must:
  - Maintain a safe and hygienic environment;
  - Monitor the progress of labor and the status of the fetus;
  - Recognize early signs of distress or complications; and
  - Enact the written emergency plan when indicated;
- Remain with the postpartal mother until the conditions of the mother and the neonate are stabilized; and
- Instill into each eye of the newborn infant a prophylactic in accordance with s. 383.04, F.S.

Section 467.0125, F.S., also includes provisions for licensure by endorsement and temporary certification of a midwife who is qualifying for endorsement to practice in an area of critical need. This statute defines the term "area of critical need" differently from every other profession which has a temporary certification that allows practice in an area of critical need. In addition, the current provisions for temporary certification of midwives require revocation if the area in which they practice loses its designation as an area of critical need.

Section 467.205, F.S., provides that any accredited or state-licensed institution of higher learning, public or private, may provide midwifery education and training. The statute sets out the DOH approval requirements for programs desiring to conduct an approved midwifery education program. Under the application and recertification process:

- The applicant must submit evidence of the program's compliance with the requirements in s. 467.009, F.S.
- The DOH must survey the organization applying for approval. If the DOH is satisfied that the program meets the requirements of s. 467.009, F.S., it must approve the program.
- The DOH must certify whether each approved midwifery program complies with the standards developed under s. 467.009, F.S., at least every three years.
  - If the DOH finds that an approved program no longer meets the required standards, it may place the program on probation until such time as the standards are restored.

[27] Section 467.015, F.S.

- If a program fails to correct these conditions within a specified period of time, the DOH may rescind the approval.
- Any program having its approval rescinded has the right to reapply.

- Provisional approval of a new program may be granted pending the licensure results of the first graduating class.[28]

**Practice of Orthotics, Prosthetics, and Pedorthics**

The practice of orthotics, prosthetics, and pedorthics is governed by part XIV of ch. 468, F.S., and all three professions evaluate, measure, design, fabricate, assemble, fit, adjust, service, or provide the initial training necessary to accomplish the fitting of an orthosis or pedorthic device.[29]

Section 468.803, F.S., provides minimum qualifications for licensure to practice orthotics, prosthetics, and pedorthics. An applicant must be 18 years of age or older and must:

- Submit an application and fee;
- Submit fingerprint forms and the cost of the state and national criminal background checks;
- Be of good moral character;
- Have completed a one year residency or internship in orthotics or prosthetics approved by the Board of Orthotists and Prosthetists (BOAP); and
- Meet the following degree requirements to take the appropriate BOAP-approved examination:
  - *Orthoptist*: A bachelor of science or higher-level postgraduate degree in orthotics and prosthetics from a regionally accredited college or university, or a bachelor's degree with a certificate in orthotics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the BOAP.
  - *Prosthetist:* A bachelor of science or higher-level postgraduate degree in orthotics and prosthetics from a regionally accredited college or university, or a bachelor's degree with a certificate in prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the BOAP; and
- Pass the BOAP-approved examination.

**Clinical Lab Personnel**

Part I of ch. 483, F.S., regulates clinical laboratory personnel. "Clinical laboratory personnel" includes a clinical laboratory director, supervisor, technologist, blood gas analyst, or technician who performs or is responsible for laboratory test procedures, but the term does not include trainees, persons who perform screening for blood banks or plasmapheresis centers, phlebotomists, or persons employed by a clinical laboratory to perform manual pretesting duties or clerical, personnel, or other administrative responsibilities.[30]

[28] Section 467.205, F.S.
[29] Section 468.80, F.S.
[30] Section 483.803(4), F.S.

Section 483.824(2), F.S., requires that the doctoral degree held by a clinical laboratory director must be from a regionally-accredited institution in a chemical, physical, or biological science.

**Psychologists**

Chapter 490, F.S., regulates the practice of psychology by psychologists. A psychologist is a person licensed by examination under s. 490.005(1), F.S., or endorsement under s. 490.006, F.S.

Section 490.003. F.S., defines a "doctoral-level psychological education" and "doctoral degree in psychology" as of July 1, 1999, to include a Psy.D., an Ed.D. in psychology, or a Ph.D. in psychology from a psychology program at an educational institution that, at the time the applicant was enrolled and graduated:

- Had institutional accreditation from an agency recognized and approved by the U.S. Department of Education or was recognized as a member in good standing with the Association of Universities and Colleges of Canada; and
- Had programmatic accreditation from the American Psychological Association (APA).

Section 490.005, F.S., provides that any person desiring to be licensed by examination as a psychologist must apply to the DOH to take the licensure examination. The DOH will license each applicant who the Board of Psychology (BOP) certifies has:

- Completed an application and submitted a fee;
- Submitted proof satisfactory to the BOP that the applicant has received:
  - Doctoral-level psychological education; or
  - The equivalent of a doctoral-level psychological education from a program at a school or university located outside the U.S.;
- Had at least two years or 4,000 hours of experience in the field of psychology; and
- Passed the licensing examination.

Section 490.0051, F.S., also requires the DOH to issue a provisional psychology license to each applicant who the BOP certifies has:

- Completed the application form and paid the fee;
- Earned a doctoral degree in psychology as defined in s. 490.003(3); and
- Met any additional requirements established by BOP rule.

Provisional licensees must practice under the supervision of a licensed psychologist until the provisional licensee receives a license or a letter from the DOH stating that he or she is licensed as a psychologist. A provisional license expires 24 months after the date it is issued and may not be renewed or reissued.

**Mental Health Professionals**

Section 491.005, F.S., sets out the educational and examination requirements for a clinical social worker, marriage and family therapist, and mental health counselor to obtain a license by examination in Florida. An individual applying for licensure by examination who has satisfied the clinical experience requirements of s. 491.005, F.S., or an individual applying for licensure by endorsement pursuant to s. 491.006, F.S., intending to provide clinical social work, marriage and family therapy, or mental health counseling services in Florida, while satisfying coursework

or examination requirements for licensure, must obtain a provisional license in the profession for which he or she is seeking licensure prior to beginning practice.[31]

An individual who has not satisfied the postgraduate or post-master's level of experience requirements under s. 491.005, F.S., must register as an intern in the profession for which he or she is seeking licensure before commencing the post-master's experience requirement. An individual who intends to satisfy part of the required graduate-level practicum, internship, or field experience outside the academic arena, must register as an intern in the profession for which he or she is seeking licensure before commencing the practicum, internship, or field experience.[32]

***Clinical Social Workers***

Section 491.005(1), F.S., relates to licensure by examination for clinical social workers. The DOH must issue a license to an applicant as a clinical social worker if the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling (Board) certifies that the applicant:

- Has submitted an application and appropriate fees;
- Has earned a doctoral degree in social work from a graduate school of social work accredited by an accrediting agency recognized by the U.S. Department of Education, or a master's degree in social work from a graduate school of social work which:
  - Was accredited by the Council on Social Work Education (CSWE);
  - Was accredited by the Canadian Association of Schools of Social Work (CASSW); or
  - Has been determined to be an equivalent program to programs approved by the CSWE by the Foreign Equivalency Determination Service of the CSWE;
  - Completed all of the following coursework:
    - A supervised field placement during which the applicant provided clinical services directly to clients; and
    - Twenty-four semester hours or 32 quarter hours in theory of human behavior and practice methods as courses in clinically oriented services, with a minimum of one course in psychopathology and no more than one course in research;
- Has completed at least two post graduate years of clinical social work experience under the supervision of a licensed clinical social worker or the equivalent supervisor as determined by the Board;[33]
- Has passed a theory and practice examination; and
- Demonstrates, in a manner designated by Board rule, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.

***Marriage and Family Therapists***

Section 491.005(3), F.S., relates to licensure by examination for marriage and family therapists.

[31] Section 491.0046, F.S.
[32] Section 491.0045, F.S.
[33] Section 491.005(1)(c), F.S. An individual who intends to practice in Florida to satisfy clinical experience requirements must register with the DOH pursuant to s. 491.0045, F.S., before commencing practice.

The DOH must issue a license to an applicant as a marriage and family therapist if the Board certifies that the applicant has:

- Submitted an application and appropriate fee;
- A minimum of a master's degree with major emphasis in marriage and family therapy or a closely related field from a:
  - Program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (CAMFTE); or
  - Florida university program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP);
- Documentation of the completion of graduate courses approved by the Board;[34]
- Completed at least two years of clinical experience during which 50 percent of the applicant's clients were receiving marriage and family therapy services:
  - At the post-master's level; and
  - Under the supervision of a licensed marriage and family therapist with at least five years of experience, or the equivalent, and whom the Board determines is a qualified supervisor;
- Passed a theory and practice examination provided by the DOH;[35]
- Demonstrated, in a manner designated by Board rule, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.[36]

The required master's degree must have been earned at an institution of higher education that, at the time the applicant graduated, was fully accredited by a regional accrediting body recognized by:

- The Commission on Recognition of Postsecondary Accreditation (CORPA);
- A member in good standing with the Association of Universities and Colleges of Canada; or
- An institution of higher education located outside the United States and Canada which, at the time the applicant attended and graduated, maintained a standard of training substantially equivalent to the standards of training of those institutions in the United States which are accredited by a regional accrediting body recognized by the CORPA.[37]

The applicant has the burden of establishing that all above requirements for licensure are met.

An applicant who has a master's degree from a program that did not emphasize marriage and family therapy may complete the coursework requirement in an institution fully accredited by the CAMFTE, and recognized by the U.S. Department of Education.

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[34] Section 491.005(3)(b), F.S. If the course title that appears on the applicant's transcript does not clearly identify the content of the coursework, the applicant must provide additional documentation, including, but not limited to, a syllabus or catalog description published for the course.

[35] *See* s. 491.004(5), F.S., and Fla. Admin. Code R. 64B4-3.003(2)(c) and 3, (2021). The DOH no longer provides the theory and practice examination for Marriage and Family Therapists. The examination used is the one developed by the Examination Advisory Committee of the Association of Marital and Family Therapy Regulatory Board (AMFTRB). The minimum passing score is established by that provider as well.

[36] *See* Fla. Admin. Code R. 64B4-3.0035, (2021).

[37] *Id.* Such foreign education and training must have been received in an institution or program of higher education officially recognized by the government of the country in which it is located as an institution or program to train students to practice as professional marriage and family therapists or psychotherapists.

To satisfy the clinical experience requirements, an individual who intends to practice in Florida must register with the DOH before he or she may commence practice.

A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.

The DOH must issue a dual license to persons licensed as psychologists, clinical social workers, mental health counselors, and psychiatric advanced practice registered nurses, if the candidate has:

- A valid, active license for at least three years; and
- Passed the examination provided by the DOH for marriage and family therapy.

**Mental Health Counselors**

Section 491.005(4), F.S., relates to licensure by examination for mental health counselors. Education and training in mental health counseling must have been received in an institution of higher education that, at the time the applicant graduated, was fully accredited by:

- A regional accrediting body recognized by the Council for Higher Education Accreditation (CHEA) or its successor;
- A publicly recognized member in good standing with the Association of Universities and Colleges of Canada; or
- An institution of higher education located outside the United States and Canada which, at the time the applicant was enrolled and at the time the applicant graduated, was officially recognized by the government of the country in which it is located as an institution or program, to train students to practice as mental health counselors that maintained a standard of training substantially equivalent to the standards of training of those institutions in the United States which are accredited by a regional accrediting body recognized by the CHEA or its successor.

The DOH must issue a license to an applicant as a mental health counselor if the Board certifies that the applicant has:

- Submitted an application and appropriate fees;
- Earned a minimum of a master's degree from:
    - A mental health counseling program accredited by the CACREP[38] which includes clinical and didactic instruction, including courses in human sexuality and substance abuse; or
    - A non-CACREP accredited program related to the practice of mental health counseling, but with coursework and practicum, internship, or fieldwork that meet all of the following:
        - Thirty-three semester hours, or 44 quarter hours, which must include a minimum of three semester hours, or four quarter hours, of graduate-level coursework in 11 specified content areas;[39]or

[38] Council for Accreditation of Counseling & Related Educational Programs, *2016 CACREP Standards*, *available at* http://www.cacrep.org/wp-content/uploads/2018/05/2016-Standards-with-Glossary-5.3.2018.pdf (last visited Nov. 20, 2021).
[39] *See* s. 491.005(4)(b)1.a., F.S. The graduate course work must include the following 11 content areas: counseling theories and practice; human growth and development; diagnosis and treatment of psychopathology; human sexuality; group theories

    - A minimum of one graduate level course emphasizing the diagnostic processes, including differential diagnosis and the use of the current diagnostic tools, such as the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. The graduate program must have emphasized the common core curricular experience; or
    - An equivalent program to the two previously described options, as determined by the Board, including at least 700 hours of university-sponsored supervised clinical practicum, internship, or field work, that includes at least 280 hours of direct client services, as required by the CACREP accrediting standards for mental health counseling programs. This experience may not be used to satisfy the post-master's clinical experience requirement;
- Had at least two years of clinical experience in mental health counseling, which must be at the post-master's level under the supervision of a licensed mental health counselor or the equivalent who is a Board qualified supervisor;[40]
- Passed a theory and practice examination provided by the DOH;[41] and
- Demonstrated, in a manner designated by Board rule, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.[42]

Beginning July 1, 2025, an applicant for mental health counseling licensure must have a master's degree from a program that is accredited by the CACREP which consists of at least 60 semester hours or 80 quarter hours.

A licensed mental health professional is required to be on the premises when clinical services are provided by a registered intern in a private practice setting. Section 491.005, F. S., contains the same provision for registered clinical social worker interns.

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and practice; individual evaluation and assessment; career and lifestyle assessment; research and program evaluation; social and cultural foundations; substance abuse; and legal, ethical, and professional standards issues in the practice of mental health counseling. Courses in research, thesis or dissertation work, practicums, internships, or fieldwork may not be applied toward this requirement.

[40] Section 491.005(4), F.S., An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045, F.S., before commencing practice. If a graduate has a master's degree with a major related to the practice of mental health counseling which did not include all the coursework required under sub-subparagraphs (b)1.a. and b., credit for the post-master's level clinical experience may not commence until the applicant has completed a minimum of seven of the courses required under sub-subparagraphs (b)1.a. and b., as determined by the Board, one of which must be a course in psychopathology or abnormal psychology. A doctoral internship may be applied toward the clinical experience requirement.

[41] *See* s. 491.004(5), F.S., and Fla. Admin Code R. 64B4-3.003(2)(b) and 3, (2021). The DOH no longer provides the theory and practice examination for mental health counselors. The examination used is the National Clinical Mental Health Counseling Examination (NCMHCE), clinical simulation examination developed by the National Board for Certified Counselors (NBCC). Applicants for licensure by endorsement may use the National Counselor Examination for Licensure and Certification (NCE) if the exam was taken prior to the year 2000. The minimum passing score is established by the test provider.

[42] Fla. Admin. Code R. 64B4-3.0035, (2021).

***Recent Legislative History of Section 491.005, F.S.***

The current program accreditation and licensure requirements in s. 491.005, F.S., for social workers, marriage and family therapists and mental health counselors were enacted during the 2020 legislative session.

As of July 1, 2020, an applicant seeking licensure under current s. 491.005(4), F.S., as a mental health counselor was required to have a master's degree from a program accredited by the CACREP beginning July 1, 2025. Until July 1, 2025, mental health counseling students in programs related to the practice of mental health counseling that were not accredited by the CACREP could still obtain a license as a mental health counselor by satisfying the additional statutory requirements in s. 491.005(4), F.S., which required coursework and practicum, internship, or fieldwork consisting of at least 60 semester hours or 80 quarter hours and meeting other specific requirements. This window of time also gave those non-CACREP accredited programs time to apply for and obtain CACREP accreditation.

However, for marriage and family therapy licensure candidates, the current s. 491.005(3), F.S., contains no similar window of time for students to obtain licensure, or programs to obtain CAMFTE or CACREP accreditation. On July 1, 2020, students who had satisfied the previous requirements of s. 491.005(3), F.S., for licensure in programs not accredited by the CAMFTE, or who were in a Florida program not accredited by the CACREP, became immediately unable to obtain a license to practice marriage and family therapy without seeking a variance from the Board.

Currently, there are six universities in Florida with a marriage and family program that are not accredited by either the COAMFTE or CACREP. They are: Carlos Albizu, Jacksonville University, Palm Beach Atlantic University, St. Thomas University, University of Miami, and University of Phoenix. As a result, students who are presently enrolled in a marriage and family program at one of the specified universities will not meet minimum requirements for Florida licensure upon graduation, although the programs did meet the requirements at the time of the student's enrollment.[43]

***Regional Accreditation***

The minimum qualifications for licensure specified in s. 491.005(3), F.S., includes the requirement of completion of a graduate program from a "regionally accredited body recognized by the Commission on Recognition of Postsecondary Accreditation." The U.S. Department of Education issued a letter of guidance on February 26, 2020, specifying that final regulations published that year omit references to "regional" and "national" accreditation. The letter specifies, "Because the Department holds all accrediting agencies to the same standards, distinctions between regional and national accrediting agencies are unfounded." Provisions implemented in 34 C.F.R. s. 602.32(d), relating to the recognition of accrediting agencies, will become effective January 1, 2021.[44]

[43] Department of Health, *Senate Bill 768 2022 Agency Legislative Bill Analysis - Mental Health Professionals* (July 23, 2021) (on file with the Senate Committee on Health Policy.)
[44] *Id.*

***Department Examination***

The DOH has discontinued the practice of conducting examinations or purchasing examinations for licensure. Applicants are presently responsible for coordinating the completion of an examination with an approved vendor and submitting passing scores to the applicable board to meet minimum qualifications. Current statutory references to the DOH collecting fees for examinations or conducting examinations is not consistent with current practice.[45]

**Florida Birth-Related Neurological Injury Compensation Association (NICA)**

In 1988, the Florida Legislature created the Florida Birth-Related Neurological Injury Compensation Association (NICA), to provide compensation, long-term medical care, and other services to persons with birth-related neurological injuries.[46] If an infant suffers such an injury, and the physician participates in NICA and delivers obstetrical services in connection with the birth, then an administrative award for a compensable injury is the infant's sole and exclusive remedy for the injury, with exceptions.[47] Although the benefits paid under the Florida Birth-Related Neurological Injury Compensation Plan (the Plan) are limited, the Plan does not require the claimant to prove malpractice and provides a streamlined administrative hearing process to resolve the claim.[48]

A "birth-related neurological injury" is an injury to the brain or spinal cord of a live infant who weighs at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant who weighs at least 2,000 grams at birth caused by oxygen deprivation or by mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital.[49] Such an injury addressed by this statute renders the infant permanently and substantially mentally and physically impaired.[50]

The NICA is an independent association, and was created by the Legislature to manage the Plan. Although it is not a state agency, NICA is subject to regulation and oversight by the Office of Insurance Regulation (OIR) and the Joint Legislative Auditing Committee. Directors on the NICA's board are appointed by the Chief Financial Officer for staggered terms of three years or until their successor is appointed, but there is no limit on the number of terms a director may serve.[51] The five-member board of directors of NICA administers the Plan.[52] The board of directors is composed of:

- One citizen representative;
- One representative of participating physicians;
- One representative of hospitals;

[45] *Id.*
[46] Chapter 88-1, ss. 60-75, Laws of Fla., was enacted by the Legislature to stabilize and reduce malpractice insurance premiums for physicians practicing obstetrics. The intent of the Legislature is to provide compensation, on a no-fault basis, for a limited class of high costs catastrophic injuries, specifically birth-related neurological injuries, that result in unusually high costs for custodial care and rehabilitation. Section 766.301, F.S.
[47] Section 766.31(1), F.S.
[48] See *Florida Birth-Related Neurological Injury Compensation Ass'n v. McKaughan*, 668 So.2d 974, 977 (Fla. 1996).
[49] Section 766.302(2), F.S.
[50] *Id.*
[51] Section 766.315, F.S., and ch. 88-1, s. 74, Laws of Fla.
[52] Sections 766.315(1) and (2), F.S.

- One representative of casualty insurers; and
- One representative of physicians other than participating physicians.[53]

The duties of the NICA board of directors include:
- Administering the Plan;
- Administering the funds collected on behalf of the Plan;
- Reviewing and paying claims;
- Directing the investment and reinvestment of any surplus funds over losses and expenses, provided that any investment income generated thereby remains credited to the Plan;
- Reinsuring the risks of the Plan in whole or in part;
- Suing and being sued, appearing and defending, in all actions and proceedings in its name;
- Exercising all powers necessary or convenient to effect any or all of the purposes for which the Plan was created;
- Entering into such contracts as are necessary or proper to administer the Plan;
- Employing or retaining such persons as are necessary to perform the administrative and financial transactions and responsibilities of the Plan;
- Taking such legal action as may be necessary to avoid payment of improper claims; and
- Indemnifying any person acting on behalf of the Plan in an official capacity, provided that such person acted in good faith.[54]

Annually, the NICA must furnish audited financial reports to:
- Any Plan participant upon request;
- The OIR; and
- The Joint Legislative Auditing Committee.[55]

The reports must be prepared in accordance with accepted accounting procedures. The OIR or the Joint Legislative Auditing Committee may conduct an audit of the Plan at any time.[56]

**NICA Funding**

The initial funding for the Plan is derived from an appropriation of $20 million by the Legislature at the time the Plan was created[57] and annual assessments paid by physicians and hospitals.[58] A participating physician is required to pay a $5,000 fee each year for coverage which runs January 1 through December 31.[59] All licensed Florida physicians pay a mandatory fee of $250, regardless of specialty. Hospitals pay $50 for each live birth during the previous calendar year. Certain exemptions apply to all of these categories, including resident physicians,

[53] Section 766.315, F.S., and ch. 88-1, s. 74, Laws of Fla.
[54] Section 766.315(4), F.S.
[55] Section 766.315(5)(e), F.S.
[56] *Id*.
[57] Section 766.314(5)(b), F.S.
[58] Section 766.314, F.S.
[59] *Id*.

retired physicians, government physicians, and facilities.[60] In 2019, NICA collected $26,989,960 in hospital and physician assessments. In 2020, NICA collected $27,000,000.[61]

Section 766.314, F.S., requires the OIR to maintain a $20 million reserve in the Insurance Regulatory Trust Fund. If the assessments collected and the appropriation of funds provided by ch. 88-277, s. 41, Laws of Florida, to the Plan from the trust fund are insufficient to maintain the Plan on an actuarially sound basis, the OIR is authorized to transfer an additional amount up to $20 million to the NICA from the Insurance Regulatory Trust Fund reserve.[62]

***Obsolete Statutory References and Provisions***

Currently, s. 766.314, F.S., contains numerous references to the Department of Business and Professional Regulation (DBPR) as the agency housing the Florida Board of Medicine and the Florida Board of Osteopathic Medicine. All medical boards were moved to the DOH in the early 2000s. The DOH accepted all of the responsibilities in this statute when the boards moved; however, the statute still indicates that these functions should be performed by the DBPR. In addition, the statute contains obsolete language related to how the initial NICA assessment was collected in 1988. This language is no longer needed.

***"Following Year" Assessments***

The statute requires the DBPR to collect the initial NICA assessment (fee) from all applicants. The statute also requires that if a license is being issued between October 1 and December 31, the DBPR is to collect the fee for the following year.

Currently, the DOH is not collecting the "following year" fees from individuals licensed during the specified period. Every licensee pays the initial NICA assessment (ranging from $0 to $5,000) at the time of application. The "following year" fees have been collected directly by NICA since the boards were moved to the DOH. NICA requires fees to be paid by January 31 of the calendar year.

***Data Sharing with NICA***

The statute requires the DBPR to provide a listing in a computer-readable format of the names and addresses of physicians licensed under chs. 458 and 459, F.S., as often "as determined to be necessary."

Currently, the DOH provides NICA with a list of newly licensed physicians each month, including their license numbers, the date they were licensed, and the fees collected. Any additional information that NICA may need can be downloaded from the DOH's website. This coincides with the transfer of those fees collected by the DOH to NICA, allowing NICA to reconcile the amount received with the fees listed in the monthly report.

[60] *Id.*
[61] Turner Consulting, Inc., *Proposed Increase in Parental Award – Section 766.31 (1) (b) (1), Florida Statutes* (Jan. 14, 2020).
[62] Section 766.314(5)(b), F.S.

## III. Effect of Proposed Changes:

### Targeted Outreach for Pregnant Women

The bill amends s. 381.0045, F.S., to:

- Add pregnant women who are suffering from mental health problems to the list of outreach targets;
- Encourage high risk pregnant women to get tested for other sexually transmissible diseases, as well as human immunodeficiency virus (HIV), per the Department of Health (DOH) rule;
- Provide pregnant women with information on:
  - The need for antiretroviral medications, deleting reference to a single type of antiretroviral (AZT), for themselves and their newborn; and
  - How to access antiretroviral medications after discharge from the hospital;
- Link women to mental health services; and
- Require additional follow up for HIV-exposed newborns to determine final HIV status and ensure continued linkages to care, if needed.

### Special Needs Shelters

The bill amends s. 381.0303, F.S., and removes Children's Medical Services (CMS) from responsibility for coordinating local medical and health care providers, the American Red Cross, and other interested parties in developing a plan for the staffing and medical management of pediatric special needs shelters. The bill instead specifies that the DOH has the sole lead-agency responsibility in the coordination of local medical and health care providers for the staffing and management of pediatric special needs shelters and is the decision-making authority for determining the medical supervision in each special needs shelter. Under the bill, the DOH will no longer share that duty with CMS.

### Medical Marijuana Sampling and Testing

The bill amends s. 381.986, F.S., related to the medical use of marijuana to:

- Allow the DOH to collect samples of marijuana and marijuana delivery devices from a medical marijuana treatment center (MMTC) for specified testing. Currently, the DOH may only collect samples of edibles;
- Expand MMTC recall requirements to all marijuana products and delivery devices, rather than only edibles; and
- Provide an exception from criminal laws for the DOH employees to acquire, possess, test, transport, and lawfully dispose of marijuana and marijuana delivery devices.

### Additional Disclosure Requirement for Physician Licensure and Renewal

The bill amends s. 456.039, F.S., requiring each physician seeking licensure, or license renewal, under chs, 458 or 459, F.S., to provide, in addition to the other requirements, proof of payment of the Neurological Injury Compensation Association (NICA) assessment required under s. 766.314, F.S., if applicable.

**Chiropractic Licensure**

The bill amends s. 460.406, F.S., to delete references to the term "regional" and replaces it with the term "institutional" to conform with the U.S. Department of Education accreditation nomenclature for approving educational institutions.

**Nursing Licensure and Disciplinary Actions**

The bill amend s. 464.008, F.S., and deletes the requirement that graduates from an approved nursing program who do not take the licensure examination within six months after graduation, must successfully complete and pay for a board-approved licensure examination preparatory course.

The bill also amends s. 464.018(1)(e), F.S., and moves the placement of the phrase, "regardless of adjudication," after the phrase "[h]aving been found guilty of, or entered a plea of nolo contendere or guilty to", to clarify that "regardless of adjudication" does not apply only to guilty pleas but to any plea to offenses listed in ss. 435.04, F.S., or 741.28, F.S.

**Midwifery**

The bill amends s. 467.003(12) to clearly define "preceptor" in the midwifery education process. Specifically, the bill provides that a preceptor may not supervise an individual as a midwifery student unless the student has been enrolled in an approved midwifery program.

The bill defines "prelicensure course" to mean a course of study, offered by an accredited midwifery program and approved by the DOH, which an applicant for licensure must complete before a license may be issued, and which provides instruction in the laws and rules of Florida and demonstrates the student's competency to practice midwifery. The bill clarifies language to promote consistency in terminology and that midwifery programs must incorporate all required standards, guidelines, and education objectives.

The bill also clarifies that both a high school diploma or the equivalent and three college-level credits in math and English or demonstration of competency in communication and computation may be required for admission to a midwifery program. The bill amends s. 467.009, F.S., and requires, for the accreditation and approval of midwifery programs, that a program's clinical training must include all of the following:

- Care for 50 women in each of the prenatal, intrapartal, and postpartal periods under the supervision of a preceptor;
- Observation of an additional 25 women in the intrapartal period before qualifying for a license;
- Training in a hospital or alternate birth settings or both; and
- Assessment and differentiation between a high-risk and low-risk pregnancy.

The bill amends s. 467.011, F.S., to require the following for the issuance of a midwifery license:

- Application and fee;
- Graduation from:
    - An accredited and approved midwifery program;

- A medical or midwifery program offered in another jurisdiction whose graduation requirements were equivalent to or exceeded those required in Florida;
- Completion of a prelicensure course offered by an accredited and approved midwifery program; and
- A passing score on the examination specified by the DOH.

The bill amends s. 467.0125, F.S, to repeal the abbreviated oral examination to determine the applicant's competency without a written examination for temporary certificates and clarifies the criteria for obtaining a license by endorsement and temporary certificate to practice in areas of critical need. The bill does not specifically define "areas of critical need" for temporary certificates but requires the applicant to:

- Specify that he or she will only practice in one or more of the following areas:
  - A county health department;
  - A correctional facility;
  - A U.S. Department of Veterans' Affairs clinic;
  - A community health center funded by s. 329, s. 330, or s. 340 of the United States Public Health Service Act;
  - Any other agency or institution that is approved by the state Surgeon General that provides health care to meet the needs of an underserved populations in this state; or
  - Areas of critical need determined by the state Surgeon General, which areas include, but are not be limited to, health professional shortage areas designated by the U.S. Department of Health and Human Services.
- Practice only under the supervision of a physician, an Advanced Practice Registered Nurse (APRN) certified nurse midwife or a midwife licensed under ch. 467, F.S., who has a minimum of three years professional experience; and
- Voluntarily relinquish the temporary certificate, or report a new practice area of critical need to the DOH, if his or her current practice area ceases to be an area of critical need.

The bill amends s. 467.205, F.S., to update the DOH's approval process of midwifery programs to allow such programs to be provisionally approved for five years. This conforms to the five-year period provisional licensure period the Florida Department of Education's Commission for Independent Education uses when seeking accreditation status. For private institutions, the bill adds to the Council for Higher Education Accreditation (CHEA), an accrediting agency approved by the U.S. Department of Education, as an institutional accrediting agency for direct-entry midwifery education programs and its licensing or provisional licensing by the Commission for Independent Education. The DOH will be able to give provisional approval to a new program that has met all requirements except for showing its students have an 80-percent passage rate on the national exam. Programs provisionally approved will have five years to demonstrate the required exam approval rate after they are preliminary approved.

The bill requires the DOH to certify every three years whether each approved midwifery program is compliant and has maintained compliance with the requirements of s. 467.009, F.S., or has lost its accreditation status. The DOH must provide its finding to the program in writing and may place the program on probationary status for a specified period of time, not to exceed three years. If a program on probationary status does not come into compliance or regain its accreditation status within the specified time, the DOH may rescind the program's approval.

**Practice of Orthotics, Prosthetics, and Pedorthics**

The bill amends part XIV of ch. 468, F.S., to reflect current procedures for applicants to obtain a criminal history check and the method of transmission to the DOH for review. The DOH no longer collects fingerprint forms or fees from applicants to process the initial criminal history check for licensure. Applicants are required to complete fingerprinting electronically through independent vendors and provide an originating agency identifier number specific to the profession for the results to be submitted to the DOH. If a criminal history is indicated, the BOAP will review the application for consideration of licensure.[63]

The bill also amends the educational requirements for orthotists and prosthetists. The orthoptist and prosthetists acceptable bachelor of science or higher-level postgraduate degree in orthotics and prosthetics from an accredited college or university must now also specifically be recognized by the Commission on Accreditation of Allied Health Education Programs.

The bill deletes references to the term "regionally accredited" and replaces it with the term "institutionally accredited" or simply references the programmatic accrediting body to conform with the U.S. Department of Education accreditation nomenclature for approving educational institutions.[64]

**Clinical Lab Personnel**

The bill amends s. 483.824(2), F.S., to delete the reference to the term "regionally" and replace it with "institutionally" in regard to the accredited institution at which a clinical laboratory director is required to have earned a doctoral degree in a chemical, physical, or biological science.

**Psychologists**

The bill amends ss. 490.003, 490.005, and 490.0051, F.S., to clarify definitions and the educational requirements for psychologists applying for licensure by examination or provisional licensure.

The bill defines a "doctoral degree from an APA accredited program" as a Psy.D., an Ed.D. in psychology, or a Ph.D. in psychology from a psychology program at an educational institution that, at the time the applicant was enrolled and graduated had both an institutional accreditation from an agency recognized and approved by the U.S. Department of Education or was recognized as a member in good standing with the Association of Universities and Colleges of Canada, and had programmatic accreditation from the American Psychological Association (APA).

The bill further defines "doctoral degree in psychology" as a Psy.D., an Ed.D. in psychology, or a Ph.D. in psychology from a psychology program at an educational institution that, at the time the applicant was enrolled and graduated, had institutional accreditation from an agency

[63] Department of Health, *Senate Bill 768 Fiscal Analysis - Practice of Orthotics, Prosthetics, and Pedorthics* (July 23, 2021) (on file with the Senate Committee on Health Policy).
[64] Department of Health, *Senate Bill 768 2022 Agency Legislative Bill Analysis - Practice of Orthotics, Prosthetics, and Pedorthics* (July 23, 2021) (on file with the Senate Committee on Health Policy).

recognized and approved by the U.S. Department of Education or was recognized as a member in good standing with the Association of Universities and Colleges of Canada.

The bill requires psychologists applying for licensure to have obtained a doctoral degree from:
- An APA accredited program; or
- The equivalent of a degree from an APA-accredited program from a school or university located outside the United States which was officially recognized by the government of the country in which it is located as an institution or program to train students to practice professional psychology.

Provisional licensure applicants must have earned a degree from an APA accredited program. Lack of a degree from an APA-accredited program would be grounds for denial of licensure under the bill.

**Mental Health Professionals**

The bill amends s. 491.005, F.S., effective upon the bill becoming law, to create three pathways to licensure for applicants for a marriage and family therapy license to meet the minimum educational requirements by one of the following methods:
- A minimum of a master's degree in marriage and family therapy from a college or university that is accredited by the Commission on Accreditation for Marriage and Family Therapy Education (CAMFTE);
- A minimum of a master's degree with an emphasis in marriage and family therapy from a college or university that is accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP) and graduate courses approved by the board; or
- A minimum of a master's degree with an emphasis in marriage and family therapy or a closely related field, with a degree conferred before September 1, 2027, from an institutionally accredited college or university.

The bill updates the education requirements for marriage and family therapists, including current law's obsolete reference to accreditation by Commission on Recognition of Postsecondary Accreditation (CORPA), which was dissolved in 1997. The bill replaces the CORPA with the CHEA or its successors.

The bill deletes references to the term "regional" in s. 491.005(3), F.S., and replaces it with the term "institutional" to conform with the U.S. Department of Education accreditation nomenclature for approving educational institutions and deletes obsolete statutory references to the DOH collecting fees for examinations or conducting examinations.

**Florida Birth-Related Neurological Injury Compensation Association (NICA)**

The bill amends s. 766.314, F.S., deleting references to the Department of Business and Professional Regulation (DBPR) and revising the frequency and content of certain reports which the DOH must submit to the NICA. The bill eliminates unnecessary and obsolete language regarding the initial fees collected in 1988.

The bill deletes obsolete language and updates provisions to conform to current law. The bill authorizes the NICA to enforce the collection of physician assessments in circuit court under certain circumstances and requires the NICA to notify the DOH and the appropriate regulatory board of any unpaid final judgments against a physician within seven days of the issuance of a final judgment.

The bill updates the provisions regarding data sharing with the NICA to reflect current DOH practice and requires the DOH to continue providing NICA with an electronic monthly report of physicians licensed in the previous month, including their license numbers, the date they were licensed, and the fees collected.

The bill provides an effective date of July 1, 2022, except as otherwise provided.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The Department of Health (DOH) indicates it will experience a non-recurring workload increase associated with updating online applications and websites; limited costs

associated with rule making; limited costs associated with updating licensure databases and the License and Enforcement System; and minimal costs associated with testing from medical marijuana treatment centers (MMTCs). According to the DOH, current resources are adequate to absorb these costs.[65]

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.0045, 381.0303, 381.986, 456.039, 460.406, 464.008, 464.018, 467.003, 467.009, 467.011, 467.0125, 467.205, 468.803, 483.824, 490.003, 490.005, 490.0051, 491.005, and 766.314.

## IX. Additional Information:

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

**CS by Health Policy on January 26, 2022:**
The CS:

- Removes the underlying bill's provisions relating to emergency medical services;
- Requires allopathic and osteopathic physicians who apply to the DOH for Florida licensure to provide proof of payment of any NICA assessments, as applicable;
- Requires NICA to inform the DOH and the applicable regulatory board of an unpaid final judgment against a physician within seven days of the final judgment;
- Removes authority granted by the underlying bill for counseling interns to provide services via telehealth under certain conditions; and
- Makes technical corrections to the underlying bill's provisions relating to practitioner education requirements for numerous practitioner types.

B. Amendments:

None.



[65] Department of Health, *Senate Bill 768 2022 Agency Legislative Bill Analysis- Practice of Orthotics, Prosthetics, and Pedorthics* (July 23, 2021) (on file with the Senate Committee on Health Policy)

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LEGISLATIVE ACTION

| Senate | . | House |
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| 02/15/2022 | . | |
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Appropriations Subcommittee on Health and Human Services (Book) recommended the following:

**Senate Amendment (with title amendment)**

Between lines 1122 and 1123
insert:

Section 15. Subsection (1) of section 484.007, Florida Statutes, is amended to read:

484.007 Licensure of opticians; permitting of optical establishments.—

(1) Any person desiring to practice opticianry shall apply to the department, upon forms prescribed by it, to take a

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licensure examination. The department shall examine each applicant who the board certifies:

(a) Has completed the application form and remitted a nonrefundable application fee set by the board, in the amount of $100 or less, and an examination fee set by the board, in the amount of $325 plus the actual per applicant cost to the department for purchase of portions of the examination from the American Board of Opticianry or a similar national organization, or less, and refundable if the board finds the applicant ineligible to take the examination;

(b) Is not less than 18 years of age;

(c) Is a graduate of an accredited high school or possesses a certificate of equivalency of a high school education; and

(d)1. Has received an associate degree, or its equivalent, in opticianry from an educational institution the curriculum of which is accredited by an accrediting agency recognized and approved by the United States Department of Education or the Council on Postsecondary Education or approved by the board;

2. Is an individual licensed to practice the profession of opticianry pursuant to a regulatory licensing law of another state, territory, or jurisdiction of the United States, who has actively practiced in such other state, territory, or jurisdiction for more than 3 years immediately preceding application, and who meets the examination qualifications as provided in this subsection; or

3. Is an individual who has actively practiced in another state, territory, or jurisdiction of the United States for more than 5 years immediately preceding application and who provides tax or business records, affidavits, or other satisfactory


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documentation of such practice and who meets the examination qualifications as provided in this subsection~~; or~~

~~4. Has registered as an apprentice with the department and paid a registration fee not to exceed $60, as set by rule of the board. The apprentice shall complete 6,240 hours of training under the supervision of an optician licensed in this state for at least 1 year or of a physician or optometrist licensed under the laws of this state. These requirements must be met within 5 years after the date of registration. However, any time spent in a recognized school may be considered as part of the apprenticeship program provided herein. The board may establish administrative processing fees sufficient to cover the cost of administering apprentice rules as promulgated by the board~~.

Section 16. Section 484.011, Florida Statutes, is amended to read:

484.011 License required ~~Supportive personnel~~.—No person other than a licensed optician may engage in the practice of opticianry~~, except that a licensed optician may delegate to nonlicensed supportive personnel those duties, tasks, and functions which fall within the purview of s. 484.002(3). All such delegated acts shall be performed under the direct supervision of a licensed optician, who shall be responsible for all such acts performed by persons under her or his supervision~~.

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

And the title is amended as follows:

Delete line 58

and insert:

directors; amending s. 484.007, F.S.; revising

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education and training requirements for optician licensure; amending s. 484.011, F.S.; removing the ability of licensed opticians to delegate certain duties, tasks, and functions to nonlicensed supportive personnel; amending s. 490.003, F.S.; defining the

**By** the Committee on Health Policy; and Senator Rodriguez

588-02346-22 2022768c1

A bill to be entitled

An act relating to the Department of Health; amending s. 381.0045, F.S.; revising the purpose of the department's targeted outreach program for certain pregnant women; requiring the department to encourage high-risk pregnant women of unknown status to be tested for sexually transmissible diseases; requiring the department to provide specified information to pregnant women who have human immunodeficiency virus (HIV); requiring the department to link women with mental health services when available; requiring the department to educate pregnant women who have HIV on certain information; requiring the department to provide, for a specified purpose, continued oversight of newborns exposed to HIV; amending s. 381.0303, F.S.; removing the Children's Medical Services office from parties required to coordinate in the development of local emergency management plans for special needs shelters; amending s. 381.986, F.S.; authorizing the department to select samples of marijuana from medical marijuana treatment center facilities for certain testing; authorizing the department to select samples of marijuana delivery devices from medical marijuana treatment centers to determine whether such devices are safe for use; requiring medical marijuana treatment centers to recall marijuana and marijuana delivery devices, instead of just edibles, under certain circumstances; exempting the department and its employees from criminal provisions if they







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acquire, possess, test, transport, or lawfully dispose of marijuana and marijuana delivery devices under certain circumstances; amending s. 456.039, F.S.; requiring certain applicants for licensure as physicians to provide specified documentation to the department at the time of application; amending s. 460.406, F.S.; revising provisions related to chiropractic physician licensing; amending s. 464.008, F.S.; deleting a requirement that certain nursing program graduates complete a specified preparatory course; amending s. 464.018, F.S.; revising grounds for disciplinary action against licensed nurses; amending s. 467.003, F.S.; revising and defining terms; amending s. 467.009, F.S.; revising provisions related to accredited and approved midwifery programs; amending s. 467.011, F.S.; revising requirements for licensure of midwives; amending s. 467.0125, F.S.; revising requirements for licensure by endorsement of midwives; revising requirements for temporary certificates to practice midwifery in this state; amending s. 467.205, F.S.; revising provisions relating to approval, continued monitoring, probationary status, provisional approval, and approval rescission of midwifery programs; amending s. 468.803, F.S.; revising provisions related to orthotist and prosthetist registration, examination, and licensing; amending s. 483.824, F.S.; revising educational requirements for clinical laboratory directors; amending s. 490.003, F.S.; defining the

terms "doctoral degree from an American Psychological Association accredited program" and "doctoral degree in psychology"; amending ss. 490.005 and 490.0051, F.S.; revising education requirements for psychologist licensure and provisional licensure, respectively; amending s. 491.005, F.S.; revising requirements for licensure of clinical social workers, marriage and family therapists, and mental health counselors; amending s. 766.314, F.S.; deleting obsolete language and updating provisions to conform to current law; revising the frequency with which the department must submit certain reports to the Florida Birth-Related Neurological Injury Compensation Association; revising the content of such reports; authorizing the association to enforce the collection of certain assessments in circuit court under certain circumstances; requiring the association to notify the department and the applicable regulatory board of any unpaid final judgment against a physician within a specified timeframe; providing effective dates.

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

Section 1. Subsections (2) and (3) of section 381.0045, Florida Statutes, are amended to read:

381.0045 Targeted outreach for pregnant women.—

(2) It is the purpose of this section to establish a targeted outreach program for high-risk pregnant women who may not seek proper prenatal care, who suffer from substance abuse







or mental health problems, or who have acquired ~~are infected with~~ human immunodeficiency virus (HIV), and to provide these women with links to much-needed ~~much needed~~ services and information.

(3) The department shall:

(a) Conduct outreach programs through contracts with, grants to, or other working relationships with persons or entities where the target population is likely to be found.

(b) Provide outreach that is peer-based, culturally sensitive, and performed in a nonjudgmental manner.

(c) Encourage high-risk pregnant women of unknown status to be tested for HIV and other sexually transmissible diseases as specified by department rule.

(d) Educate women not receiving prenatal care as to the benefits of such care.

(e) Provide ~~HIV-infected~~ pregnant women who have HIV with information on the need for antiretroviral medication for their newborn, their medication options, and how they can access the medication after their discharge from the hospital ~~so they can make an informed decision about the use of Zidovudine (AZT)~~.

(f) Link women with substance abuse treatment and mental health services, when available, and act as a liaison with Healthy Start coalitions, children's medical services, Ryan White-funded providers, and other services of the Department of Health.

(g) Educate pregnant women who have HIV on the importance of engaging in and continuing HIV care.

(h) Provide continued oversight of any newborn exposed to HIV to determine the newborn's final HIV status and ensure

continued linkage to care if the newborn is diagnosed with HIV ~~to HIV exposed newborns~~.

Section 2. Paragraphs (a) and (c) of subsection (2) of section 381.0303, Florida Statutes, are amended to read:

381.0303 Special needs shelters.—

(2) SPECIAL NEEDS SHELTER PLAN; STAFFING; STATE AGENCY ASSISTANCE.—If funds have been appropriated to support disaster coordinator positions in county health departments:

(a) The department shall assume lead responsibility for the coordination of local medical and health care providers, the American Red Cross, and other interested parties in developing a plan for the staffing and medical management of special needs shelters and~~. The local Children's Medical Services offices shall assume lead responsibility for the coordination of local medical and health care providers, the American Red Cross, and other interested parties in developing a plan for the staffing and medical management of~~ pediatric special needs shelters. Plans must conform to the local comprehensive emergency management plan.

(c) The appropriate county health department~~, Children's Medical Services office,~~ and local emergency management agency shall jointly decide who has responsibility for medical supervision in each special needs shelter.

Section 3. Present paragraphs (e) through (h) of subsection (14) of section 381.986, Florida Statutes, are redesignated as paragraphs (f) through (i), respectively, a new paragraph (e) is added to that subsection, and paragraph (e) of subsection (8) of that section is amended, to read:

381.986 Medical use of marijuana.—





(8) MEDICAL MARIJUANA TREATMENT CENTERS.—

(e) A licensed medical marijuana treatment center shall cultivate, process, transport, and dispense marijuana for medical use. A licensed medical marijuana treatment center may not contract for services directly related to the cultivation, processing, and dispensing of marijuana or marijuana delivery devices, except that a medical marijuana treatment center licensed pursuant to subparagraph (a)1. may contract with a single entity for the cultivation, processing, transporting, and dispensing of marijuana and marijuana delivery devices. A licensed medical marijuana treatment center must, at all times, maintain compliance with the criteria demonstrated and representations made in the initial application and the criteria established in this subsection. Upon request, the department may grant a medical marijuana treatment center a variance from the representations made in the initial application. Consideration of such a request shall be based upon the individual facts and circumstances surrounding the request. A variance may not be granted unless the requesting medical marijuana treatment center can demonstrate to the department that it has a proposed alternative to the specific representation made in its application which fulfills the same or a similar purpose as the specific representation in a way that the department can reasonably determine will not be a lower standard than the specific representation in the application. A variance may not be granted from the requirements in subparagraph 2. and subparagraphs (b)1. and 2.

1. A licensed medical marijuana treatment center may transfer ownership to an individual or entity who meets the

requirements of this section. A publicly traded corporation or publicly traded company that meets the requirements of this section is not precluded from ownership of a medical marijuana treatment center. To accommodate a change in ownership:

a. The licensed medical marijuana treatment center shall notify the department in writing at least 60 days before the anticipated date of the change of ownership.

b. The individual or entity applying for initial licensure due to a change of ownership must submit an application that must be received by the department at least 60 days before the date of change of ownership.

c. Upon receipt of an application for a license, the department shall examine the application and, within 30 days after receipt, notify the applicant in writing of any apparent errors or omissions and request any additional information required.

d. Requested information omitted from an application for licensure must be filed with the department within 21 days after the department's request for omitted information or the application shall be deemed incomplete and shall be withdrawn from further consideration and the fees shall be forfeited.

e. Within 30 days after the receipt of a complete application, the department shall approve or deny the application.

2. A medical marijuana treatment center, and any individual or entity who directly or indirectly owns, controls, or holds with power to vote 5 percent or more of the voting shares of a medical marijuana treatment center, may not acquire direct or indirect ownership or control of any voting shares or other form





of ownership of any other medical marijuana treatment center.

3. A medical marijuana treatment center may not enter into any form of profit-sharing arrangement with the property owner or lessor of any of its facilities where cultivation, processing, storing, or dispensing of marijuana and marijuana delivery devices occurs.

4. All employees of a medical marijuana treatment center must be 21 years of age or older and have passed a background screening pursuant to subsection (9).

5. Each medical marijuana treatment center must adopt and enforce policies and procedures to ensure employees and volunteers receive training on the legal requirements to dispense marijuana to qualified patients.

6. When growing marijuana, a medical marijuana treatment center:

a. May use pesticides determined by the department, after consultation with the Department of Agriculture and Consumer Services, to be safely applied to plants intended for human consumption, but may not use pesticides designated as restricted-use pesticides pursuant to s. 487.042.

b. Must grow marijuana within an enclosed structure and in a room separate from any other plant.

c. Must inspect seeds and growing plants for plant pests that endanger or threaten the horticultural and agricultural interests of the state in accordance with chapter 581 and any rules adopted thereunder.

d. Must perform fumigation or treatment of plants, or remove and destroy infested or infected plants, in accordance with chapter 581 and any rules adopted thereunder.

7. Each medical marijuana treatment center must produce and make available for purchase at least one low-THC cannabis product.

8. A medical marijuana treatment center that produces edibles must hold a permit to operate as a food establishment pursuant to chapter 500, the Florida Food Safety Act, and must comply with all the requirements for food establishments pursuant to chapter 500 and any rules adopted thereunder. Edibles may not contain more than 200 milligrams of tetrahydrocannabinol, and a single serving portion of an edible may not exceed 10 milligrams of tetrahydrocannabinol. Edibles may have a potency variance of no greater than 15 percent. Edibles may not be attractive to children; be manufactured in the shape of humans, cartoons, or animals; be manufactured in a form that bears any reasonable resemblance to products available for consumption as commercially available candy; or contain any color additives. To discourage consumption of edibles by children, the department shall determine by rule any shapes, forms, and ingredients allowed and prohibited for edibles. Medical marijuana treatment centers may not begin processing or dispensing edibles until after the effective date of the rule. The department shall also adopt sanitation rules providing the standards and requirements for the storage, display, or dispensing of edibles.

9. Within 12 months after licensure, a medical marijuana treatment center must demonstrate to the department that all of its processing facilities have passed a Food Safety Good Manufacturing Practices, such as Global Food Safety Initiative or equivalent, inspection by a nationally accredited certifying





body. A medical marijuana treatment center must immediately stop processing at any facility which fails to pass this inspection until it demonstrates to the department that such facility has met this requirement.

10. A medical marijuana treatment center that produces prerolled marijuana cigarettes may not use wrapping paper made with tobacco or hemp.

11. When processing marijuana, a medical marijuana treatment center must:

a. Process the marijuana within an enclosed structure and in a room separate from other plants or products.

b. Comply with department rules when processing marijuana with hydrocarbon solvents or other solvents or gases exhibiting potential toxicity to humans. The department shall determine by rule the requirements for medical marijuana treatment centers to use such solvents or gases exhibiting potential toxicity to humans.

c. Comply with federal and state laws and regulations and department rules for solid and liquid wastes. The department shall determine by rule procedures for the storage, handling, transportation, management, and disposal of solid and liquid waste generated during marijuana production and processing. The Department of Environmental Protection shall assist the department in developing such rules.

d. Test the processed marijuana using a medical marijuana testing laboratory before it is dispensed. Results must be verified and signed by two medical marijuana treatment center employees. Before dispensing, the medical marijuana treatment center must determine that the test results indicate that low-

THC cannabis meets the definition of low-THC cannabis, the concentration of tetrahydrocannabinol meets the potency requirements of this section, the labeling of the concentration of tetrahydrocannabinol and cannabidiol is accurate, and all marijuana is safe for human consumption and free from contaminants that are unsafe for human consumption. The department shall determine by rule which contaminants must be tested for and the maximum levels of each contaminant which are safe for human consumption. The Department of Agriculture and Consumer Services shall assist the department in developing the testing requirements for contaminants that are unsafe for human consumption in edibles. The department shall also determine by rule the procedures for the treatment of marijuana that fails to meet the testing requirements of this section, s. 381.988, or department rule. The department may select samples of marijuana ~~a random sample~~ from ~~edibles available for purchase in~~ a medical marijuana treatment center ~~dispensing~~ facility which shall be tested by the department to determine whether ~~that~~ the marijuana ~~edible~~ meets the potency requirements of this section, is safe for human consumption, and is accurately labeled with ~~the labeling of~~ the tetrahydrocannabinol and cannabidiol concentration or to verify the result of marijuana testing conducted by a marijuana testing laboratory. The department may also select samples of marijuana delivery devices from a medical marijuana treatment center to determine whether the marijuana delivery device is safe for use by qualified patients ~~is accurate~~. A medical marijuana treatment center may not require payment from the department for the sample. A medical marijuana treatment center must recall marijuana ~~edibles~~, including all





marijuana and marijuana products ~~edibles~~ made from the same batch of marijuana, that fails ~~which fail~~ to meet the potency requirements of this section, that is ~~which are~~ unsafe for human consumption, or for which the labeling of the tetrahydrocannabinol and cannabidiol concentration is inaccurate. A medical marijuana treatment center must also recall all marijuana delivery devices determined to be unsafe for use by qualified patients. The medical marijuana treatment center must retain records of all testing and samples of each homogenous batch of marijuana for at least 9 months. The medical marijuana treatment center must contract with a marijuana testing laboratory to perform audits on the medical marijuana treatment center's standard operating procedures, testing records, and samples and provide the results to the department to confirm that the marijuana or low-THC cannabis meets the requirements of this section and that the marijuana or low-THC cannabis is safe for human consumption. A medical marijuana treatment center shall reserve two processed samples from each batch and retain such samples for at least 9 months for the purpose of such audits. A medical marijuana treatment center may use a laboratory that has not been certified by the department under s. 381.988 until such time as at least one laboratory holds the required certification, but in no event later than July 1, 2018.

e. Package the marijuana in compliance with the United States Poison Prevention Packaging Act of 1970, 15 U.S.C. ss. 1471 et seq.

f. Package the marijuana in a receptacle that has a firmly affixed and legible label stating the following information:

(I) The marijuana or low-THC cannabis meets the requirements of sub-subparagraph d.

(II) The name of the medical marijuana treatment center from which the marijuana originates.

(III) The batch number and harvest number from which the marijuana originates and the date dispensed.

(IV) The name of the physician who issued the physician certification.

(V) The name of the patient.

(VI) The product name, if applicable, and dosage form, including concentration of tetrahydrocannabinol and cannabidiol. The product name may not contain wording commonly associated with products marketed by or to children.

(VII) The recommended dose.

(VIII) A warning that it is illegal to transfer medical marijuana to another person.

(IX) A marijuana universal symbol developed by the department.

12. The medical marijuana treatment center shall include in each package a patient package insert with information on the specific product dispensed related to:

a. Clinical pharmacology.

b. Indications and use.

c. Dosage and administration.

d. Dosage forms and strengths.

e. Contraindications.

f. Warnings and precautions.

g. Adverse reactions.

13. In addition to the packaging and labeling requirements





specified in subparagraphs 11. and 12., marijuana in a form for smoking must be packaged in a sealed receptacle with a legible and prominent warning to keep away from children and a warning that states marijuana smoke contains carcinogens and may negatively affect health. Such receptacles for marijuana in a form for smoking must be plain, opaque, and white without depictions of the product or images other than the medical marijuana treatment center's department-approved logo and the marijuana universal symbol.

14. The department shall adopt rules to regulate the types, appearance, and labeling of marijuana delivery devices dispensed from a medical marijuana treatment center. The rules must require marijuana delivery devices to have an appearance consistent with medical use.

15. Each edible shall be individually sealed in plain, opaque wrapping marked only with the marijuana universal symbol. Where practical, each edible shall be marked with the marijuana universal symbol. In addition to the packaging and labeling requirements in subparagraphs 11. and 12., edible receptacles must be plain, opaque, and white without depictions of the product or images other than the medical marijuana treatment center's department-approved logo and the marijuana universal symbol. The receptacle must also include a list of all the edible's ingredients, storage instructions, an expiration date, a legible and prominent warning to keep away from children and pets, and a warning that the edible has not been produced or inspected pursuant to federal food safety laws.

16. When dispensing marijuana or a marijuana delivery device, a medical marijuana treatment center:

a. May dispense any active, valid order for low-THC cannabis, medical cannabis and cannabis delivery devices issued pursuant to former s. 381.986, Florida Statutes 2016, which was entered into the medical marijuana use registry before July 1, 2017.

b. May not dispense more than a 70-day supply of marijuana within any 70-day period to a qualified patient or caregiver. May not dispense more than one 35-day supply of marijuana in a form for smoking within any 35-day period to a qualified patient or caregiver. A 35-day supply of marijuana in a form for smoking may not exceed 2.5 ounces unless an exception to this amount is approved by the department pursuant to paragraph (4)(f).

c. Must have the medical marijuana treatment center's employee who dispenses the marijuana or a marijuana delivery device enter into the medical marijuana use registry his or her name or unique employee identifier.

d. Must verify that the qualified patient and the caregiver, if applicable, each have an active registration in the medical marijuana use registry and an active and valid medical marijuana use registry identification card, the amount and type of marijuana dispensed matches the physician certification in the medical marijuana use registry for that qualified patient, and the physician certification has not already been filled.

e. May not dispense marijuana to a qualified patient who is younger than 18 years of age. If the qualified patient is younger than 18 years of age, marijuana may only be dispensed to the qualified patient's caregiver.

f. May not dispense or sell any other type of cannabis,





alcohol, or illicit drug-related product, including pipes or wrapping papers made with tobacco or hemp, other than a marijuana delivery device required for the medical use of marijuana and which is specified in a physician certification.

g. Must, upon dispensing the marijuana or marijuana delivery device, record in the registry the date, time, quantity, and form of marijuana dispensed; the type of marijuana delivery device dispensed; and the name and medical marijuana use registry identification number of the qualified patient or caregiver to whom the marijuana delivery device was dispensed.

h. Must ensure that patient records are not visible to anyone other than the qualified patient, his or her caregiver, and authorized medical marijuana treatment center employees.

(14) EXCEPTIONS TO OTHER LAWS.—

(e) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other law, but subject to the requirements of this section, the department, including an employee of the department acting within the scope of his or her employment, may acquire, possess, test, transport, and lawfully dispose of marijuana and marijuana delivery devices as provided in this section, in s. 381.988, and by department rule.

Section 4. Subsection (1) of section 456.039, Florida Statutes, is amended to read:

456.039 Designated health care professionals; information required for licensure.—

(1) Each person who applies for initial licensure or license renewal as a physician under chapter 458, chapter 459, chapter 460, or chapter 461, except a person applying for registration pursuant to ss. 458.345 and 459.021, must furnish

the following information to the department~~,~~ at the time of application or~~, and each physician who applies for license renewal under chapter 458, chapter 459, chapter 460, or chapter 461, except a person registered pursuant to ss. 458.345 and 459.021, must,~~ in conjunction with the renewal of such license ~~and~~ under procedures adopted by the department ~~of Health,~~ and in addition to any other information that may be required from the applicant~~, furnish the following information to the Department of Health~~:

(a)1. The name of each medical school that the applicant has attended, with the dates of attendance and the date of graduation, and a description of all graduate medical education completed by the applicant, excluding any coursework taken to satisfy medical licensure continuing education requirements.

2. The name of each hospital at which the applicant has privileges.

3. The address at which the applicant will primarily conduct his or her practice.

4. Any certification that the applicant has received from a specialty board that is recognized by the board to which the applicant is applying.

5. The year that the applicant began practicing medicine.

6. Any appointment to the faculty of a medical school which the applicant currently holds and an indication as to whether the applicant has had the responsibility for graduate medical education within the most recent 10 years.

7. A description of any criminal offense of which the applicant has been found guilty, regardless of whether adjudication of guilt was withheld, or to which the applicant







has pled guilty or nolo contendere. A criminal offense committed in another jurisdiction which would have been a felony or misdemeanor if committed in this state must be reported. If the applicant indicates that a criminal offense is under appeal and submits a copy of the notice for appeal of that criminal offense, the department must state that the criminal offense is under appeal if the criminal offense is reported in the applicant's profile. If the applicant indicates to the department that a criminal offense is under appeal, the applicant must, upon disposition of the appeal, submit to the department a copy of the final written order of disposition.

8. A description of any final disciplinary action taken within the previous 10 years against the applicant by the agency regulating the profession that the applicant is or has been licensed to practice, whether in this state or in any other jurisdiction, by a specialty board that is recognized by the American Board of Medical Specialties, the American Osteopathic Association, or a similar national organization, or by a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home. Disciplinary action includes resignation from or nonrenewal of medical staff membership or the restriction of privileges at a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home taken in lieu of or in settlement of a pending disciplinary case related to competence or character. If the applicant indicates that the disciplinary action is under appeal and submits a copy of the document initiating an appeal of the disciplinary action, the department must state that the disciplinary action is under

appeal if the disciplinary action is reported in the applicant's profile.

9. Relevant professional qualifications as defined by the applicable board.

(b) In addition to the information required under paragraph (a), for each applicant seeking ~~who seeks~~ licensure under chapter 458, chapter 459, or chapter 461~~, and~~ who has practiced previously in this state or in another jurisdiction or a foreign country, ~~must provide~~ the information required of licensees under those chapters pursuant to s. 456.049. An applicant for licensure under chapter 460 who has practiced previously in this state or in another jurisdiction or a foreign country must provide the same information as is required of licensees under chapter 458, pursuant to s. 456.049.

(c) For each applicant seeking licensure under chapter 458 or chapter 459, proof of payment of the assessment required under s. 766.314, if applicable.

Section 5. Subsection (1) of section 460.406, Florida Statutes, is amended to read:

460.406 Licensure by examination.—

(1) Any person desiring to be licensed as a chiropractic physician must apply to the department to take the licensure examination. There shall be an application fee set by the board not to exceed $100 which shall be nonrefundable. There shall also be an examination fee not to exceed $500 plus the actual per applicant cost to the department for purchase of portions of the examination from the National Board of Chiropractic Examiners or a similar national organization, which may be refundable if the applicant is found ineligible to take the





examination. The department shall examine each applicant whom ~~who~~ the board certifies has met all of the following criteria:

(a) Completed the application form and remitted the appropriate fee.

(b) Submitted proof satisfactory to the department that he or she is not less than 18 years of age.

(c) Submitted proof satisfactory to the department that he or she is a graduate of a chiropractic college which is accredited by or has status with the Council on Chiropractic Education or its predecessor agency. However, any applicant who is a graduate of a chiropractic college that was initially accredited by the Council on Chiropractic Education in 1995, who graduated from such college within the 4 years immediately preceding such accreditation, and who is otherwise qualified is ~~shall be~~ eligible to take the examination. An ~~No~~ application for a license to practice chiropractic medicine may not ~~shall~~ be denied solely because the applicant is a graduate of a chiropractic college that subscribes to one philosophy of chiropractic medicine as distinguished from another.

(d)1. For an applicant who has matriculated in a chiropractic college before ~~prior to~~ July 2, 1990, completed at least 2 years of residence college work, consisting of a minimum of one-half the work acceptable for a bachelor's degree granted on the basis of a 4-year period of study, in a college or university accredited by an institutional accrediting agency recognized and approved by the United States Department of Education. However, before ~~prior to~~ being certified by the board to sit for the examination, each applicant who has matriculated in a chiropractic college after July 1, 1990, must ~~shall~~ have

been granted a bachelor's degree, based upon 4 academic years of study, by a college or university accredited by an institutional ~~a regional~~ accrediting agency that ~~which~~ is a member of the Commission on Recognition of Postsecondary Accreditation.

2. Effective July 1, 2000, completed, before ~~prior to~~ matriculation in a chiropractic college, at least 3 years of residence college work, consisting of a minimum of 90 semester hours leading to a bachelor's degree in a liberal arts college or university accredited by an institutional accrediting agency recognized and approved by the United States Department of Education. However, before ~~prior to~~ being certified by the board to sit for the examination, each applicant who has matriculated in a chiropractic college after July 1, 2000, must ~~shall~~ have been granted a bachelor's degree from an institution holding accreditation for that degree from an institutional ~~a regional~~ accrediting agency that ~~which~~ is recognized by the United States Department of Education. The applicant's chiropractic degree must consist of credits earned in the chiropractic program and may not include academic credit for courses from the bachelor's degree.

(e) Successfully completed the National Board of Chiropractic Examiners certification examination in parts I, II, III, and IV, and the physiotherapy examination of the National Board of Chiropractic Examiners, with a score approved by the board.

(f) Submitted to the department a set of fingerprints on a form and under procedures specified by the department, along with payment in an amount equal to the costs incurred by the Department of Health for the criminal background check of the





applicant.

The board may require an applicant who graduated from an institution accredited by the Council on Chiropractic Education more than 10 years before the date of application to the board to take the National Board of Chiropractic Examiners Special Purposes Examination for Chiropractic, or its equivalent, as determined by the board. The board shall establish by rule a passing score.

Section 6. Subsection (4) of section 464.008, Florida Statutes, is amended to read:

464.008 Licensure by examination.—

~~(4) If an applicant who graduates from an approved program does not take the licensure examination within 6 months after graduation, he or she must enroll in and successfully complete a board approved licensure examination preparatory course. The applicant is responsible for all costs associated with the course and may not use state or federal financial aid for such costs. The board shall by rule establish guidelines for licensure examination preparatory courses.~~

Section 7. Paragraph (e) of subsection (1) of section 464.018, Florida Statutes, is amended to read:

464.018 Disciplinary actions.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in ss. 456.072(2) and 464.0095:

(e) Having been found guilty of~~, regardless of adjudication,~~ or entered a plea of nolo contendere or guilty to, regardless of adjudication, any offense prohibited under s.

435.04 or similar statute of another jurisdiction; or having committed an act which constitutes domestic violence as defined in s. 741.28.

Section 8. Present subsections (13) and (14) of section 467.003, Florida Statutes, are redesignated as subsections (14) and (15), respectively, a new subsection (13) is added to that section, and subsections (1) and (12) of that section are amended, to read:

467.003 Definitions.—As used in this chapter, unless the context otherwise requires:

(1) "Approved midwifery program" means ~~a midwifery school or~~ a midwifery training program ~~which is~~ approved by the department pursuant to s. 467.205.

(12) "Preceptor" means a physician licensed under chapter 458 or chapter 459, a ~~licensed~~ midwife licensed under this chapter, or a certified nurse midwife licensed under chapter 464~~,~~ who has a minimum of 3 years' professional experience~~,~~ and who directs, teaches, supervises, and evaluates the learning experiences of a ~~the~~ student midwife as part of an approved midwifery program.

(13) "Prelicensure course" means a course of study, offered by an accredited midwifery program and approved by the department, which an applicant for licensure must complete before a license may be issued and which provides instruction in the laws and rules of this state and demonstrates the student's competency to practice midwifery under this chapter.

Section 9. Section 467.009, Florida Statutes, is amended to read:

467.009 Accredited and approved midwifery programs;







education and training requirements.—

(1) The department shall adopt standards for accredited and approved midwifery programs which must include, but need not be limited to, standards for all of the following:

(a) ~~. The standards shall encompass~~ Clinical and classroom instruction in all aspects of prenatal, intrapartal, and postpartal care, including all of the following:

1. Obstetrics.~~,~~
2. Neonatal pediatrics.~~,~~
3. Basic sciences.~~,~~
4. Female reproductive anatomy and physiology.~~,~~
5. Behavioral sciences.~~,~~
6. Childbirth education.~~,~~
7. Community care.~~,~~
8. Epidemiology.~~,~~
9. Genetics.~~,~~
10. Embryology.~~,~~
11. Neonatology.~~,~~
12. Applied pharmacology.~~,~~
13. The medical and legal aspects of midwifery.~~,~~
14. Gynecology and women's health.~~,~~
15. Family planning.~~,~~
16. Nutrition during pregnancy and lactation.~~,~~
17. Breastfeeding.~~, and~~
18. Basic nursing skills~~; and any other instruction determined by the department and council to be necessary~~.

(b) ~~The standards shall incorporate the~~ Core competencies, incorporating those established by the American College of Nurse Midwives and the Midwives Alliance of North America, including

knowledge, skills, and professional behavior in all of the following areas:

1. Primary management, collaborative management, referral, and medical consultation.~~;~~

2. Antepartal, intrapartal, postpartal, and neonatal care.~~;~~

3. Family planning and gynecological care.~~;~~

4. Common complications.~~; and~~

5. Professional responsibilities.

(c) Noncurricular ~~The standards shall include noncurriculum~~ matters under this section, including, but not limited to, staffing and teacher qualifications.

(2) An accredited and approved midwifery program must offer ~~shall include~~ a course of study ~~and clinical training~~ for a minimum of 3 years which incorporates all of the standards, curriculum guidelines, and educational objectives provided in this section and the rules adopted hereunder.

(3) An accredited and approved midwifery program may reduce ~~If the applicant is a registered nurse or a licensed practical nurse or has previous nursing or midwifery education,~~ the required period of training ~~may be reduced~~ to the extent of the student's ~~applicant's~~ qualifications as a registered nurse or licensed practical nurse or based on prior completion of equivalent nursing or midwifery education, as determined ~~under rules adopted~~ by ~~the~~ department rule~~. In no case shall the training be reduced to a period of less than 2 years~~.

(4)~~(3)~~ An accredited and approved midwifery program may accept students who ~~To be accepted into an approved midwifery program, an applicant shall~~ have both:

(a) A high school diploma or its equivalent.







(b) Taken three college-level credits each of math and English or demonstrated competencies in communication and computation.

(5)~~(4)~~ As part of its course of study, an accredited and approved midwifery program must require clinical training that includes all of the following:

(a) ~~A student midwife, during training, shall undertake, under the supervision of a preceptor,~~ The care of 50 women in each of the prenatal, intrapartal, and postpartal periods under the supervision of a preceptor.~~, but~~ The same women need not be seen through all three periods.

(b)~~(5)~~ Observation of ~~The student midwife shall observe~~ an additional 25 women in the intrapartal period ~~before qualifying for a license~~.

(6) Clinical ~~The~~ training required under this section must include all of the following:

(a) ~~shall include~~ Training in ~~either~~ hospitals or alternative birth settings, or both.

(b) A requirement that students demonstrate competency in the assessment of and differentiation~~, with particular emphasis on learning the ability to differentiate~~ between low-risk pregnancies and high-risk pregnancies.

(7) A hospital or birthing center receiving public funds shall be required to provide student midwives access to observe labor, delivery, and postpartal procedures, provided the woman in labor has given informed consent. The Department of Health shall assist in facilitating access to hospital training for accredited and approved midwifery programs.

(8)~~(7)~~ The Department of Education shall adopt curricular

frameworks for midwifery programs offered by ~~conducted within~~ public educational institutions under ~~pursuant to~~ this section.

~~(8) Nonpublic educational institutions that conduct approved midwifery programs shall be accredited by a member of the Commission on Recognition of Postsecondary Accreditation and shall be licensed by the Commission for Independent Education.~~

Section 10. Section 467.011, Florida Statutes, is amended to read:

467.011 Licensed midwives; qualifications; examination ~~Licensure by examination~~.—

~~(1) The department shall administer an examination to test the proficiency of applicants in the core competencies required to practice midwifery as specified in s. 467.009.~~

~~(2) The department shall develop, publish, and make available to interested parties at a reasonable cost a bibliography and guide for the examination.~~

~~(3)~~ The department shall issue a license to practice midwifery to an applicant who meets all of the following criteria:

(1) Demonstrates that he or she has graduated from one of the following:

(a) An accredited and approved midwifery program.

(b) A medical or midwifery program offered in another state, jurisdiction, territory, or country whose graduation requirements were equivalent to or exceeded those required by s. 467.009 and the rules adopted thereunder at the time of graduation.

(2) Demonstrates that he or she has ~~and~~ successfully completed a prelicensure course offered by an accredited and







approved midwifery program. Students graduating from an accredited and approved midwifery program may meet this requirement by showing that the content requirements for the prelicensure course were covered as part of their course of study.

(3) Submits an application for licensure on a form approved by the department and pays the appropriate fee.

(4) Demonstrates that he or she has received a passing score on an ~~the~~ examination specified by the department~~, upon payment of the required licensure fee~~.

Section 11. Section 467.0125, Florida Statutes, is amended to read:

467.0125 Licensed midwives; qualifications; ~~Licensure by~~ endorsement; temporary certificates.—

(1) The department shall issue a license by endorsement to practice midwifery to an applicant who, upon applying to the department, demonstrates to the department that she or he meets all of the following criteria:

(a)~~1. Holds a valid certificate or diploma from a foreign institution of medicine or midwifery or from a midwifery program offered in another state, bearing the seal of the institution or otherwise authenticated, which renders the individual eligible to practice midwifery in the country or state in which it was issued, provided the requirements therefor are deemed by the department to be substantially equivalent to, or to exceed, those established under this chapter and rules adopted under this chapter, and submits therewith a certified translation of the foreign certificate or diploma; or~~

~~2.~~ Holds an active, unencumbered ~~a valid certificate or~~

license to practice midwifery in another state, jurisdiction, or territory ~~issued by that state~~, provided the licensing requirements of that state, jurisdiction, or territory at the time the license was issued were ~~therefor are deemed by the department to be~~ substantially equivalent to~~,~~ or exceeded ~~to exceed,~~ those established under this chapter and the rules adopted hereunder ~~under this chapter~~.

(b) Has successfully completed a ~~4 month~~ prelicensure course conducted by an accredited and approved midwifery program ~~and has submitted documentation to the department of successful completion~~.

(c) Submits an application for licensure on a form approved by the department and pays the appropriate fee ~~Has successfully passed the licensed midwifery examination~~.

(2) The department may issue a temporary certificate to practice in areas of critical need to an applicant ~~any midwife who is~~ qualifying for a midwifery license ~~licensure by endorsement~~ under subsection (1) who meets all of the following criteria~~, with the following restrictions~~:

(a) Submits an application for a temporary certificate on a form approved by the department and pays the appropriate fee, which may not exceed $50 and is in addition to the fee required for licensure by endorsement under subsection (1).

(b) Specifies on the application that he or she will ~~The Department of Health shall determine the areas of critical need, and the midwife so certified shall~~ practice only in one or more of the following locations:

1. A county health department.

2. A correctional facility.







3. A United States Department of Veterans Affairs clinic.

4. A community health center funded by s. 329, s. 330, or s. 340 of the Public Health Service Act.

5. Any other agency or institution that is approved by the State Surgeon General and provides health care to meet the needs of an underserved population in this state.

(c) Will practice only ~~those specific areas,~~ under the supervision ~~auspices~~ of a physician licensed under ~~pursuant to~~ chapter 458 or chapter 459, a certified nurse midwife licensed under ~~pursuant to~~ part I of chapter 464, or a midwife licensed under this chapter~~,~~ who has a minimum of 3 years' professional experience.

(3) The department may issue a temporary certificate under this section with the following restrictions:

(a) A requirement that a temporary certificateholder practice only in areas of critical need. The State Surgeon General shall determine the areas of critical need, which ~~Such areas shall~~ include, but are not ~~be~~ limited to, health professional shortage areas designated by the United States Department of Health and Human Services.

(b) A requirement that if a temporary certificateholder's practice area ceases to be an area of critical need, within 30 days after such change the certificateholder must either:

1. Report a new practice area of critical need to the department; or

2. Voluntarily relinquish the temporary certificate.

(4) The department shall review a temporary certificateholder's practice at least annually to determine whether the certificateholder is meeting the requirements of

subsections (2) and (3) and the rules adopted thereunder. If the department determines that a certificateholder is not meeting these requirements, the department must revoke the temporary certificate.

(5) A temporary certificate issued under this section is ~~shall be~~ valid ~~only as long as an area~~ for ~~which it is issued remains an area of critical need, but no longer than~~ 2 years~~,~~ and is ~~shall~~ not ~~be~~ renewable.

~~(c) The department may administer an abbreviated oral examination to determine the midwife's competency, but no written regular examination shall be necessary.~~

~~(d) The department shall not issue a temporary certificate to any midwife who is under investigation in another state for an act which would constitute a violation of this chapter until such time as the investigation is complete, at which time the provisions of this section shall apply.~~

~~(e) The department shall review the practice under a temporary certificate at least annually to ascertain that the minimum requirements of the midwifery rules promulgated under this chapter are being met. If it is determined that the minimum requirements are not being met, the department shall immediately revoke the temporary certificate.~~

~~(f) The fee for a temporary certificate shall not exceed $50 and shall be in addition to the fee required for licensure.~~

Section 12. Section 467.205, Florida Statutes, is amended to read:

467.205 Approval of midwifery programs.—

(1) The department must approve an accredited or state-licensed public or private institution seeking to provide







midwifery education and training as an approved midwifery program in this state if the institution meets all of the following criteria:

(a) Submits an application for approval on a form approved by the department.

(b) Demonstrates to the department's satisfaction that the proposed midwifery program complies with s. 467.009 and the rules adopted thereunder.

(c) For a private institution, demonstrates its accreditation by a member of the Council for Higher Education Accreditation or an accrediting agency approved by the United States Department of Education as an institutional accrediting agency for direct-entry midwifery education programs and its licensing or provisional licensing by the Commission for Independent Education ~~An organization desiring to conduct an approved program for the education of midwives shall apply to the department and submit such evidence as may be required to show that it complies with s. 467.009 and with the rules of the department. Any accredited or state licensed institution of higher learning, public or private, may provide midwifery education and training.~~

~~(2) The department shall adopt rules regarding educational objectives, faculty qualifications, curriculum guidelines, administrative procedures, and other training requirements as are necessary to ensure that approved programs graduate midwives competent to practice under this chapter.~~

~~(3) The department shall survey each organization applying for approval. If the department is satisfied that the program meets the requirements of s. 467.009 and rules adopted pursuant~~

~~to that section, it shall approve the program~~.

(2)~~(4)~~ The department shall, at least once every 3 years, certify whether each approved midwifery program is currently compliant, and has maintained compliance, ~~complies~~ with the requirements of ~~standards developed under~~ s. 467.009 and the rules adopted thereunder.

(3)~~(5)~~ If the department finds that an approved midwifery program is not in compliance with the requirements of s. 467.009 or the rules adopted thereunder, or has lost its accreditation status, the department must provide its finding to the program in writing and ~~no longer meets the required standards, it~~ may place the program on probationary status for a specified period of time, which may not exceed 3 years ~~until such time as the standards are restored~~.

(4) If a program on probationary status does not come into compliance with the requirements of s. 467.009 or the rules adopted thereunder, or regain its accreditation status, as applicable, within the period specified by the department ~~fails to correct these conditions within a specified period of time~~, the department may rescind the program's approval.

(5) A ~~Any~~ program that has ~~having~~ its approval rescinded has ~~shall have~~ the right to reapply for approval.

(6) The department may grant provisional approval of a new program seeking accreditation status, for a period not to exceed 5 years, provided that all other requirements of this section are met.

(7) The department may rescind provisional approval of a program that fails to meet the requirements of s. 467.009, this section, or the rules adopted thereunder, in accordance with







procedures provided in subsections (3) and (4) ~~may be granted pending the licensure results of the first graduating class~~.

Section 13. Subsections (2), (3), and (4) and paragraphs (a) and (b) of subsection (5) of section 468.803, Florida Statutes, are amended to read:

468.803 License, registration, and examination requirements.—

(2) An applicant for registration, examination, or licensure must apply to the department on a form prescribed by the board for consideration of board approval. Each initial applicant shall submit ~~a set of~~ fingerprints to the department in accordance with ~~on a form and under~~ procedures specified by the department~~, along with payment in an amount equal to the costs incurred by the department~~ for state and national criminal history checks of the applicant. ~~The department shall submit the fingerprints provided by an applicant to the Department of Law Enforcement for a statewide criminal history check, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history check of the applicant.~~ The board shall screen the results to determine if an applicant meets licensure requirements. The board shall consider for examination, registration, or licensure each applicant whom ~~who~~ the board verifies:

(a) Has submitted the completed application and completed the fingerprinting requirements ~~fingerprint forms~~ and has paid the applicable application fee, not to exceed $500~~, and the cost of the state and national criminal history checks~~. The application fee is ~~and cost of the criminal history checks shall~~

~~be~~ nonrefundable;

(b) Is of good moral character;

(c) Is 18 years of age or older; and

(d) Has completed the appropriate educational preparation.

(3) A person seeking to attain the orthotics or prosthetics experience required for licensure in this state must be approved by the board and registered as a resident by the department. Although a registration may be held in both disciplines, for independent registrations the board may not approve a second registration until at least 1 year after the issuance of the first registration. Notwithstanding subsection (2), a person who has been approved by the board and registered by the department in one discipline may apply for registration in the second discipline without an additional state or national criminal history check during the period in which the first registration is valid. Each independent registration or dual registration is valid for 2 years after the date of issuance unless otherwise revoked by the department upon recommendation of the board. The board shall set a registration fee not to exceed $500 to be paid by the applicant. A registration may be renewed once by the department upon recommendation of the board for a period no longer than 1 year, as such renewal is defined by ~~the~~ board ~~by~~ rule. The renewal fee may not exceed one-half the current registration fee. To be considered by the board for approval of registration as a resident, the applicant must have one of the following:

(a) A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from an institutionally ~~a regionally~~ accredited college or university recognized by the







Commission on Accreditation of Allied Health Education Programs.

(b) A minimum of a bachelor's degree from an institutionally ~~a regionally~~ accredited college or university and a certificate in orthotics or prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board.

(c) A minimum of a bachelor's degree from an institutionally ~~a regionally~~ accredited college or university and a dual certificate in both orthotics and prosthetics from programs recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board.

(4) The department may develop and administer a state examination for an orthotist or a prosthetist license, or the board may approve the existing examination of a national standards organization. The examination must be predicated on a minimum of a baccalaureate-level education and formalized specialized training in the appropriate field. Each examination must demonstrate a minimum level of competence in basic scientific knowledge, written problem solving, and practical clinical patient management. The board shall require an examination fee not to exceed the actual cost to the board in developing, administering, and approving the examination, which fee must be paid by the applicant. To be considered by the board for examination, the applicant must have:

(a) For an examination in orthotics:

1. A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from an institutionally ~~a~~

~~regionally~~ accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a minimum, a bachelor's degree from an institutionally ~~a~~ ~~regionally~~ accredited college or university and a certificate in orthotics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board; and

2. An approved orthotics internship of 1 year of qualified experience, as determined by the board, or an orthotic residency or dual residency program recognized by the board.

(b) For an examination in prosthetics:

1. A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from an institutionally ~~a~~ ~~regionally~~ accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a minimum, a bachelor's degree from an institutionally ~~a~~ ~~regionally~~ accredited college or university and a certificate in prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board; and

2. An approved prosthetics internship of 1 year of qualified experience, as determined by the board, or a prosthetic residency or dual residency program recognized by the board.

(5) In addition to the requirements in subsection (2), to be licensed as:

(a) An orthotist, the applicant must pay a license fee not to exceed $500 and must have:

1. A Bachelor of Science or higher-level postgraduate





degree in orthotics and prosthetics from an institutionally ~~a~~ ~~regionally~~ accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs, or a bachelor's degree from an institutionally accredited college or university and ~~with~~ a certificate in orthotics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board;

2. An approved ~~appropriate~~ internship of 1 year of qualified experience, as determined by the board, or a residency program recognized by the board;

3. Completed the mandatory courses; and

4. Passed the state orthotics examination or the board-approved orthotics examination.

(b) A prosthetist, the applicant must pay a license fee not to exceed $500 and must have:

1. A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from an institutionally ~~a~~ ~~regionally~~ accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs, or a bachelor's degree from an institutionally accredited college or university and ~~with~~ a certificate in prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board;

2. An internship of 1 year of qualified experience, as determined by the board, or a residency program recognized by the board;

3. Completed the mandatory courses; and

4. Passed the state prosthetics examination or the board-approved prosthetics examination.

Section 14. Section 483.824, Florida Statutes, is amended to read:

483.824 Qualifications of clinical laboratory director.—A clinical laboratory director must have 4 years of clinical laboratory experience with 2 years of experience in the specialty to be directed or be nationally board certified in the specialty to be directed, and must meet one of the following requirements:

(1) Be a physician licensed under chapter 458 or chapter 459;

(2) Hold an earned doctoral degree in a chemical, physical, or biological science from an institutionally ~~a regionally~~ accredited institution and maintain national certification requirements equal to those required by the federal Health Care Financing Administration; or

(3) For the subspecialty of oral pathology, be a physician licensed under chapter 458 or chapter 459 or a dentist licensed under chapter 466.

Section 15. Subsection (3) of section 490.003, Florida Statutes, is amended to read:

490.003 Definitions.—As used in this chapter:

(3)(a) "Doctoral degree from an American Psychological Association accredited program" means ~~Effective July 1, 1999, "doctoral-level psychological education" and "doctoral degree in psychology" mean~~ a Psy.D., an Ed.D. in psychology, or a Ph.D. in psychology from a psychology program at an educational institution that, at the time the applicant was enrolled and







graduated:

1.~~(a)~~ Had institutional accreditation from an agency recognized and approved by the United States Department of Education or was recognized as a member in good standing with Universities Canada ~~the Association of Universities and Colleges of Canada~~; and

2.~~(b)~~ Had programmatic accreditation from the American Psychological Association.

(b) "Doctoral degree in psychology" means a Psy.D., an Ed.D. in psychology, or a Ph.D. in psychology from a psychology program at an educational institution that, at the time the applicant was enrolled and graduated, had institutional accreditation from an agency recognized and approved by the United States Department of Education or was recognized as a member in good standing with Universities Canada.

Section 16. Subsection (1) of section 490.005, Florida Statutes, is amended to read:

490.005 Licensure by examination.—

(1) Any person desiring to be licensed as a psychologist shall apply to the department to take the licensure examination. The department shall license each applicant whom ~~who~~ the board certifies has met all of the following requirements:

(a) Completed the application form and remitted a nonrefundable application fee not to exceed $500 and an examination fee set by the board sufficient to cover the actual per applicant cost to the department for development, purchase, and administration of the examination, but not to exceed $500.

(b) Submitted proof satisfactory to the board that the applicant has received:

1. A doctoral degree from an American Psychological Association accredited program ~~Doctoral level psychological education~~; or

2. The equivalent of a doctoral degree from an American Psychological Association accredited program ~~doctoral level psychological education, as defined in s. 490.003(3),~~ from ~~a program at~~ a school or university located outside the United States of America which was officially recognized by the government of the country in which it is located as an institution or program to train students to practice professional psychology. The applicant has the burden of establishing that this requirement has been met.

(c) Had at least 2 years or 4,000 hours of experience in the field of psychology in association with or under the supervision of a licensed psychologist meeting the academic and experience requirements of this chapter or the equivalent as determined by the board. The experience requirement may be met by work performed on or off the premises of the supervising psychologist if the off-premises work is not the independent, private practice rendering of psychological services that does not have a psychologist as a member of the group actually rendering psychological services on the premises.

(d) Passed the examination. However, an applicant who has obtained a passing score, as established by the board by rule, on the psychology licensure examination designated by the board as the national licensure examination need only pass the Florida law and rules portion of the examination.

Section 17. Subsection (1) of section 490.0051, Florida Statutes, is amended to read:







490.0051 Provisional licensure; requirements.—

(1) The department shall issue a provisional psychology license to each applicant whom ~~who~~ the board certifies has met all of the following criteria:

(a) Completed the application form and remitted a nonrefundable application fee not to exceed $250, as set by board rule.

(b) Earned a doctoral degree from an American Psychological Association accredited program ~~in psychology as defined in s. 490.003(3)~~.

(c) Met any additional requirements established by board rule.

Section 18. Effective upon this act becoming a law, subsections (1), (3), and (4) of section 491.005, Florida Statutes, are amended to read:

491.005 Licensure by examination.—

(1) CLINICAL SOCIAL WORK.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, ~~plus the actual per applicant cost to the department for purchase of the examination from the American Association of State Social Worker's Boards or a similar national organization,~~ the department shall issue a license as a clinical social worker to an applicant whom ~~who~~ the board certifies has met all of the following criteria:

(a) ~~Has~~ Submitted an application and paid the appropriate fee.

(b)1. ~~Has~~ Received a doctoral degree in social work from a graduate school of social work which at the time the applicant graduated was accredited by an accrediting agency recognized by

the United States Department of Education or ~~has~~ received a master's degree in social work from a graduate school of social work which at the time the applicant graduated:

a. Was accredited by the Council on Social Work Education;

b. Was accredited by the Canadian Association for ~~of Schools of~~ Social Work Education; or

c. Has been determined to have been a program equivalent to programs approved by the Council on Social Work Education by the Foreign Equivalency Determination Service of the Council on Social Work Education. An applicant who graduated from a program at a university or college outside of the United States or Canada must present documentation of the equivalency determination from the council in order to qualify.

2. The applicant's graduate program ~~must have~~ emphasized direct clinical patient or client health care services, including, but not limited to, coursework in clinical social work, psychiatric social work, medical social work, social casework, psychotherapy, or group therapy. The applicant's graduate program must have included all of the following coursework:

a. A supervised field placement which was part of the applicant's advanced concentration in direct practice, during which the applicant provided clinical services directly to clients.

b. Completion of 24 semester hours or 32 quarter hours in theory of human behavior and practice methods as courses in clinically oriented services, including a minimum of one course in psychopathology, and no more than one course in research, taken in a school of social work accredited or approved pursuant





to subparagraph 1.

3. If the course title which appears on the applicant's transcript does not clearly identify the content of the coursework, the applicant provided ~~shall be required to provide~~ additional documentation, including, but not limited to, a syllabus or catalog description published for the course.

(c) Completed ~~Has had~~ at least 2 years of clinical social work experience, which took place subsequent to completion of a graduate degree in social work at an institution meeting the accreditation requirements of this section, under the supervision of a licensed clinical social worker or the equivalent who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If the applicant's graduate program was not a program which emphasized direct clinical patient or client health care services as described in subparagraph (b)2., the supervised experience requirement must take place after the applicant has completed a minimum of 15 semester hours or 22 quarter hours of the coursework required. A doctoral internship may be applied toward the clinical social work experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.

(d) ~~Has~~ Passed a theory and practice examination designated by board rule ~~provided by the department for this purpose~~.

(e) ~~Has~~ Demonstrated, in a manner designated by board rule ~~of the board~~, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy,

and mental health counseling.

(3) MARRIAGE AND FAMILY THERAPY.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, ~~plus the actual cost of the purchase of the examination from the Association of Marital and Family Therapy Regulatory Board, or similar national organization,~~ the department shall issue a license as a marriage and family therapist to an applicant whom ~~who~~ the board certifies has met all of the following criteria:

(a) ~~Has~~ Submitted an application and paid the appropriate fee.

(b) 1. Attained one of the following:

a. A minimum of a master's degree in marriage and family therapy from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education.

b. A minimum of a master's degree with a major emphasis in marriage and family therapy or a closely related field from a university program accredited by the Council on Accreditation of Counseling and Related Educational Programs and graduate courses approved by the board.

c. ~~Has~~ A minimum of a master's degree with an ~~major~~ emphasis in marriage and family therapy or a closely related field, with a degree conferred before September 1, 2027, from an institutionally accredited college or university ~~from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education or from a Florida university program accredited by the Council for Accreditation of Counseling and Related Educational Programs~~ and graduate courses approved by the board ~~of Clinical Social Work, Marriage and Family Therapy,~~







~~and Mental Health Counseling~~.

2. If the course title that appears on the applicant's transcript does not clearly identify the content of the coursework, the applicant provided ~~shall provide~~ additional documentation, including, but not limited to, a syllabus or catalog description published for the course. The required master's degree must have been received in an institution of higher education that, at the time the applicant graduated, was fully accredited by an institutional ~~a regional~~ accrediting body recognized by the Council for Higher Education Accreditation or its successor organization ~~Commission on Recognition of Postsecondary Accreditation~~ or was ~~publicly recognized as~~ a member in good standing with Universities Canada ~~the Association of Universities and Colleges of Canada~~, or an institution of higher education located outside the United States and Canada which, at the time the applicant was enrolled and at the time the applicant graduated, maintained a standard of training substantially equivalent to the standards of training of those institutions in the United States which are accredited by an institutional ~~a regional~~ accrediting body recognized by the Council for Higher Education Accreditation or its successor organization ~~Commission on Recognition of Postsecondary Accreditation~~. Such foreign education and training must have been received in an institution or program of higher education officially recognized by the government of the country in which it is located as an institution or program to train students to practice as professional marriage and family therapists or psychotherapists. The applicant has the burden of establishing that the requirements of this provision have been met, and the

board shall require documentation, such as an evaluation by a foreign equivalency determination service, as evidence that the applicant's graduate degree program and education were equivalent to an accredited program in this country. An applicant with a master's degree from a program that did not emphasize marriage and family therapy may complete the coursework requirement in a training institution fully accredited by the Commission on Accreditation for Marriage and Family Therapy Education recognized by the United States Department of Education.

(c) Completed ~~Has had~~ at least 2 years of clinical experience during which 50 percent of the applicant's clients were receiving marriage and family therapy services, which must be at the post-master's level under the supervision of a licensed marriage and family therapist with at least 5 years of experience, or the equivalent, who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If a graduate has a master's degree with a major emphasis in marriage and family therapy or a closely related field which did not include all of the coursework required by paragraph (b), credit for the post-master's level clinical experience may not commence until the applicant has completed a minimum of 10 of the courses required by paragraph (b), as determined by the board, and at least 6 semester hours or 9 quarter hours of the course credits must have been completed in the area of marriage and family systems, theories, or techniques. Within the 2 years of required experience, the applicant shall provide direct





individual, group, or family therapy and counseling to cases including those involving unmarried dyads, married couples, separating and divorcing couples, and family groups that include children. A doctoral internship may be applied toward the clinical experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.

(d) ~~Has~~ Passed a theory and practice examination designated by board rule ~~provided by the department~~.

(e) ~~Has~~ Demonstrated, in a manner designated by board rule, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.

For the purposes of dual licensure, the department shall license as a marriage and family therapist any person who meets the requirements of s. 491.0057. Fees for dual licensure may not exceed those stated in this subsection.

(4) MENTAL HEALTH COUNSELING.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, ~~plus the actual per-applicant cost of purchase of the examination from the National Board for Certified Counselors or its successor organization,~~ the department shall issue a license as a mental health counselor to an applicant whom ~~who~~ the board certifies has met all of the following criteria:

(a) ~~Has~~ Submitted an application and paid the appropriate fee.

(b)1. Attained ~~Has~~ a minimum of an earned master's degree from a mental health counseling program accredited by the

Council for the Accreditation of Counseling and Related Educational Programs which consists of at least 60 semester hours or 80 quarter hours of clinical and didactic instruction, including a course in human sexuality and a course in substance abuse. If the master's degree is earned from a program related to the practice of mental health counseling which is not accredited by the Council for the Accreditation of Counseling and Related Educational Programs, then the coursework and practicum, internship, or fieldwork must consist of at least 60 semester hours or 80 quarter hours and meet all of the following requirements:

a. Thirty-three semester hours or 44 quarter hours of graduate coursework, which must include a minimum of 3 semester hours or 4 quarter hours of graduate-level coursework in each of the following 11 content areas: counseling theories and practice; human growth and development; diagnosis and treatment of psychopathology; human sexuality; group theories and practice; individual evaluation and assessment; career and lifestyle assessment; research and program evaluation; social and cultural foundations; substance abuse; and legal, ethical, and professional standards issues in the practice of mental health counseling. Courses in research, thesis or dissertation work, practicums, internships, or fieldwork may not be applied toward this requirement.

b. A minimum of 3 semester hours or 4 quarter hours of graduate-level coursework addressing diagnostic processes, including differential diagnosis and the use of the current diagnostic tools, such as the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of





Mental Disorders. The graduate program must have emphasized the common core curricular experience.

c. The equivalent, as determined by the board, of at least 700 hours of university-sponsored supervised clinical practicum, internship, or field experience that includes at least 280 hours of direct client services, as required in the accrediting standards of the Council for Accreditation of Counseling and Related Educational Programs for mental health counseling programs. This experience may not be used to satisfy the post-master's clinical experience requirement.

2. ~~Has~~ Provided additional documentation if a course title that appears on the applicant's transcript does not clearly identify the content of the coursework. The documentation must include, but is not limited to, a syllabus or catalog description published for the course.

Education and training in mental health counseling must have been received in an institution of higher education that, at the time the applicant graduated, was fully accredited by an institutional ~~a regional~~ accrediting body recognized by the Council for Higher Education Accreditation or its successor organization or was ~~publicly recognized as~~ a member in good standing with Universities Canada ~~the Association of Universities and Colleges of Canada~~, or an institution of higher education located outside the United States and Canada which, at the time the applicant was enrolled and at the time the applicant graduated, maintained a standard of training substantially equivalent to the standards of training of those institutions in the United States which are accredited by an

institutional ~~a regional~~ accrediting body recognized by the Council for Higher Education Accreditation or its successor organization. Such foreign education and training must have been received in an institution or program of higher education officially recognized by the government of the country in which it is located as an institution or program to train students to practice as mental health counselors. The applicant has the burden of establishing that the requirements of this provision have been met, and the board shall require documentation, such as an evaluation by a foreign equivalency determination service, as evidence that the applicant's graduate degree program and education were equivalent to an accredited program in this country. Beginning July 1, 2025, an applicant must have a master's degree from a program that is accredited by the Council for Accreditation of Counseling and Related Educational Programs, the Masters in Psychology and Counseling Accreditation Council, or an equivalent accrediting body which consists of at least 60 semester hours or 80 quarter hours to apply for licensure under this paragraph.

(c) Completed ~~Has had~~ at least 2 years of clinical experience in mental health counseling, which must be at the post-master's level under the supervision of a licensed mental health counselor or the equivalent who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If a graduate has a master's degree with a major related to the practice of mental health counseling which did not include all the coursework required under sub-







subparagraphs (b)1.a. and b., credit for the post-master's level clinical experience may not commence until the applicant has completed a minimum of seven of the courses required under sub-subparagraphs (b)1.a. and b., as determined by the board, one of which must be a course in psychopathology or abnormal psychology. A doctoral internship may be applied toward the clinical experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.

(d) ~~Has~~ Passed a theory and practice examination designated by board rule ~~provided by the department for this purpose~~.

(e) ~~Has~~ Demonstrated, in a manner designated by board rule, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.

Section 19. Subsection (6) and paragraph (c) of subsection (9) of section 766.314, Florida Statutes, are amended to read:

766.314 Assessments; plan of operation.—

(6)(a) The association shall make all assessments required by this section, except initial assessments of physicians licensed ~~on or after October 1, 1988, which assessments will be made~~ by the Department of Health ~~Business and Professional Regulation~~, and except assessments of casualty insurers pursuant to subparagraph (5)(c)1., which assessments will be made by the Office of Insurance Regulation. ~~Beginning October 1, 1989, for any physician licensed between October 1 and December 31 of any year, the Department of Business and Professional Regulation shall make the initial assessment plus the assessment for the following calendar year.~~ The Department of Health ~~Business and~~

~~Professional Regulation~~ shall provide the association, in an electronic format, with a monthly report ~~such frequency as determined to be necessary, a listing, in a computer readable form,~~ of the names and license numbers ~~addresses~~ of all physicians licensed under chapter 458 or chapter 459.

(b)1. The association may enforce collection of assessments required to be paid pursuant to ss. 766.301-766.316 by suit filed in county court, or in circuit court if the amount due could exceed the jurisdictional limits of county court. The association is ~~shall be~~ entitled to an award of attorney ~~attorney's~~ fees, costs, and interest upon the entry of a judgment against a physician for failure to pay such assessment, with such interest accruing until paid. Notwithstanding ~~the provisions of~~ chapters 47 and 48, the association may file such suit in either Leon County or the county of the residence of the defendant. The association shall notify the Department of Health and the applicable board of any unpaid final judgment against a physician within 7 days after the entry of final judgment.

2. The Department of Health ~~Business and Professional Regulation~~, upon notification by the association that an assessment has not been paid and that there is an unsatisfied judgment against a physician, shall refuse to ~~not~~ renew any license issued to ~~practice for~~ such physician under ~~issued pursuant to~~ chapter 458 or chapter 459 until the association notifies the Department of Health that ~~such time as~~ the judgment is satisfied in full.

(c) The Agency for Health Care Administration shall, upon notification by the association that an assessment has not been timely paid, enforce collection of such assessments required to





be paid by hospitals pursuant to ss. 766.301-766.316. Failure of a hospital to pay such assessment is grounds for disciplinary action pursuant to s. 395.1065 notwithstanding any ~~provision of~~ law to the contrary.

(9)

(c) If ~~In the event~~ the total of all current estimates equals 80 percent of the funds on hand and the funds that will become available to the association within the next 12 months from all sources described in subsections (4) and (5) and paragraph (7)(a), the association may ~~shall~~ not accept any new claims without express authority from the Legislature. Nothing in this section precludes ~~herein shall preclude~~ the association from accepting any claim if the injury occurred 18 months or more before ~~prior to~~ the effective date of this suspension. Within 30 days after ~~of~~ the effective date of this suspension, the association shall notify the Governor, the Speaker of the House of Representatives, the President of the Senate, the Office of Insurance Regulation, the Agency for Health Care Administration, and the Department of Health~~, and the Department of Business and Professional Regulation~~ of this suspension.

Section 20. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2022.

The Florida Senate

# APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/16/22
Meeting Date

Approps Hhs
Committee

768 Tab 1
Bill Number or Topic

Amendment Barcode (if applicable)

**Name** Melissa Villar **Phone** (850) 354-8424

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Tallahassee FL 32312
*City* *State* *Zip*

**Speaking:** ☐ For ☐ Against ☑ Information **OR** **Waive Speaking:** ☐ In Support ☐ Against

**PLEASE CHECK ONE OF THE FOLLOWING:**

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

*While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)*

**This form is part of the public record for this meeting.**

S-001 (08/10/2021)

**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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 1120 |
| INTRODUCER: | Children, Families, and Elder Affairs Committee and Senator Rodriguez |
| SUBJECT: | Child Welfare |
| DATE: | February 15, 2022 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Berger | Cox | CF | **Fav/CS** |
| 2. | Sneed | Money | AHS | **Recommend: Favorable** |
| 3. | | | AP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:


CS/SB 1120 authorizes the Department of Children and Families (DCF) to place children who meet the definition of a "child or adolescent who has an emotional disturbance" or a "child or adolescent who has a serious emotional disturbance or mental illness" in therapeutic group homes for mental health treatment without prior court approval under certain circumstances.

The DCF has established a process for credentialing existing licensed therapeutic group homes (TGHs) as a qualified residential treatment program (QRTP). The bill ensures that the credentialing process the DCF has established will result in placements that are in accordance with rule and in compliance with federal requirements.

The bill makes a number of changes to definitions in section 39.407, Florida Statutes, relating to medical, psychiatric, and psychological examinations and treatment of the child, to:

- Define the term "therapeutic group home" to mean a 24-hour residential program providing community-based mental health treatment and mental health support services in a nonsecure, homelike setting to children who meet the criteria in section 394.492(5) or (6), Florida Statutes.
- Amend the definition of "residential treatment" or "residential treatment program" to include a therapeutic group home as defined above.
- Clarify the definition of "suitable for residential treatment" or "suitability" to apply when the child requires residential treatment program if the child is expected to benefit from mental, emotional, or behavioral health treatment.

The bill codifies current practice, requiring the DCF, rather than the Agency for Health Care Administration (AHCA), to appoint the qualified evaluator to conduct suitability assessments and modifies the time frame for providing a copy of the assessment to the child's guardian ad litem and the court to within 5 days of receipt of the assessment.

The bill requires a qualified evaluator for a TGH or a QRTP to be a licensed clinician with at least two years of experience in the diagnosis and treatment of serious emotional disturbances in children and adolescents, as opposed to a psychiatrist or a psychologist licensed in Florida with three years of experience, as required for residential treatment. According to the DCF, this is expected to increase the pool of qualified evaluators beyond the 18 currently used for suitability assessments.[1]

Lastly, the bill authorizes the DCF to adopt rules to administer the provisions of the bill.

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

The bill takes effect upon becoming a law.

## II. Present Situation:

### Family First Prevention Services Act (FFPSA)

The FFPSA, included in the 2018 Bipartisan Budget Act,[2] focuses on evidence-based services to prevent children from entering foster care; limits reimbursement for congregate (group home) care; and makes changes affecting adoption subsidies, reunification, and extended foster care supports. This act reforms the federal child welfare financing streams, Title IV-E and Title IV-B of the Social Security Act, to provide services to families who are at risk of entering the child welfare system. The bill aims to prevent children from entering foster care by allowing federal reimbursement for mental health services, substance use treatment, and in-home parenting skill training. It also seeks to improve the well-being of children already in foster care by incentivizing states to reduce the placement of children in residential group care. States can now receive 50 percent reimbursement for specifically approved evidence-based prevention services that address mental health, substance abuse, family counseling, and parent skills training in an effort to avoid an out-of-home placement for children. The FFPSA also limits federal funding for group homes placements.[3]

Congress made the FFPSA effective October 1, 2018, but gave states the opportunity to delay implementation of select provisions of the law.[4] Florida received approval to delay the implementation of the FFPSA until October 1, 2021.

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[1] The DCF, *Agency Analysis for SB 1120*, p. 3, (on file with the Senate Committee on Children and Families).
[2] H.R. 1862 of 2018. Pub.L. 115-123
[3] The DCF, *The Florida Center for Child Welfare FFPSA Updates*, available at Florida's Center for Child Welfare | FFPSA Updates (usf.edu); *see also* the National Conference of State Legislatures (NCSL), *Family First Prevention Services Act*, available at https://www.ncsl.org/research/human-services/family-first-prevention-services-act-ffpsa.aspx (all sites last visited January 18, 2022).
[4] The NCSL, *Family First Prevention Services Act*, available at https://www.ncsl.org/research/human-services/family-first-prevention-services-act-ffpsa.aspx (last visited January 18, 2022).

**Mental Health Residential Treatment Programs**

Residential Treatment Centers for Children and Adolescents (RTC) are 24 hour residential programs, including therapeutic group homes, licensed by the AHCA.[5] These centers were designed to provide mental health treatment and services to children under the age of 18 who have been diagnosed as having mental, emotional, or behavioral disorders.[6] All providers rendering Florida Medicaid therapeutic group care services to recipients must be in compliance with the provisions of the Florida Medicaid Therapeutic Group Care Services Coverage Policy, July 2017.[7]

Section 394.4781, F.S., authorizes the DCF to pay a portion of the costs associated with residential care for children who have been diagnosed with severe emotional disturbance, who are recommended to need a residential level of mental health treatment by a Florida licensed psychologist or psychiatrist, and who are not eligible for public or private insurance.[8] Due to limited funds, the DCF must review applications monthly to approve or deny applications for treatment according to the following criteria:[9]

- The severity level of the child's mental health;
- The financial means of the child's family;
- The availability of the needed residential care; and
- The funds available to the DCF.[10]

Mental health treatment is aimed to assist children to live successfully in their community and with their families. Placement into a residential mental health treatment center is made only after careful consideration and assessments. Before a placement, all other avenues of less restrictive treatment are weighed and must be deemed non appropriate.[11] Only if the needed services cannot be provided in a less restrictive environment, a residential mental health treatment program is then considered for the child.[12]

***Qualified Residential Treatment Programs***

Qualified Residential Treatment Programs (QRTP) are a new placement setting created by the FFPSA which were implemented in Florida in May 2021.[13] Placement of a child in a QRTP is for the specific purpose of addressing the child's emotional and behavioral health needs through observation, diagnosis, and treatment in a treatment setting.[14]

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[5] *See* the ACHA, *Residential Treatment Centers for Children and Adolescents*, available at https://ahca.myflorida.com/mchq/health_facility_regulation/hospital_outpatient/rtc.shtml (last visited January 20, 2022)
[6] *Id*.
[7] Rule 59G-4.295, F.A.C.
[8] Section 394.4781, F.S.
[9] *See* the DCF, *Children's Mental Health Residential Treatment*, available at https://www.myflfamilies.com/service-programs/samh/childrens-mental-health/residential-treatment.shtml (last visited January 18, 2022).
[10] *Id*.
[11] *Id*.
[12] *Id*.
[13] The DCF, *Agency Analysis for SB 1120*, January 21, 2022, p. 2-3 (on file with Senate Committee on Children, Families, and Elder Affairs) (hereinafter cited "The DCF SB 1120 Analysis"). Florida has defined QRTPs through rulemaking authority under Rule 65C-28.021, F.A.C.
[14] *Id*.

Florida currently has five licensed QRTPs with a total capacity of 50 beds. A QRTP must obtain a residential treatment center license through the AHCA and a credential from the DCF, which aligns the QRTP with all federal requirements.[15] Each facility that aims to be a QRTP must meet the licensing requirements set forth in s. 394.875, F.S., and the credentialing standards set forth in Rule 65C-46.021, F.A.C.

The DCF states that reimbursement for the service delivery is available for children placed in the QRTP through the bundled specialized therapeutic group home fee as a result of the state agency collaborative approach to license and credential a QRTP.[16]

The FFPSA requires an assessment using an evidence-based tool within 30 days of placement. The DCF states it has identified the Child and Adolescent Needs and Strengths (CANS) – Trauma version as the evidence-based tool which has been incorporated into the suitability assessment.[17] Although Florida law does not contemplate QRTP assessments, any child in need of placement in a QRTP is required to submit to a suitability assessment to align with s. 39.407, F.S.

***Specific Children In Need of Placement in a RTC or QRTP***

RTCs and QRTPS serve children and adolescents with emotional disturbance or serious emotional disturbance or mental illness. Section 394.492(5), F.S., defines a "child or adolescent who has an emotional disturbance" to mean a person under 18 years of age who is diagnosed with a mental, emotional, or behavioral disorder of sufficient duration to meet one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, but who does not exhibit behaviors that substantially interfere with or limit his or her role or ability to function in the family, school, or community.[18]

Additionally, s. 394.492(6), F.S., defines a "child or adolescent who has a serious emotional disturbance or mental illness" to mean a person under 18 years of age who:

- Is diagnosed as having a mental, emotional, or behavioral disorder that meets one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association; and
- Exhibits behaviors that substantially interfere with or limit his or her role or ability to function in the family, school, or community, which behaviors are not considered to be a temporary response to a stressful situation.

Both of these terms do not include a child or adolescent who meets the criteria for involuntary placement under s. 394.467(1), F.S., also known as the Baker Act.[19]

[15] *Id*.
[16] The DCF SB 1120 Analysis, p. 3.
[17] *Id.*
[18] The definition further provides that that the emotional disturbance must not be considered to be a temporary response to a stressful situation.
[19] The Baker Act is contained in ch. 394, F.S.

**Licensure of Mental Health Residential Treatment Facilities**

Under Rule 65E-4.016 of the Florida Administrative Code, to be licensed as a mental health residential treatment facility an applicant must provide a long term, homelike residential environment that provides care, support, assistance and limited supervision in daily living to adults diagnosed with a serious and persistent major mental illness who do not have another primary residence.[20] Any facility licensed as a residential treatment facility must sustain a 60 day average or greater length of stay of residents, except as specifically provided for in s. 394.875(11), F.S.[21]

**Qualified Evaluators and Suitability Assessments for Placement**

Section 39.407(6), F.S., requires the DCF to conduct an examination and suitability assessment if it is believed that a child needs residential treatment and prior to placing the child in a Psychiatric Residential Treatment Facility (PRTF/SIPP) or a Therapeutic Group Home (TGH). [22] Currently, the suitability assessment must be conducted by a qualified evaluator appointed by AHCA. [23]

The Department contracts with the Qualified Evaluator Network (QEN) who is responsible for recruiting qualified evaluators to conduct suitability assessments and render a recommendation within eleven business days from receipt of the referral.

The Qualified Evaluator Network (QEN) was established by Magellan in July 2001 to provide assessment services for children in the care and custody of the DCF. The DCF contracts with the QEN who is responsible for recruiting qualified evaluators to conduct suitability assessments. Each assessment must provide an independent, professional assessment of suitability for residential treatment for mental health.[24] QENs are intended to prevent premature or inappropriate referrals to residential psychiatric placements and utilizing the QEN results in a return to community-based services as soon as clinically possible.[25]

Once a qualified evaluator receives a referral, the contract requires that a recommendation be rendered within 11 business days from receipt of the referral.[26] The DCF states that at this time there are only 18 qualified evaluators statewide who are completing assessments within an average of six business days. Through the implementation of teleconference, the QEN was able to reduce the time it takes to complete an assessment with final submission by the QEN to the Community-Based Care lead agency.[27]

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[20] Rule 65E-4.016, F.A.C.
[21] *Id*.
[22] Section 39.407(6), F.S.
[23] *See* the DCF, *Suitability for Residential Placement Guidelines*, available at https://www.myflfamilies.com/service-programs/community-based-care/docs/SuitabilityAssessmentGuidance.pdf (last visited January 20, 2022).
[24] *See* Magellan Healthcare, *Qualified Evaluator Network*, available at https://www.magellancompletecareoffl.com/documents/2019/09/florida-qen-overview.pdf/#:~:text=All%20Qualified%20Evaluators%20are%20required,in%2Dpatient%20or%20STGH%20facility (last visited January 21, 2022).
[25] *Id*.
[26] The DCF SB 1120 Analysis, p. 2-3.
[27] *Id*., p. 3.

Initially, the suitability assessment was conducted by a qualified evaluator appointed through a contract with Magellan procured by the AHCA. During this time, the DCF was the primary executor the contract, but the AHCA held the rulemaking authority, set the fee schedule for the evaluators, and maintained the list of providers. However, in 2016, the contract under Magellan was transferred entirely to the DCF to determine the qualified evaluator requirements.[28] This contract transfer allotted for a more cohesive execution of services. The DCF currently continues to contract with this third-party vendor for the management of the QEN.[29]

Under s. 39.407(6)(d), F.S., the timeframe to provide the assessments to the guardian ad litem and the court is "immediately" upon placement.[30]

***Rulemaking Authority***

The rulemaking authority for suitability assessments is currently split between the DCF and AHCA, specifically requiring:

- The DCF to adopt rules for implementing timeframes for the completion of suitability assessments by qualified evaluators and a procedure that includes timeframes for completing the 60-day independent review by the qualified evaluators of the child's progress toward achieving the goals and objectives of the treatment plan.
- The AHCA to adopt rules for the registration of qualified evaluators, the procedure for selecting the evaluators to conduct the reviews required under s. 39.407, F.S., and a reasonable, cost-efficient fee schedule for qualified evaluators.[31]

**Florida Medicaid Program**

The Medicaid program is a joint federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults, and persons with disabilities.[32] The Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for administering the federal Medicaid program. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the AHCA and financed through state and federal funds.[33]

A Medicaid state plan is an agreement between a state and the federal government describing how the state administers its Medicaid programs. The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements.

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[28] *See* Magellan Complete Care, *Am I Eligible*, available at https://www.magellancompletecareoffl.com/enrollment-and-renewal/are-you-eligible/; *see also* Magellan Complete Care; *Qualified Evaluator Network (QEN)*, p. 7, available at PowerPoint Presentation (magellanofflorida.com) (all sites last visited January 20, 2022).
[29] *See* Magellan of Florida, *QEN Training Manual*, available at https://www.magellanofflorida.com/documents/2019/09/2019-florida-qen-training-manual.pdf/ (last visited January 20, 2022).
[30] Section 39.407(6)(d), F.S.
[31] Section 39.407(6)(i), F.S.
[32] Medicaid.gov, *Medicaid*, available at https://www.medicaid.gov/medicaid/index.html (last visited January 23, 2022).
[33] Section 20.42, F.S.

In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives states the flexibility to cover other population groups (optional eligibility groups). States set individual eligibility criteria within federal minimum standards. The AHCA may seek an amendment to the state plan as necessary to comply with federal or state laws or to implement program changes. States send state plan amendments to the federal CMS for review and approval.[34]

Florida Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, the AHCA contracts with private managed care plans for the coordination and payment of services for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan.

In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two components, the Managed Medical Assistance (MMA) program and the Long-term Care program. Florida's SMMC offers a health care package covering both acute and long-term care. The SMMC benefits are authorized by federal authority and are specifically required in ss. 409.973 and 409.98, F.S.

The AHCA contracts with managed care plans on a regional basis to provide services to eligible recipients. The MMA program, which covers most medical and acute care services for managed care plan enrollees, was fully implemented in August 2014 and was re-procured for a period beginning December 2018 and ending in 2023.

## III. Effect of the Bill

The bill amends s. 39.407, F.S, authorizing the DCF to place a child or adolescent who meets the definition of a "child or adolescent who has an emotional disturbance" or a "child or adolescent who has a serious emotional disturbance or mental illness" in therapeutic group homes for mental health treatment without prior court approval, under certain circumstances.

The bill makes a number of changes to definitions to s. 39.407, F.S., relating to medical, psychiatric, and psychological examination and treatment of child, to:

- Add the term "therapeutic group home," which is not currently defined in ch. 39, F.S., and define such term to mean a 24-hour residential program providing community-based mental health treatment and mental health support services to children who meet the criteria in s. 394.492(5) or (6), F.S., in a nonsecure, homelike setting;
- Amend the definition of a "residential treatment" or "residential treatment program" to include a therapeutic group home as defined above; and

[34] Medicaid.gov, *Medicaid State Plan Amendments,* available at https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html (last visited January 23, 2022).

- Expand the definition of "suitable for residential treatment" or "suitability" to include if the child is expected to benefit from emotional, or behavioral health treatment, in addition to mental health treatment.

Through the above definitions and the application of such terms throughout s. 39.407, F.S., the bill ensures that the process the DCF has established for credentialing an existing licensed therapeutic group home as a QRTP will result in placements that occur in accordance with rule and in compliance with federal requirements for QRTPs.

The bill also updates the qualified evaluators' process to reflect current practices providing that the DCF, rather than the AHCA, must appoint qualified evaluators to conduct suitability assessments.

The bill requires the qualified evaluator for STGH and QRTP to be a psychiatrist licensed under chapter 458 or 459, F.S., psychologist licensed under chapter 490, F.S. or a mental health counselor licensed under chapter 491, F.S., with at least two years of experience in the diagnosis and treatment of serious emotional disturbances in children and adolescents, as opposed to the stricter requirements for a PRTF/SIPP which requires the evaluator to be a psychiatrist or a psychologist licensed in Florida with three years of experience.

These changes to the qualifications are expected to expand the pool of qualified evaluators for conducting suitability assessments for STGH and QRTP placements to more than the 18 currently used for PRTF/SIPP suitability assessments[35] and create a larger recruitment pool for TGH and QRTP assessors. The third-party vendor contracted by the DCF for the management of the qualified evaluator network estimates that this change in requirements will increase the pool of potentially qualified evaluators by approximately 2,000.

The bill also amends s. 39.407, F.S., requiring the DCF to provide the guardian ad litem and the court with a copy of the assessment by the qualified evaluator within five days after the DCF's receipt of the assessment, rather than immediately upon placement as required in current law.

The bill authorizes the DCF to adopt rules to administer the provisions of s. 39.407, F.S. This expanded authority will allow the DCF flexibility to adapt to the different needs of children being served, the needs of the provider community, and the ability to make changes in response to federal policy changes.

This act shall take effect upon becoming a law.

## IV. Constitutional Issues:

### A. Municipality/County Mandates Restrictions:

The bill does not appear to require cities and counties to expend funds or limit their authority to raise revenue or receive state-shared revenues as specified by Article VII, Section 18 of the Florida Constitution.

[35] The DCF SB 1120 Analysis, p. 3.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends section 39.407 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.)

**CS by Children, Families, and Elder Affairs on January 25, 2022.**
The committee substitute:

- Modifies the definition of the term "therapeutic group home" (TGH) to remove the cross-reference to s. 419.001, F.S., and to remove the limitation of 16 beds for the TGHs; and
- Expands persons who can be qualified evaluators to include psychiatrists licensed under ch. 459, F.S., in addition to those licensed under ch. 458, F.S.

B. Amendments:

None.

**By** the Committee on Children, Families, and Elder Affairs; and Senator Rodriguez

586-02285-22 20221120c1

A bill to be entitled

An act relating to child welfare; amending s. 39.407, F.S.; authorizing the Department of Children and Families, under certain circumstances, to place children in its custody in therapeutic group homes for residential mental health treatment without prior court approval; revising definitions; defining the term "therapeutic group home"; providing that the department, rather than the Agency for Health Care Administration, shall appoint qualified evaluators to conduct suitability assessments of certain children in the department's custody; specifying qualifications for evaluators conducting suitability assessments for placement in a therapeutic group home; revising requirements for suitability assessments; specifying when the department must provide a copy of the assessment to the guardian ad litem and the court; revising the department's and the agency's rulemaking authority; providing an effective date.

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

Section 1. Subsection (6) of section 39.407, Florida Statutes, is amended to read:

39.407 Medical, psychiatric, and psychological examination and treatment of child; physical, mental, or substance abuse examination of person with or requesting child custody.—

(6) Children ~~who are~~ in the legal custody of the department may be placed by the department, without prior approval of the







586-02285-22 20221120c1

court, in a residential treatment center licensed under s. 394.875, a therapeutic group home, or a hospital licensed under chapter 395 for residential mental health treatment only pursuant to this section or may be placed by the court in accordance with an order of involuntary examination or involuntary placement entered pursuant to s. 394.463 or s. 394.467. All children placed in a residential treatment program under this subsection must have a guardian ad litem appointed.

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

2.~~1.~~ "Residential treatment" or "residential treatment program" means a placement for observation, diagnosis, or treatment of an emotional disturbance in a residential treatment center licensed under s. 394.875, a therapeutic group home, or a hospital licensed under chapter 395.

1.~~2.~~ "Least restrictive alternative" means the treatment and conditions of treatment that, separately and in combination, are no more intrusive or restrictive of freedom than reasonably necessary to achieve a substantial therapeutic benefit or to protect the child or adolescent or others from physical injury.

3. "Suitable for residential treatment" or "suitability" means a determination concerning a child or adolescent with an emotional disturbance as defined in s. 394.492(5) or a serious emotional disturbance as defined in s. 394.492(6) that each of the following criteria is met:

a. The child requires residential treatment.

b. The child is in need of a residential treatment program and is expected to benefit from mental, emotional, or behavioral health treatment.

c. An appropriate, less restrictive alternative to

residential treatment is unavailable.

4. "Therapeutic group home" means a 24-hour residential program providing community-based mental health treatment and mental health support services to children who meet the criteria in s. 394.492(5) or (6) in a nonsecure, homelike setting.

(b) Whenever the department believes that a child in its legal custody is emotionally disturbed and may need residential treatment, an examination and suitability assessment must be conducted by a qualified evaluator ~~who is~~ appointed by the department ~~Agency for Health Care Administration~~. This suitability assessment must be completed before the placement of the child in a residential treatment program ~~center for emotionally disturbed children and adolescents or a hospital~~.

1. The qualified evaluator for placement in a residential treatment center or a hospital must be a psychiatrist or a psychologist licensed in this state ~~Florida~~ who has at least 3 years of experience in the diagnosis and treatment of serious emotional disturbances in children and adolescents and who has no actual or perceived conflict of interest with any inpatient facility or residential treatment center or program.

2. The qualified evaluator for placement in a therapeutic group home must be a psychiatrist licensed under chapter 458 or chapter 459, a psychologist licensed under chapter 490, or a mental health counselor licensed under chapter 491 who has at least 2 years of experience in the diagnosis and treatment of serious emotional or behavioral disturbance in children and adolescents and who has no actual or perceived conflict of interest with any residential treatment center or program.

(c) Consistent with the requirements of this section ~~Before~~





~~a child is admitted under this subsection~~, the child shall be assessed for suitability for ~~residential~~ treatment by a qualified evaluator who has conducted an ~~a personal~~ examination and assessment of the child and has made written findings that:

1. The child appears to have an emotional disturbance serious enough to require treatment in a residential treatment program and is reasonably likely to benefit from the treatment.

2. The child has been provided with a clinically appropriate explanation of the nature and purpose of the treatment.

3. All available modalities of treatment less restrictive than residential treatment have been considered, and a less restrictive alternative that would offer comparable benefits to the child is unavailable.

A copy of the written findings of the evaluation and suitability assessment must be provided to the department, to the guardian ad litem, and, if the child is a member of a Medicaid managed care plan, to the plan that is financially responsible for the child's care in residential treatment, all of whom must be provided with the opportunity to discuss the findings with the evaluator.

(d) Immediately upon placing a child in a residential treatment program under this section, the department must notify the guardian ad litem and the court having jurisdiction over the child. Within 5 days after the department's receipt of the assessment, the department shall ~~and must~~ provide the guardian ad litem and the court with a copy of the assessment by the qualified evaluator.

(e) Within 10 days after the admission of a child to a residential treatment program, the director of the residential treatment program or the director's designee must ensure that an individualized plan of treatment has been prepared by the program and has been explained to the child, to the department, and to the guardian ad litem, and submitted to the department. The child must be involved in the preparation of the plan to the maximum feasible extent consistent with his or her ability to understand and participate, and the guardian ad litem and the child's foster parents must be involved to the maximum extent consistent with the child's treatment needs. The plan must include a preliminary plan for residential treatment and aftercare upon completion of residential treatment. The plan must include specific behavioral and emotional goals against which the success of the residential treatment may be measured. A copy of the plan must be provided to the child, to the guardian ad litem, and to the department.

(f) Within 30 days after admission, the residential treatment program must review the appropriateness and suitability of the child's placement in the program. The residential treatment program must determine whether the child is receiving benefit toward the treatment goals and whether the child could be treated in a less restrictive treatment program. The residential treatment program shall prepare a written report of its findings and submit the report to the guardian ad litem and to the department. The department must submit the report to the court. The report must include a discharge plan for the child. The residential treatment program must continue to evaluate the child's treatment progress every 30 days thereafter





and must include its findings in a written report submitted to the department. The department may not reimburse a facility until the facility has submitted every written report that is due.

(g)1. The department must submit, at the beginning of each month, to the court having jurisdiction over the child, a written report regarding the child's progress toward achieving the goals specified in the individualized plan of treatment.

2. The court must conduct a hearing to review the status of the child's residential treatment plan no later than 60 days after the child's admission to the residential treatment program. An independent review of the child's progress toward achieving the goals and objectives of the treatment plan must be completed by a qualified evaluator and submitted to the court before its 60-day review.

3. For any child in residential treatment at the time a judicial review is held pursuant to s. 39.701, the child's continued placement in residential treatment must be a subject of the judicial review.

4. If at any time the court determines that the child is not suitable for continued residential treatment, the court shall order the department to place the child in the least restrictive setting that is best suited to meet his or her needs.

(h) After the initial 60-day review, the court must conduct a review of the child's residential treatment plan every 90 days.

(i) The department may adopt rules to administer this subsection ~~must adopt rules for implementing timeframes for the~~

~~completion of suitability assessments by qualified evaluators and a procedure that includes timeframes for completing the 60-day independent review by the qualified evaluators of the child's progress toward achieving the goals and objectives of the treatment plan which review must be submitted to the court. The Agency for Health Care Administration must adopt rules for the registration of qualified evaluators, the procedure for selecting the evaluators to conduct the reviews required under this section, and a reasonable, cost-efficient fee schedule for qualified evaluators~~.

Section 2. This act shall take effect upon becoming a law.

The Florida Senate

# Committee Agenda Request

**To:** Senator Aaron Bean, Chair
Appropriations Subcommittee on Health and Human Service

**Subject:** Committee Agenda Request

**Date:** January 25, 2022

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I respectfully request that SB 1120, relating to Child Welfare, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Ana Maria Rodriguez
Florida Senate, District 39

File signed original with committee office

Tab 2

The Florida Senate

# APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

| 2.16.2022 | SB 1120 |
|---|---|
| Meeting Date | Bill Number or Topic |
| Appropriations Subcommittee on Health and Human Services | |
| Committee | Amendment Barcode (if applicable) |

Name John Paul Fiore, Director of Legislative Affairs, DCF Phone 850-488-9410

Address 2415 N. Monroe Street Email
*Street*

Tallahassee Florida 32303
*City* *State* *Zip*

**Speaking:** ☐ For ☐ Against ☐ Information **OR** **Waive Speaking:** ☑ In Support ☐ Against

**PLEASE CHECK ONE OF THE FOLLOWING:**

☑ **I am appearing without compensation or sponsorship.**

☐ **I am a registered lobbyist, representing:**

☐ **I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:**

*While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)*

**This form is part of the public record for this meeting.**

S-001 (08/10/2021)

**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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | PCS/CS/SB 1262 (430576) |
| INTRODUCER: | Appropriations Subcommittee on Health and Human Services; Children, Families, and Elder Affairs Committee; and Senators Burgess and Rouson |
| SUBJECT: | Mental Health and Substance Abuse |
| DATE: | February 18, 2022 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Delia | Cox | CF | **Fav/CS** |
| 2. | Sneed | Money | AHS | **Recommend: Fav/CS** |
| 3. | | | AP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

PCS/CS/SB 1262 makes several changes to procedures surrounding voluntary and involuntary examinations of individuals under the Baker and Marchman Acts. The bill prohibits restrictions on visitors, phone calls, and written correspondence for Baker Act patients unless certain qualified medical professionals document specific conditions are met. The bill requires law enforcement officers to search certain electronic databases for emergency contact information of Baker and Marchman Act patients being transported to a receiving facility.

Under the bill, patients subject to an involuntary Baker Act examination who do not meet the criteria for a petition for involuntary services must be released at the end of 72 hours, regardless of whether the examination period ends on a weekend or holiday, as long as certain discharge criteria are met.

The bill makes it a first degree misdemeanor for a person to knowingly and willfully:

- Furnish false information for the purpose of obtaining emergency or other involuntary admission for any person;
- Cause, or conspire with another to cause, any emergency or other involuntary mental health procedure for the person under false pretenses; or,
- Cause, or conspire with another to cause, without lawful justification, any person to be denied their rights under the Baker Act statutes.

The bill requires receiving facilities to offer voluntary Baker and Marchman Act patients the option to authorize the release of clinical information to certain individuals known to the patient within 24 hours of admission.

The bill clarifies that telehealth may be used when discharging patients under an involuntary Baker Act examination, and directs facilities receiving transportation reports detailing the circumstances of a Baker Act to share such reports with the Department of Children and Families (DCF) for use in analyzing annual Baker Act data.

The bill also makes several changes to the Commission on Mental Health and Substance Abuse (Commission), including:

- Authorizing the Commission to conduct meetings in person at locations throughout the state or via teleconference or other electronic means;
- Authorizing members to receive per diem and reimbursement and travel expenses;
- Authorizing the Commission to access information and records necessary to carry out its duties, including exempt and confidential information, provided that the Commission does not disclose such exempt or confidential information; and
- Modifying the due date for the Commission's interim report from September 1, 2022 to January 1, 2023.

The bill is expected to have a negative fiscal impact on state government. See Section V. Fiscal Impact Statement.

The bill takes effect July 1, 2022.

## II. Present Situation:

Refer to Section III (Effect of Proposed Changes) for discussion of the relevant portions of current law.

## III. Effect of Proposed Changes:

### The Baker Act

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.[1] The Baker Act deals with Florida's mental health commitment laws, and includes legal procedures for mental health examination and treatment, including voluntary and involuntary examinations.[2] The Baker Act also protects the rights of all individuals examined or treated for mental illness in Florida.[3]

#### *Involuntary Examination*

Individuals suffering from an acute mental health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be

[1] Ch. 71-131, LO.F.; The Baker Act is contained in ch. 394, F.S.
[2] Sections 394.451-394.47891, F.S.
[3] Section 394.459, F.S.

provided on a voluntary or involuntary basis.[4] An involuntary examination is required if there is reason to believe that the person has a mental illness and because of his or her mental illness:

- The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination or is unable to determine for himself or herself whether examination is necessary; and
- Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or
- There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.[5]

The involuntary examination may be initiated by:

- A court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;[6]
- A law enforcement officer taking a person who appears to meet the criteria for involuntary examination into custody and delivering the person or having him or her delivered to a receiving facility for examination;[7] or
- A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker executing a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination, including a statement of the professional's observations supporting such conclusion.[8]

A law enforcement officer who delivers an individual to a receiving facility must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made a part of the patient's clinical record.[9] Any facility accepting the patient based on this certificate must send a copy of the certificate to the DCF within 5 working days.[10] The same reporting requirements apply in instances where a law enforcement officer delivers a person to a receiving facility pursuant to a certificate executed by a health care professional.[11]

Involuntary patients must be taken to either a public or private facility which has been designated by the DCF as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold, or refer, as appropriate, involuntary patients under emergency conditions for psychiatric evaluation and to provide short-term treatment or transportation to the appropriate service provider.[12]

[4] Sections 394.4625 and 394.463, F.S.
[5] Section 394.463(1), F.S.
[6] Section 394.463(2)(a)1., F.S. Additionally, the order of the court must be made a part of the patient's clinical record.
[7] Section 394.463(2)(a)2., F.S.
[8] Section 394.463(2)(a)3., F.S.
[9] Section 394.463(2)(a)2., F.S.
[10] *Id*.
[11] Section 394.463(2)(a)3., F.S.
[12] Section 394.455(40), F.S.

The patient must be examined by the receiving facility within 72 hours of the initiation of the involuntary examination. The examination may be performed by:

- A physician;[13]
- A clinical psychologist;[14] or
- A psychiatric nurse[15] performing within the framework of an established protocol with a psychiatrist at a facility.[16]

The patient may not be released by the receiving facility without the documented approval of one of the following:

- A psychiatrist;
- A clinical psychologist; or
- If the receiving facility is owned or operated by a hospital or health system:
  - A psychiatric nurse performing within the framework of an established protocol with a psychiatrist;[17] or
  - An attending emergency department physician with experience in the diagnosis and treatment of mental illness after completion of an involuntary examination.[18]

By the end of the 72 hour period, or if the period ends on a weekend or holiday, no later than the next working day, one of the following actions must be taken to address the individual needs of the patient:

- The patient must be released, unless he or she is charged with a crime, in which case the patient is to be returned to the custody of a law enforcement officer;
- The patient must be released for voluntary outpatient treatment;
- The patient, unless he or she is charged with a crime, must be asked to give express and informed consent to placement as a voluntary patient and, if such consent is given, the patient must be admitted as a voluntary patient; or
- A petition for involuntary services must be filed in the circuit court if inpatient treatment is deemed necessary or with the criminal county court, as applicable. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition must be made available. A petition for involuntary inpatient placement must be filed by the facility administrator.[19]

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[13] "Physician" means a medical practitioner licensed under ch. 458, F.S., or ch. 459, F.S., who has experience in the diagnosis and treatment of mental illness or a physician employed by a facility operated by the United States Department of Veterans Affairs or the United States Department of Defense. Section 394.455(33), F.S.

[14] "Clinical psychologist" means a psychologist as defined in s. 490.003(7), F.S., with 3 years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure, or a psychologist employed by a facility operated by the United States Department of Veterans Affairs that qualifies as a receiving or treatment facility. Section 394.455(5), F.S.

[15] "Psychiatric nurse" means an advanced practice registered nurse licensed under s. 464.012, F.S., who has a master's or doctoral degree in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has 2 years of post-master's clinical experience under the supervision of a physician. Section 394.455(36), F.S.

[16] Section 394.463(2)(f), F.S.

[17] A psychiatric nurse may not approve the release of a patient if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist. Section 394.463(2)(f), F.S.

[18] Section 394.463(2)(f), F.S.

[19] Section 394.463(2)(g), F.S.

Receiving facilities must also ensure that a patient's discharge plan considers all of the following prior to the patient's release:

- The patient's transportation resources;
- The patient's access to stable living arrangements;
- How assistance in securing needed living arrangements or shelter will be provided to patients at risk of readmission within the 3 weeks immediately following discharge due to homelessness or transient status. The discharging facility must document that, before discharging the patient, it has requested a commitment from a shelter provider that assistance will be rendered;
- The availability of assistance in obtaining a timely aftercare appointment for needed services, including continuation of prescribed psychotropic medications. Aftercare appointments for psychotropic medication and case management must be requested to occur not later than 7 days after the expected date of discharge; if the discharge is delayed, the discharging facility must document notification of the delay to the aftercare provider. The discharging facility shall coordinate with the aftercare service provider and document the aftercare planning;
- The availability of, and access to, prescribed psychotropic medications in the community. To ensure a patient's safety and provision of continuity of essential psychotropic medications, such prescribed psychotropic medications, prescriptions, multiple partial prescriptions for psychotropic medications, or a combination thereof, must be provided to the patient upon discharge to cover the intervening days until the first scheduled psychotropic medication aftercare appointment, up to a maximum of 21 calendar days;
- The provision of education and written information about the patient's illness and psychotropic medications, including other prescribed and over-the-counter medications; the common side-effects of any medications prescribed; and any common adverse clinically significant drug-to-drug interactions between that medication and other commonly available prescribed and over-the-counter medications;
- The provision of contact and program information about, and referral to, any community-based peer support services in the community;
- The provision of contact and program information about, and referral to, any needed community resources;
- Referral to substance abuse treatment programs, trauma or abuse recovery-focused programs, or other self-help groups, if indicated by assessments; and
- The provision of information about advance directives, including how to prepare and use them.[20]

***Involuntary Inpatient Placement***

A person may be placed in involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:

- He or she is mentally ill and because of his or her mental illness:
  - He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement or is unable to determine for himself or herself whether placement is necessary; and
  - He or she is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services; and

[20] Rule 65E-5.1303, F.A.C.

  - Without treatment, is likely to suffer from neglect or refuse to care for himself or herself; and
  - Such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or
  - There is a substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and
- All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.[21]

The administrator of the receiving or treatment facility that is retaining a patient for involuntary inpatient treatment must file a petition for involuntary inpatient placement in the court in the county where the patient is located.[22] Upon filing, the clerk of the court must provide copies to the DCF, the patient, the patient's guardian or representative, and the state attorney and public defender of the judicial circuit in which the patient is located.[23] The court must hold a hearing on involuntary inpatient placement within 5 court working days, unless a continuance is granted.[24]

**The Marchman Act**

In the early 1970s, the federal government enacted laws creating formula grants for states to develop continuums of care for individuals and families affected by substance abuse.[25] The laws resulted in separate funding streams and requirements for alcoholism and drug abuse. In response to the laws, the Florida Legislature enacted chs. 396 and 397, F.S., relating to alcohol and drug abuse, respectively.[26] Each of these laws governed different aspects of addiction, and thus had different rules promulgated by the state to fully implement the respective pieces of legislation.[27] However, because persons with substance abuse issues often do not restrict their misuse to one substance or another, having two separate laws dealing with the prevention and treatment of addiction was cumbersome and did not adequately address Florida's substance abuse problem.[28] In 1993, legislation was adopted to combine ch. 396 and 397, F.S., into a single law, the Hal S. Marchman Alcohol and Other Drug Services Act (Marchman Act).[29]

The Marchman Act encourages individuals to seek services on a voluntary basis within the existing financial and space capacities of a service provider. An individual who wishes to enter treatment may apply to a service provider for voluntary admission.[30] Within the financial and space capabilities of the service provider, the individual must be admitted to treatment when sufficient evidence exists that he or she is impaired by substance abuse and his or her medical and behavioral conditions are not beyond the safe management capabilities of the service

[21] Section 394.467(1), F.S.
[22] Section 394.467(2) and (3), F.S.
[23] Section 394.467(3), F.S.
[24] Section 394.467(5), F.S.
[25] The DCF, *Baker Act and Marchman Act Project Team Report for Fiscal Year 2016-2017*, p. 4-5. (On file with the Senate Children, Families, and Elder Affairs Committee).
[26] *Id*.
[27] *Id*.
[28] *Id*.
[29] Ch. 93-39, s. 2, L.O.F. (creating ch. 397, F.S., effective October 1, 1993).
[30] Section 397.601(1), F.S

provider.[31] However, denial of addiction is a prevalent symptom of SUD, creating a barrier to timely intervention and effective treatment.[32] As a result, treatment typically must stem from a third party providing the intervention needed for SUD treatment.[33]

***Involuntary Admissions***

The Marchman Act establishes a variety of methods under which substance abuse assessment, stabilization, and treatment can be obtained on an involuntary basis. There are five involuntary admission procedures that can be broken down into two categories depending upon whether the court is involved.[34] Three of the procedures do not involve the court, while two require direct petitions to the circuit court. The same criteria for involuntary admission apply regardless of the admission process used.[35]

An individual meets the criteria for an involuntary admission under the Marchman Act when there is good faith reason to believe the individual is substance abuse impaired and, because of such impairment, has lost the power of self-control with respect to substance use, and either:

- Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that he or she is incapable of appreciating his or her need for such services and of making a rational decision in that regard;[36] or
- Without care or treatment:
  - The person is likely to suffer from neglect or refuse to care for himself or herself;
  - Such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and
  - It is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or
  - There is substantial likelihood that the person:
    - Has inflicted, or threatened to or attempted to inflict physical harm on himself, herself, or another; or
    - Is likely to inflict, physical harm on himself, herself, or another unless he or she is admitted.[37]

***Non-Court Involved Involuntary Admissions***

The three types of non-court procedures for involuntary admission for substance abuse treatment under the Marchman Act include protective custody, emergency admission, and the alternative involuntary assessment for minors.

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[31] Section 397.601(2), F.S.
[32] Darran Duchene and Patrick Lane, *Fundamentals of the Marchman Act*, Risk RX, Vol. 6 No. 2 (Apr. – Jun. 2006) State University System of Florida Self-Insurance Programs, available at http://flbog.sip.ufl.edu/risk-rx-article/fundamentals-of-the-marchman-act/ (last visited January 19, 2022) (hereinafter cited as "Fundamentals of the Marchman Act").
[33] *Id*.
[34] *Id*.
[35] *Id*.
[36] Section 394.675(2)(a), F.S. However, mere refusal to receive services does not constitute evidence of lack of judgment with respect to the person's need for such services.
[37] Section 397.675(2)(b), F.S.

Law enforcement officers use the protective custody procedure when an individual is substance-impaired or intoxicated in public and such impairment is brought to the attention of the officer.[38] The purpose of this procedure is to allow the person to be taken to a safe environment for observation and assessment to determine the need for treatment. A law enforcement officer may take the individual to their residence, a hospital, a detoxification center, or an addiction receiving facility, whichever the officer determines is most appropriate.[39] The officer is also required to execute a written report[40] detailing the circumstances under which the individual was taken into custody.[41] The current version of the form developed and disseminated by the DCF must also include information on transportation, family members or others present when the individual was taken into custody, and next of kin or other contact information, if known.[42]

If the individual in these circumstances does not consent to protective custody, the officer may do so against the person's will, without using unreasonable force. Additionally, the officer has the option of taking an individual to a jail or detention facility for his or her own protection. Such detention cannot be considered an arrest for any purpose and no record can be made to indicate that the person has been detained or charged with any crime.[43] However, if the individual is a minor, the law enforcement officer must notify the nearest relative of a minor in protective custody without consent.[44]

The second process, emergency admission, authorizes an individual who appears to meet the criteria for involuntary admission to be admitted to a hospital, an addiction receiving facility, or a detoxification facility for emergency assessment and stabilization, or to a less intensive component of a licensed service provider for assessment only.[45] Individuals admitted for involuntary assessment and stabilization under this provision must have a certificate from a specified health professional[46] demonstrating the need for this type of placement and recommending the least restrictive type of service that is appropriate to the needs of the individual.[47]

[38] Section 397.677, F.S. The individual can be a minor or adult under this process.
[39] Section 397.6771, F.S. A person may be held in protective custody for no more than 72 hours, unless a petition for involuntary assessment or treatment has been timely filed with the court within that timeframe to extend protective custody.
[40] The DCF is required to develop the form pursuant to s. 397.321(19), F.S.
[41] Section 397.6772(1)(a), F.S.
[42] The current version of the form is available at https://eds.myflfamilies.com/DCFFormsInternet/Search/OpenDCFForm.aspx?FormId=1061 (last visited January 19, 2022).
[43] Section 397.6772(1), F.S.
[44] Section 397.6772(2), F.S.
[45] Section 397.679, F.S.
[46] Section 397.6793(1), F.S., provides a list of professionals that include a physician, a clinical psychologist, a physician assistant working under the scope of practice of the supervising physician, a psychiatric nurse, an advanced practice registered nurse, a mental health counselor, a marriage and family therapist, a master's-level-certified addictions professional for substance abuse services, or a clinical social worker.
[47] Section 397.6793, F.S. The certificate can be from a physician, advanced practice registered nurse, a psychiatric nurse, a clinical psychologist, a clinical social worker, a marriage and family therapist, a mental health counselor, or a physician assistant working under the scope of a practice of the supervising physician, or a master's-level-certified addictions professional for substance abuse services.

Lastly, the alternative involuntary assessment for minors provides a way for a parent, legal guardian, or legal custodian to have a minor admitted to an addiction receiving facility to assess the minor's need for treatment by a qualified professional.[48]

***Telehealth (Sections 1 and 5)***

Section 456.47, F.S., defines the term "telehealth" as the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

"Synchronous" telehealth refers to the live, real-time, or interactive transmission of information between a patient and a health care provider during the same time period. The use of live video to evaluate and diagnosis a patient would be considered synchronous telehealth.

"Asynchronous" telehealth refers to the transfer of data between a patient and a health care provider over a period of time and typically in separate time frames. This is commonly referred to as "store-and-forward."

"Remote patient monitoring" refers to the collection, transmission, evaluation, and communication of individual health data to a health care provider from the patient's location through technology such as wireless devices, wearable sensors, implanted health monitors, smartphones, and mobile apps.[49] Remote monitoring is used to monitor physiologic parameters, including weight, blood pressure, blood glucose, pulse, temperature, oximetry, respiratory flow rate, and more. Remote monitoring can be useful for ongoing condition monitoring and chronic disease management. Depending upon the patient's needs, remote monitoring can be synchronous or asynchronous.

***Florida Telehealth Providers***

In 2019, the Legislature passed and the Governor approved CS/CS/HB 23, creating s. 456.47, F.S., which became effective on July 1, 2019.[50] It authorized Florida-licensed health care providers[51] to use telehealth to deliver health care services within their respective scopes of practice.

Telehealth providers who treat patients located in Florida must be one of the licensed health care practitioners listed below and be either Florida-licensed, licensed under a multi-state health care licensure compact of which Florida is a member state, or registered as an out-of-state telehealth provider:

- Behavioral Analyst;[52]

[48] Section 397.6798, F.S.
[49] American Board of Telehealth, *Telehealth: Defining 21st Century Care*, available at https://www.americantelemed.org/resource/why-telemedicine/ (last visited January 19, 2022).
[50] Chapter 2019-137, s. 6, L.O.F.
[51] Section 456.47(1)(b), F.S.
[52] Section 393.17, F.S.

- Acupuncturist;[53]
- Allopathic physician;[54]
- Osteopathic physician;[55]
- Chiropractor;[56]
- Podiatrist;[57]
- Optometrist;[58]
- Nurse;[59]
- Pharmacist;[60]
- Dentist;[61]
- Dental Hygienist;[62]
- Midwife;[63]
- Speech Therapist;[64]
- Occupational Therapist;[65]
- Radiology Technician;[66]
- Electrologist;[67]
- Orthotist;[68]
- Pedorthist;[69]
- Prosthetist;[70]
- Medical Physicist;[71]
- Emergency Medical Technician;[72]
- Paramedic;[73]
- Massage Therapist;[74]
- Optician;[75]
- Hearing Aid Specialist;[76]

[53] Chapter 457, F.S.
[54] Chapter 458, F.S.
[55] Chapter 459, F.S.
[56] Chapter 460, F.S.
[57] Chapter 461, F.S.
[58] Chapter 463, F.S.
[59] Chapter 464, F.S.
[60] Chapter 465, F.S.
[61] Chapter 466, F.S.
[62] *Id*.
[63] Chapter 467, F.S.
[64] Chapter 468, F.S.
[65] *Id*.
[66] *Id*.
[67] Chapter 458, F.S.
[68] Chapter 468, F.S.
[69] *Id*.
[70] *Id*.
[71] Chapter 483, F.S.
[72] Chapter 401, F.S.
[73] *Id*.
[74] Chapter 480, F.S.
[75] Chapter 484, F.S.
[76] *Id*.

- Clinical Laboratory Personnel;[77]
- Respiratory Therapist;[78]
- Psychologist;[79]
- Psychotherapist;[80]
- Dietician/Nutritionist;[81]
- Athletic Trainer;[82]
- Clinical Social Worker;[83]
- Marriage and Family Therapist;[84] and
- Mental Health Counselor.[85]

***Effect of the Bill***

The bill provides a definition for "telehealth," specifically that telehealth has the same meaning as defined in s. 456.47, F.S. The bill permits receiving facilities holding patients for an involuntary examination under the Baker Act to authorize the release of a patient via telehealth.

Under the bill, if a patient's 72-hour examination period ends on a weekend or holiday, and the receiving facility:

- Intends to file a petition for involuntary services, the patient may be held at a receiving facility through the next working day thereafter and the petition for involuntary services must be filed no later than that date. If the receiving facility fails to file a petition at the close of the next working day, the patient must be released from the receiving facility.
- Does not intend to file a petition for involuntary services, a receiving facility may postpone release of a patient until the next working day thereafter only if a qualified professional documents that adequate discharge planning and procedures in accordance with s. 394.468, F.S.,[86] are not possible until the next working day.

Specifically, receiving facilities must include, and document consideration of the following newly established discharge planning and procedure requirements delineated in s. 394.468, F.S.:

- Follow-up behavioral health appointments;
- Information on how to obtain prescribed medications; and
- Information pertaining to:
  - Available living arrangements;
  - Transportation; and
  - Recovery support opportunities.

[77] Chapter 483, F.S.
[78] Chapter 468, F.S.
[79] Chapter 490, F.S.
[80] Chapter 491, F.S.
[81] Chapter 468, F.S.
[82] Chapter 468, F.S.
[83] Chapter 491, F.S.
[84] *Id*.
[85] *Id*.
[86] Section 394.468, F.S., currently provides that admission and discharge and treatment policies of the DCF are governed solely by ch. 394, F.S., and are not subject to control by court procedure rules. The matters within the purview of this part are deemed to be substantive, not procedural.

The bill applies these requirements to all patients discharged from a receiving or treatment facility.

These changes will help to ensure patients are not held by a facility for longer than necessary, while maintaining sound and proper discharge considerations.

**Notice Requirements (Sections 3 through 7)**

Receiving facilities must give prompt notice[87] of the whereabouts of a patient who is being involuntarily held for examination to the patient's guardian,[88] guardian advocate,[89] health care surrogate or proxy, attorney, and representative.[90] If the patient is a minor, the receiving facility must give prompt notice to the minor's parent, guardian, caregiver, or guardian advocate. Notice for an adult may be provided within 24 hours of arrival; however, notice for a minor must be provided immediately after the minor's arrival at the facility.[91] The facility may delay the notification for a minor for up to 24 hours if it has submitted a report to the central abuse hotline.

The receiving facility must attempt to notify the minor's parent, guardian, caregiver, or guardian advocate until it receives confirmation that the notice has been received. Attempts must be repeated at least once every hour during the first 12 hours after the minor's arrival and then once every 24 hours thereafter until confirmation is received, the minor is released, or a petition for involuntary services is filed with the court.[92]

***Emergency Contact Information and Florida Databases***

On December 7, 2005, Tiffiany Marie Olson was killed in a traffic crash on U.S. 19 in Manatee County.[93] Following her mother not being notified of her death for several hours, her mother was instrumental in getting emergency contact information (ECI) added to a person's driver license or identification card record.[94] The Florida Department of Highway Safety and Motor Vehicles (the FLHSMV) launched the program on October 2, 2006, and it has since been adopted by 15 other states.[95]

ECI allows law enforcement to contact designated individuals in the event of an emergency.[96] The system is securely maintained by the FLHSMV and can be accessed by law enforcement

[87] Notice may be provided in person or by telephone; however, in the case of a minor, notice may also be provided by other electronic means. Section 394.455(2), F.S.
[88] "Guardian" means the natural guardian of a minor, or a person appointed by a court to act on behalf of a ward's person if the ward is a minor or has been adjudicated incapacitated. Section 394.455(17), F.S.
[89] "Guardian advocate" means a person appointed by a court to make decisions regarding mental health treatment on behalf of a patient who has been found incompetent to consent to treatment. Section 394.455(18), F.S.
[90] Section 394.4599(2)(b), F.S.
[91] Section 394.4599(2)(b)-(c), F.S.
[92] Section 394.4599(c)2., F.S.
[93] The Florida Highway Safety and Motor Vehicles (the FLHSMV), *Emergency Contact Information History*, available at https://www.flhsmv.gov/driver-licenses-id-cards/emergency-contact-information-history/ (last visited January 19, 2022).
[94] *Id*.
[95] To Inform Families First, *About TIFF*, available at https://www.toinformfamiliesfirst.org/ (last visited January 19, 2022) (hereinafter "About TIFF").
[96] The FLHSMV, *ECI Brochure*, available at https://flhsmv.gov/pdf/eci/eci_brochure.pdf (last visited January 19, 2022).

only in an emergency situation.[97] Floridians with a valid driver's license or ID card may enter up to two emergency contacts.[98] Residents can register or update their ECI without cost at *flhsmv.gov/eci*[99] or at local driver license offices statewide.[100]

***Driver and Vehicle Information Database (DAVID)***

The DAVID system is the FLHSMV's multifaceted database that provides accurate, concise, and up-to-date driver and motor vehicle information to law enforcement, criminal justice officials, and other state agencies.[101] To maintain the integrity of this information, the records are regulated and can only be accessed and used by authorized personnel in accordance with state and federal law.[102]

The DAVID system also contains ECI for Florida drivers who have chosen to list emergency contacts.[103] ECI available through DAVID may only be accessed by law enforcement and may only be used in emergency situations.[104]

***Florida Crime Information Center (FCIC) System***

The FCIC system is Florida's central database for tracking various crime-related information. The system is designed "to provide services, information, and capabilities to the law enforcement and criminal justice community" in the state, and gives them access to other criminal justice information systems nationwide.[105] All employees that access the FCIC must be certified by the Florida Department of Law Enforcement, and all information obtained through the system is restricted to criminal justice purposes.[106]

Law enforcement can also use FCIC to access information pertaining to a driver's specific license, providing an officer with information including a driver's name, date of birth, residential address and licensure status. If a driver has chosen to add ECI, it will also be provided to an officer along with the rest of the driver-specific information at the bottom of the screen when he or she queries the FCIC database.[107]

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[97] *Id*.
[98] *Id*.
[99] The FLHSMV, *Emergency Contact Information History*, available at https://www.flhsmv.gov/driver-licenses-id-cards/emergency-contact-information-history/ (last visited February 9, 2022).
[100] *Id*.
[101] The FLHSMV Office of Inspector General, *DAVID Audits*, p. 1, available at https://www.flhsmv.gov/pdf/igoffice/20171823.pdf (last visited January 19, 2022).
[102] *Id.*, s. 119.0712(2)(d), F.S.
[103] About TIFF.
[104] The Fort Lauderdale Police Department, *Access to Criminal Justice Information*, p. 4, available at https://www.flpd.org/home/showpublisheddocument/4061/637662691735570000 (last visited January 19, 2022).
[105] Florida Highway Patrol Policy Manual, *Criminal Justice Information Services: Policy 14.02.04C.* (Rev. Mar. 2015), available at https://www.flhsmv.gov/fhp/Manuals/1402.pdf (last visited Nov. 21, 2017).
[106] *Id.* at Policy 14.02.07C. and D.
[107] News 6 Orlando, *Do Florida Drivers Need to Set Up Emergency Contact Information?*, available at https://www.clickorlando.com/news/local/2022/01/17/do-florida-drivers-need-to-set-up-emergency-contact-information/ (last visited January 19, 2022).

***Effect of the Bill***

***Involuntary Admissions***

Baker Act

The bill adds emergency contacts, identified by law enforcement through the DAVID or FCIC electronic databases, to the list of individuals a receiving facility may contact when a patient is brought to a receiving facility for an involuntary examination under the Baker Act.

Under the bill, an officer who delivers a patient to a receiving facility must include all ECI discoverable through FCIC, DAVID, or other electronic databases maintained by the FDLE or the FLHSMV in the report detailing the circumstances under which the person was taken into custody. Such information must be included in reports following instances where a law enforcement officer:

- Determines an individual meets the criteria for involuntary examination and delivers the individual to a receiving facility;
- Delivers an individual to a receiving facility pursuant to a certificate executed by a health care professional under s. 394.463(2)(a)3., F.S.; or
- Determines that a hospital or addictions receiving facility is the most appropriate place for a person who:
  - Is in protective custody; or
  - Refuses to consent to assistance.

Such information may not be used for any purpose other than informing emergency contacts of a patient's whereabouts, and shall otherwise remain confidential and exempt from Florida's public records disclosure requirements.

Marchman Act

When a law enforcement officer delivers a person to a hospital or addictions receiving facility under the Marchman Act, the bill requires the officer to attempt to notify the nearest relative or emergency contact of the person and document such notification, and attempts at notification, in the report.

***Voluntary Admissions***

The bill requires receiving facilities and substance abuse service providers serving Baker Act and Marchman Act patients, respectively, to document that individuals admitted on a voluntary basis have been provided with the option to authorize the release of clinical information, within 24 hours of admission, to the individual's:

- Health care surrogate or proxy;
- Attorney;
- Representative; or
- Other known emergency contact.

The release authorization will help to ensure patients admitted on a voluntary basis will have the option of sharing important information regarding health care decisions with the individuals specified above.

**Individual Bill of Rights (Sections 2 and 5)**

Both the Marchman Act and the Baker Act provide an individual bill of rights.[108] Rights in common include the right to:

- Dignity;
- Quality of treatment;
- Not be refused treatment at a state-funded facility due to an inability to pay;
- Communicate with others;
- Care and custody of personal effects; and
- Petition the court on a writ of habeas corpus.[109]

The individual bill of rights also imposes liability for damages on persons who violate individual rights.[110] The Marchman Act ensures the right to habeas corpus, which means that a petition for release may be filed with the court by an individual involuntarily retained or his or her parent or representative.[111] In addition to the petitioners authorized in the Marchman Act, the Baker Act permits the DCF to file a writ for habeas corpus on behalf of the individual.[112]

The Marchman Act also makes it a first degree misdemeanor[113] for a person to:

- Knowingly furnishing false information for the purpose of obtaining emergency or other involuntary admission for any person;
- Causing or otherwise securing, or conspiring with or assisting another to cause or secure, without reason for believing a person to be impaired, any emergency or other involuntary procedure for the person; or
- Causing, or conspiring with or assisting another to cause, the denial to any person of any right accorded under the Marchman Act.[114]

The Baker Act currently does not contain similar criminal penalties for activities that infringe upon patients' rights.

***Right to Outside Communication and Visitation***

All patients held at a receiving facility have the explicit right to communicate freely and privately with others outside the facility unless it is determined that communication will likely harm the patient or others.[115] Similar conditions apply to the right of patients to send, receive, and mail correspondence, and to access outside visitors.[116] Facilities must review restrictions on

[108] Section 394.459, F.S., provides "Rights of Individuals" for individuals served through the Baker Act; section 397.501, F.S., provides "Rights of Individuals" for individuals served through the Marchman Act.
[109] *Id*.
[110] Sections 394.459(10) and 397.501(10)(a), F.S.
[111] Section 397.501(9), F.S.
[112] Section 394.459(8)(a), F.S.
[113] A first degree misdemeanor is punishable by a term of imprisonment not exceeding one year and a fine of $1,000. Sections 775.082 and 775.083, F.S. However, s. 397.581, F.S., specifically provides that this offense is punishable by a fine of up to $5,000.
[114] Section 397.581, F.S.
[115] Section 394.459(5)(a), F.S.
[116] Section 394.459(5)(b)-(c), F.S.

a patient's right to communicate, send or receive sealed, unopened correspondence, or receive visitors at least once every 7 days.[117]

***Effect of the Bill***

Patient Access and Communication

The bill prohibits receiving facilities from restricting any of the following patients' rights unless a qualified professional determines that failing to do so would be detrimental to the clinical well-being of any patient or the general well-being of staff, including:

- The right to communicate freely and privately with persons outside of the receiving facility;
- The right to receive, send, and mail sealed, unopened correspondence; and
- The right to access to any patient, subject to the patient's right to deny or withdraw consent at any time, by the patient's family, guardian, guardian advocate, representative, Florida statewide or local advocacy council, or attorney.

A "qualified professional" is defined in s. 394.455(39), F.S., to mean:

- A physician licensed under ch. 458, F.S.;
- A physician assistant licensed under ch. 459, F.S.;
- A psychiatrist licensed under ch. 458, F.S., or ch. 459, F.S.;
- A psychologist as defined in s. 490.003(7), F.S.; or
- A psychiatric nurse as defined in s. 394.455(36), F.S.

The bill also reduces the number of days within which a receiving facility must review restrictions on a patient's right to communicate or receive visitors from 7 days to 3 days. A qualified professional must document such restrictions within 24 hours of the restriction being implemented.

Criminal Penalty

The bill also makes it a first degree misdemeanor to knowingly and willfully:

- Furnish false information for the purpose of obtaining emergency or other involuntary admission for any person;
- Cause, or conspire with another to cause, any involuntary mental health procedure for the person without a reason for believing a person is impaired; or
- Cause, or conspire with another to cause, without lawful justification, any person to be denied their rights under the mental health statutes.

The bill also provides that a person who is convicted of this offense may be punished by a fine not exceeding $5,000.

**Mental Health Data Reporting and Analysis (Section 5)**

The DCF collects and maintains copies of ex parte orders, involuntary outpatient services orders, involuntary inpatient placement orders, and professional certificates initiating Baker Act

[117] Section 394.459(5)(c), F.S.

examinations.[118] Such documents are considered part of a patient's clinical record and are used to prepare annual reports analyzing the de-identified data contained therein.[119] The DCF contracts with the Louis de la Parte Florida Mental Health Institute at the University of South Florida (the Institute) to perform the data analysis and prepare the reports.[120] The Institute also analyzes other information relating to mental health and acts as a provider of crisis services to certain patients.[121] The reports are provided to the DCF, the President of the Senate, the Speaker of the House of Representatives, and the minority leaders of the Senate and the House of Representatives.[122]

***Transportation to a Facility***

Baker Act

The Baker Act requires each county to designate a single law enforcement agency to transfer the person in need of services. If the person is in custody based on noncriminal or minor criminal behavior, the law enforcement officer will transport the person to the nearest receiving facility. If, however, the person is arrested for a felony the person must first be processed in the same manner as any other criminal suspect. The law enforcement officer must then transport the person to the nearest facility, unless the facility is unable to provide adequate security.[123] Law enforcement must then relinquish the person, along with corresponding documentation, to a responsible individual at the facility.[124]

Marchman Act

The Marchman Act authorizes an applicant seeking to have a person admitted to a facility, the person's spouse or guardian, a law enforcement officer, or a health officer to transport the individual for an emergency assessment and stabilization.[125]

If a person in circumstances which justify protective custody[126] fails or refuses to consent to assistance and a law enforcement officer has determined that a hospital or a licensed detoxification or addictions receiving facility is the most appropriate place for the person, the officer may, after giving due consideration to the expressed wishes of the person:

- Take the person to a hospital or to a licensed detoxification or addictions receiving facility against the person's will but without using unreasonable force; or

[118] Section 394.463(2)(e), F.S.
[119] *Id*.
[120] The University of South Florida, Baker Act Reporting Center, *About Us*, available at https://www.usf.edu/cbcs/baker-act/about/index.aspx (last visited January 19, 2022).
[121] *See* The University of South Florida, Baker Act Reporting Center, *What We Do*, available at https://www.usf.edu/cbcs/baker-act/about/whatwedo.aspx (last visited Jan. 7, 2022); and The University of South Florida, Louis de la Parte Florida Mental Health Institute, *About the Institute*, available at https://www.usf.edu/cbcs/fmhi/about/ (last visited January 19, 2022).
[122] *Id*.
[123] Section 394.462(1)(f)-(g), F.S.
[124] Section 394.462(3), F.S.
[125] Section 397.6795, F.S.
[126] Section 397.677, F.S., states that a law enforcement officer may implement protective custody measures when a minor or an adult who appears to meet the involuntary admission criteria in s. 397.675, F.S., is brought to the attention of law enforcement or in a public space.

- In the case of an adult, detain the person for his or her own protection in any municipal or county jail or other appropriate detention facility.[127]

The officer must use a standard form developed by the DCF to execute a written report detailing the circumstances under which the person was taken into custody, and the written report shall be included in the patient's clinical record.

***Effect of the Bill***

The bill adds reports completed by law enforcement when a person is transported to a receiving facility to the documents received and maintained by the DCF for use in preparing annual reports on Baker Act data. The bill also makes such reports a part of a patient's clinical record. The transportation reports will allow the Baker Act Reporting Center to provide a more comprehensive overview of Baker Act data statewide.

**Commission on Mental Health and Substance Abuse**

In 2021, the Legislature created the Commission on Mental Health and Substance Abuse (Commission), adjunct to the DCF, in response to recommendations of the 20th Statewide Grand Jury.[128] The DCF is required to provide administrative staff and support services for the Commission.[129]

The purposes of the Commission include:
- Examining the current methods of providing mental health and substance abuse services in the state;
- Improving the effectiveness of current practices, procedures, programs, and initiatives in providing such services;
- Identifying any barriers or deficiencies in the delivery of such services; and
- Recommending changes to existing laws, rules, and policies necessary to implement the Commission's recommendations.[130]

The Commission is comprised of 19 members, including the Secretaries of AHCA and DCF.[131] Membership of the Commission also includes:
- Seven members appointed by the Governor, including:
  - A psychologist licensed under ch. 490, F.S., practicing within the mental health delivery system;
  - A mental health professional licensed under ch. 491, F.S.;
  - A representative of mental health courts;
  - An emergency room physician;
  - A representative from the field of law enforcement;
  - A representative from the criminal justice system; and

[127] Section 397.6772(1)(a)-(b), F.S.
[128] Chapter 2021-170, L.O.F.
[129] Section 394.9086(1), F.S.
[130] Section 394.9086(2), F.S.
[131] Section 394.9086(3)(a), F.S.

  - A representative of a child welfare agency involved in the delivery of behavioral health services.
- Five members appointed by the President of the Senate, including:
  - A member of the Senate;
  - A person living with a mental health disorder;
  - A family member of a consumer of publicly funded mental health services;
  - A representative of the Louis de la Parte Mental Health Institute within the University of South Florida; and
  - A representative of a county school district.
- Five members appointed by the Speaker of the House of Representatives, including:
  - A member of the House of Representatives;
  - A representative of a treatment facility;
  - A representative of a managing entity;
  - A representative of a community substance abuse provider; and
  - A psychiatrist licensed under chs. 458 or 459, F.S., practicing within the mental health delivery system.[132]

The Governor appoints the Commission chair from among its members, and members serve at the pleasure of the officer who appointed the member.[133] The Commission is required to hold its meetings via teleconference or other electronic means.[134] A vacancy on the Commission is required to be filled in the same manner as the original appointment.[135]

The duties of the Commission include:
- Conducting a review and evaluation of the management and functioning of existing publicly supported mental health and substance abuse systems in the DCF, AHCA, and all other relevant state departments;
  - At a minimum, such review must include a review of current goals and objectives, current planning, service strategies, coordination management, purchasing, contracting, financing, local government funding responsibility, and accountability mechanisms.
- Considering the unique needs of people who are dually diagnosed;
- Addressing access to, financing of, and scope of responsibility in the delivery of emergency behavioral health care services;
- Addressing the quality and effectiveness of current service delivery systems and professional staffing and clinical structure of services, roles, and responsibilities of public and private providers;
- Addressing priority population groups for publicly funded services, identifying the comprehensive delivery systems, needs assessment and planning activities, and local government responsibilities for funding services;
- Reviewing the implementation of ch. 2020-107, Laws of Fla.;[136]

[132] *Id*.
[133] Section 394.9086(3)(b), F.S.
[134] Section 394.9086(3)(c), F.S.
[135] Section 394.9086(3)(b), F.S.
[136] HB 945 (2020) required managing entities to implement the features of a coordinated system of mental health care for children and expands the use of mobile response teams (MRT) across the state. It required the Florida Mental Health Institute within the University of South Florida to develop a model protocol for school use of MRTs. The bill also required the AHCA and the DCF to identify children and adolescents who are the highest users of crisis stabilization services and take action to

- Identifying gaps in the provision of mental health and substance abuse services;
- Providing recommendations on how managing entities may promote service continuity;
- Making recommendations about the mission and objectives of state-supported mental health and substance abuse services and the planning, management, staffing, financing, contracting, coordination, and accountability of mechanisms best suited for the recommended mission and objectives; and
- Evaluating and making recommendations regarding the establishment of a permanent, agency-level entity to manage mental health, behavioral health, substance abuse, and related services statewide, including the:
  - Duties and organizational structure;
  - Resource needs and possible sources of funding;
  - Impact on access to and the quality of services;
  - Impact on individuals with behavioral health needs, and their families, who are currently receiving services and those who are in need of services; and
  - Relation to and integration with service providers, managing entities, communities, state agencies, and provider systems.[137]

The Commission is required to submit an initial report by September 1, 2022, and a final report by September 1, 2023, to the Governor, President of the Senate, and Speaker of the House of Representatives on its findings and recommendations on how to best provide and facilitate mental health and substance abuse services.[138]

***Effect of the Bill***

The bill amends s. 394.9086, F.S., making the following changes to the Commission, including:
- Authorizing the Commission to conduct meetings in person at locations throughout the state or via teleconference or other electronic means;
- Authorizing Commission members to receive per diem and reimbursement and travel expenses;
- Authorizing the Commission to access information and records necessary to carry out its duties, including exempt and confidential information, provided that the Commission does not disclose such exempt or confidential information; and
- Changes the due date for the Commission's interim report from September 1, 2022 to January 1, 2023.

**Cross-References**

The bill amends ss. 409.972 and 744.2007, F.S., relating to mandatory and voluntary managed care enrollment, and the powers and duties of public guardians, respectively, to conform cross-references to changes made by the act.

meet the needs of such children. Lastly, the bill required the AHCA to continually test the Medicaid managed care provider network databases to ensure behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems.

[137] Section 394.9086(4)(a), F.S.

[138] Section 394.9086(5), F.S.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The bill does not appear to require cities and counties to expend funds or limit their authority to raise revenue or receive state-shared revenues as specified by Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The Department of Children and Families (DCF) contracts with the Baker Act Reporting Center at the University of South Florida (USF) to collect and analyze Baker Act data. The USF Baker Act Reporting Center is responsible for producing an Annual Baker Act report on behalf of the DCF for submission to the Legislature. The DCF will need to amend its contract with the Reporting Center to require collection and analysis of transportation forms. The cost for DCF to contract with the Reporting Center is anticipated to be $90,000 for the first year, and $75,000 for each subsequent year.[139]

PCS/CS/SB 1262 also requires the Commission on Mental Health and Substance Abuse (Commission) to conduct their meetings in person at locations throughout the state. The

[139] The DCF, *Agency Analysis for SB 1262*, p. 5, February 11, 2022 (on file with the Senate Committee on Children, Families, and Elder Affairs).

bill entitles commission members to receive reimbursement for per diem and travel expenses. The 18 commission members may hold meetings in-person at locations throughout the state or may use teleconference or other electronic means as an alternative to in-person meetings. The cost to the DCF for the commission's travel and per diem is indeterminate, however, it is likely that these costs can be absorbed within the department's base budget.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.455, 394.459, 394.4599, 394.4615, 394.463, 394.468, 394.9086, 397.601, 397.6772, 409.972, and 744.2007.

## IX. Additional Information:

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

**Recommended CS/CS by Appropriations Subcommittee on Health and Human Services on February 16, 2022:**
The committee substitute:

- Clarifies that a person who without lawful justification, knowingly or willfully causes, conspires with or assists another to cause the denial to any person any right accorded to that person pursuant to ch. 394, F.S., commits a first degree misdemeanor.
- Clarifies that the Commission on Mental Health and Substance Abuse may hold meetings in person at locations throughout the state or via teleconference or other electronic means.
- Authorizes the Commission on Mental Health and Substance Abuse to access any information or records, including exempt and confidential records and information that may be necessary for the commission to have to carry out its duties. The commission may not disclose such exempt or confidential information.

**CS by Children, Families, and Elder Affairs on January 25, 2022:**
The committee substitute:

- Revises the conditions for restricting a patient's access to telephonic communications, mail correspondence, and in-person visitation to instances where the restriction is necessary to ensure the clinical well-being of the patient, clinical well-being of another patient, or general well-being of staff.

- Requires that any restrictions on in-person visitation be reviewed every 3 days, rather than every 4 days as currently provided for in the bill, and requires a qualified professional to document any such restrictions within 24 hours of implementation.
- Provides that, under both the Baker and Marchman Acts, emergency contact information obtained through electronic databases used by law enforcement cannot be used for purposes other than letting the contact know the whereabouts of the patient.
- Clarifies that a receiving facility can hold a patient until the next working day after the weekend or holiday if the intent is to file a petition for involuntary services, but requires that the facility release the patient if such petition is not filed by the next working day.
- Provides that a person commits a first degree, rather than second degree misdemeanor if he or she knowingly and willfully, rather than only knowingly commits any of the acts listed in section 5 of the bill.
- Makes the following changes to provisions related to discharge planning and procedures:
  - Moves the discharge planning requirements from s. 394.463, F.S. to s. 394.468, F.S.;
  - Applies the requirements to all patients being discharged from a receiving or treatment facility under ch. 394, F.S.; and
  - Modifies the requirements such that receiving facilities must documents and consider, at a minimum, follow-up behavioral health appointments and information on how to obtain prescribed medications and pertaining to available living arrangements, transportation, and recovery support opportunities.
- Makes the following changes to the Commission on Mental Health and Substance Abuse:
  - Requires the Commission on Mental Health and Substance Abuse to conduct their meetings in person at locations throughout the state. Currently, the Commission is holding meetings remotely.
  - Requires Commission members to be reimbursed for travel expenses.
  - Moves the due date of the Commission's interim report from September 1, 2022 to January 1, 2023.
- Provides an effective date of July 1, 2022.

B. Amendments:

None.

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LEGISLATIVE ACTION

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| Senate | . | House |
| Comm: RCS | . | |
| 02/16/2022 | . | |
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Appropriations Subcommittee on Health and Human Services (Burgess) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 332 - 384

and insert:

from the receiving facility following approval pursuant to paragraph (f).

b. Does not intend to file a petition for involuntary services, a receiving facility may postpone release of a patient until the next working day thereafter only if a qualified professional documents that adequate discharge planning and

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procedures in accordance with s. 394.468, and approval pursuant to paragraph (f), are not possible until the next working day.

(5) UNLAWFUL ACTIVITIES RELATING TO EXAMINATION AND TREATMENT; PENALTIES.—

(a) A person may not knowingly and willfully:

1. Furnish false information for the purpose of obtaining emergency or other involuntary admission of another;

2. Cause or otherwise secure, or conspire with or assist another to cause or secure, any emergency or other involuntary procedure of another person under false pretenses; or

3. Cause, or conspire with or assist another to cause, without lawful justification, the denial to any person of any right accorded pursuant to this chapter.

(b) A person who violates this subsection commits a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000.

Section 6. Section 394.468, Florida Statutes, is amended to read:

394.468 Admission and discharge procedures.—

(1) Admission and discharge procedures and treatment policies of the department are governed solely by this part. Such procedures and policies shall not be subject to control by court procedure rules. The matters within the purview of this part are deemed to be substantive, not procedural.

(2) Discharge planning and procedures for any patient’s release from a receiving facility or treatment facility must include and document consideration of, at a minimum:

(a) Follow-up behavioral health appointments;

(b) Information on how to obtain prescribed medications;

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and

(c) Information pertaining to:

1. Available living arrangements;

2. Transportation; and

3. Recovery support opportunities.

Section 7. Paragraph (c) of subsection (3) and subsection (5) of section 394.9086, Florida Statutes, are amended, and paragraphs (d) and (e) are added to subsection (3) of that section, to read:

394.9086 Commission on Mental Health and Substance Abuse.—

(3) MEMBERSHIP; TERM LIMITS; MEETINGS.—

(c) The commission shall convene no later than September 1, 2021. The commission shall meet quarterly or upon the call of the chair. The commission may ~~shall~~ hold its meetings in person at locations throughout the state or via teleconference or other electronic means.

(d) Members of the commission are entitled to receive reimbursement for per diem and travel expenses pursuant to s. 112.061.

(e) Notwithstanding any other law, the commission may request and shall be provided with access to any information or records, including exempt and confidential information or records, which are necessary for the commission to carry out its duties. Information or records obtained by the commission which are otherwise exempt or confidential and exempt shall retain such exempt or confidential and exempt status, and the commission may not disclose such information or records.

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

And the title is amended as follows:

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Delete line 46

and insert:

commission; authorizing the commission to access certain information or records; revising the due date for the commission's

**By** the Committee on Children, Families, and Elder Affairs; and Senator Burgess

586-02288-22 20221262c1

A bill to be entitled

An act relating to mental health and substance abuse; amending s. 394.455, F.S.; defining the term "telehealth"; amending s. 394.459, F.S.; revising the conditions under which a patient's communication with persons outside of a receiving facility may be restricted; revising the conditions under which a patient's sealed and unopened incoming or outgoing correspondence may be restricted; revising the conditions under which a patient's contact and visitation with persons outside of a receiving facility may be restricted; revising the frequency with which the restriction on a patient's right to receive visitors must be reviewed; amending s. 394.4599, F.S.; requiring a receiving facility to notify specified emergency contacts of individuals who are being involuntarily held for examination; amending s. 394.4615, F.S.; requiring receiving facilities to document that an option to authorize the release of specified information has been provided, within a specified timeframe, to individuals admitted on a voluntary basis; amending s. 394.463, F.S.; requiring that reports issued by law enforcement officers when delivering a person to a receiving facility contain certain information related to emergency contacts; limiting the use of certain information provided; maintaining the confidential and exempt status of certain information provided to a receiving facility; requiring the Department of Children and Families to





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receive and maintain reports relating to the transportation of patients; authorizing receiving facility discharge examinations to be conducted through telehealth; requiring a facility administrator to file a petition for involuntary placement by a specified time; authorizing a receiving facility to postpone the release of a patient if certain requirements are met; prohibiting certain activities relating to examination and treatment; providing a criminal penalty; amending s. 394.468, F.S.; requiring that discharge and planning procedures include and document the consideration of specified factors and actions; amending s. 394.9086; modifying meeting requirements of the Commission on Mental Health and Substance Abuse; authorizing reimbursement for per diem and travel expenses for members of the commission; revising the due date for the commission's interim report; amending s. 397.601, F.S.; requiring service providers to document that an option to authorize the release of specified information has been provided, within a specified timeframe, to individuals admitted on a voluntary basis; amending s. 397.6772, F.S.; requiring law enforcement officers to include certain information relating to emergency contacts in reports relating to the delivery of a person to a hospital or licensed detoxification or addictions receiving facility; limiting the use of certain information provided; maintaining the confidential and exempt status of certain information



**CODING:** Words ~~stricken~~ are deletions; words underlined are additions.

provided to a hospital or licensed detoxification or addictions receiving facility; amending ss. 409.972 and 744.2007, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Present subsections (47), (48), and (49) of section 394.455, Florida Statutes, are redesignated as subsections (48), (49), and (50), respectively, and a new subsection (47) is added to that section, to read:

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

(47) "Telehealth" has the same meaning as provided in s. 456.47.

Section 2. Subsection (5) of section 394.459, Florida Statutes is amended to read:

394.459 Rights of patients.—

(5) COMMUNICATION, ABUSE REPORTING, AND VISITS.—

(a) Each person receiving services in a facility providing mental health services under this part has the right to communicate freely and privately with persons outside the facility unless a qualified professional determines ~~it is determined~~ that such communication is likely to be harmful to the person or others in a manner directly related to the person's clinical well-being, the clinical well-being of other patients, or the general safety of staff. Each facility shall make available as soon as reasonably possible to persons receiving services a telephone that allows for free local calls and access to a long-distance service. A facility is not





required to pay the costs of a patient's long-distance calls. The telephone shall be readily accessible to the patient and shall be placed so that the patient may use it to communicate privately and confidentially. The facility may establish reasonable rules for the use of this telephone, provided that the rules do not interfere with a patient's access to a telephone to report abuse pursuant to paragraph (f) ~~(e)~~.

(b) Each patient admitted to a facility under the provisions of this part shall be allowed to receive, send, and mail sealed, unopened correspondence; and no patient's incoming or outgoing correspondence shall be opened, delayed, held, or censored by the facility unless a qualified professional determines that such correspondence is likely to be harmful to the patient or others in a manner directly related to the patient's clinical well-being, the clinical well-being of other patients, or the general safety of staff. If there is reason to believe that such correspondence ~~it~~ contains items or substances which may be harmful to the patient or others, ~~in which case~~ the administrator may direct reasonable examination of such mail and may regulate the disposition of such items or substances.

(c) Each facility must permit immediate access to any patient, subject to the patient's right to deny or withdraw consent at any time, by the patient's family members, guardian, guardian advocate, representative, Florida statewide or local advocacy council, or attorney, unless a qualified professional determines that such access would be detrimental to the patient in a manner directly related to the patient's clinical well-being, the clinical well-being of other patients, or the general safety of staff.

(d) If a patient's right to communicate with outside persons; receive, send, or mail sealed, unopened correspondence; or ~~to~~ receive visitors is restricted by the facility, written notice of such restriction and the reasons for the restriction shall be served on the patient, the patient's attorney, and the patient's guardian, guardian advocate, or representative; a qualified professional must document any restriction within 24 hours and such restriction shall be recorded on the patient's clinical record with the reasons therefor. The restriction of a patient's right to communicate or to receive visitors shall be reviewed at least every 3 ~~7~~ days. The right to communicate or receive visitors shall not be restricted as a means of punishment. Nothing in this paragraph shall be construed to limit the provisions of paragraph (e)~~(d)~~.

(e)~~(d)~~ Each facility shall establish reasonable rules governing visitors, visiting hours, and the use of telephones by patients in the least restrictive possible manner. Patients shall have the right to contact and to receive communication from their attorneys at any reasonable time.

(f)~~(e)~~ Each patient receiving mental health treatment in any facility shall have ready access to a telephone in order to report an alleged abuse. The facility staff shall orally and in writing inform each patient of the procedure for reporting abuse and shall make every reasonable effort to present the information in a language the patient understands. A written copy of that procedure, including the telephone number of the central abuse hotline and reporting forms, shall be posted in plain view.

(g)~~(f)~~ The department shall adopt rules providing a





procedure for reporting abuse. Facility staff shall be required, as a condition of employment, to become familiar with the requirements and procedures for the reporting of abuse.

Section 3. Paragraph (b) of subsection (2) of section 394.4599, Florida Statutes, is amended to read:

394.4599 Notice.—

(2) INVOLUNTARY ADMISSION.—

(b) A receiving facility shall give prompt notice of the whereabouts of an individual who is being involuntarily held for examination to the individual's guardian, guardian advocate, health care surrogate or proxy, attorney or representative, or other emergency contact identified through electronic databases pursuant to s. 394.463(2)(a), by telephone or in person within 24 hours after the individual's arrival at the facility. Contact attempts shall be documented in the individual's clinical record and shall begin as soon as reasonably possible after the individual's arrival.

Section 4. Paragraph (a) of subsection (2) of section 394.4615, Florida Statutes, is amended to read:

394.4615 Clinical records; confidentiality.—

(2) The clinical record shall be released when:

(a) The patient or the patient's guardian authorizes the release. The guardian or guardian advocate shall be provided access to the appropriate clinical records of the patient. The patient or the patient's guardian or guardian advocate may authorize the release of information and clinical records to appropriate persons to ensure the continuity of the patient's health care or mental health care. A receiving facility must document that, within 24 hours of admission, individuals

admitted on a voluntary basis have been provided with the option to authorize the release of information from their clinical record to the individual's health care surrogate or proxy, attorney, representative, or other known emergency contact.

Section 5. Paragraphs (a), (e), (f), and (g) of subsection (2) of section 394.463, Florida Statutes, are amended, and subsection (5) is added to that section, to read:

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.—

(a) An involuntary examination may be initiated by any one of the following means:

1. A circuit or county court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination and specifying the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on written or oral sworn testimony that includes specific facts that support the findings. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The order of the court shall be made a part of the patient's clinical record. A fee may not be charged for the filing of an order under this subsection. A facility accepting the patient based on this order must send a copy of the order to the department within 5 working days. The order may be submitted electronically through existing data systems, if available. The order shall be valid only until





the person is delivered to the facility or for the period specified in the order itself, whichever comes first. If a time limit is not specified in the order, the order is valid for 7 days after the date that the order was signed.

2. A law enforcement officer shall take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for examination. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, which must be made a part of the patient's clinical record. The report must include all emergency contact information for the person that is readily accessible to the law enforcement officer, including information available through electronic databases maintained by the Department of Law Enforcement or by the Department of Highway Safety and Motor Vehicles. Such emergency contact information may be used by a receiving facility only for the purpose of informing listed emergency contacts of a patient's whereabouts and shall otherwise remain confidential and exempt pursuant to s. 119.0712(2)(d). Any facility accepting the patient based on this report must send a copy of the report to the department within 5 working days.

3. A physician, a physician assistant, a clinical psychologist, a psychiatric nurse, an advanced practice registered nurse registered under s. 464.0123, a mental health counselor, a marriage and family therapist, or a clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that

the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means, such as voluntary appearance for outpatient evaluation, are not available, a law enforcement officer shall take into custody the person named in the certificate and deliver him or her to the appropriate, or nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody. The report must include all emergency contact information for the person that is readily accessible to the law enforcement officer, including information available through electronic databases maintained by the Department of Law Enforcement or by the Department of Highway Safety and Motor Vehicles. Such emergency contact information may be used by a receiving facility only for the purpose of informing listed emergency contacts of a patient's whereabouts and shall otherwise remain confidential and exempt pursuant to s. 119.0712(2)(d). The report and certificate shall be made a part of the patient's clinical record. Any facility accepting the patient based on this certificate must send a copy of the certificate to the department within 5 working days. The document may be submitted electronically through existing data systems, if applicable.

When sending the order, report, or certificate to the department, a facility shall, at a minimum, provide information about which action was taken regarding the patient under





paragraph (g), which information shall also be made a part of the patient's clinical record.

(e) The department shall receive and maintain the copies of ex parte orders, involuntary outpatient services orders issued pursuant to s. 394.4655, involuntary inpatient placement orders issued pursuant to s. 394.467, professional certificates, ~~and~~ law enforcement officers' reports, and reports relating to the transportation of patients. These documents shall be considered part of the clinical record, governed by the provisions of s. 394.4615. These documents shall be used to prepare annual reports analyzing the data obtained from these documents, without information identifying patients, and shall provide copies of reports to the department, the President of the Senate, the Speaker of the House of Representatives, and the minority leaders of the Senate and the House of Representatives.

(f) A patient shall be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility without unnecessary delay to determine if the criteria for involuntary services are met. Emergency treatment may be provided upon the order of a physician if the physician determines that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist or a clinical psychologist or, if the receiving facility is owned or operated by a hospital or health system, the release may also be approved by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist, or an attending

emergency department physician with experience in the diagnosis and treatment of mental illness after completion of an involuntary examination pursuant to this subsection. A psychiatric nurse may not approve the release of a patient if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist. The release may be approved through telehealth.

(g) The examination period must be for up to 72 hours. For a minor, the examination shall be initiated within 12 hours after the patient's arrival at the facility. Within the examination period ~~or, if the examination period ends on a weekend or holiday, no later than the next working day thereafter~~, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;

2. The patient shall be released, subject to subparagraph 1., for voluntary outpatient treatment;

3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient and, if such consent is given, the patient shall be admitted as a voluntary patient; or

4. A petition for involuntary services shall be filed in the circuit court if inpatient treatment is deemed necessary or with the criminal county court, as defined in s. 394.4655(1), as applicable. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available.





When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(4)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator. If a patient's 72-hour examination period ends on a weekend or holiday, and the receiving facility:

a. Intends to file a petition for involuntary services, such patient may be held at a receiving facility through the next working day thereafter and such petition for involuntary services must be filed no later than such date. If the receiving facility fails to file a petition for involuntary services at the close of the next working day, the patient shall be released from the receiving facility.

b. Does not intend to file a petition for involuntary services, a receiving facility may postpone release of a patient until the next working day thereafter only if a qualified professional documents that adequate discharge planning and procedures in accordance with s. 394.468 are not possible until the next working day.

(5) UNLAWFUL ACTIVITIES RELATING TO EXAMINATION AND TREATMENT; PENALTIES.—

(a) A person may not knowingly and willfully:

1. Furnish false information for the purpose of obtaining emergency or other involuntary admission of another;

2. Cause or otherwise secure, or conspire with or assist another to cause or secure, any emergency or other involuntary procedure of another person under false pretenses; or

3. Cause, or conspire with or assist another to cause, the denial to any person of any right accorded pursuant to this

chapter.

(b) A person who violates this subsection commits a misdemeanor of the first degree, punishable as provided in s. 775.082 and by a fine not exceeding $5,000.

Section 6. Section 394.468, Florida Statutes, is amended to read:

394.468 Admission and discharge procedures.—

(1) Admission and discharge procedures and treatment policies of the department are governed solely by this part. Such procedures and policies shall not be subject to control by court procedure rules. The matters within the purview of this part are deemed to be substantive, not procedural.

(2) Discharge planning and procedures for any patient's release from a receiving facility or treatment facility must include and document consideration of, at a minimum:

(a) Follow-up behavioral health appointments;

(b) Information on how to obtain prescribed medications; and

(c) Information pertaining to:

1. Available living arrangements;

2. Transportation; and

3. Recovery support opportunities.

Section 7. Paragraph (c) of subsection (3) of section 394.9086, Florida Statutes, is amended, a new paragraph (d) is added to that subsection, and subsection (5) of that section is amended, to read:

394.9086 Commission on Mental Health and Substance Abuse.—

(3) MEMBERSHIP; TERM LIMITS; MEETINGS.—

(c) The commission shall convene no later than September 1,







2021. The commission shall meet quarterly or upon the call of the chair. The commission shall hold its meetings in person at locations throughout the state ~~via teleconference or other electronic means~~.

(d) Members of the commission are entitled to receive reimbursement for per diem and travel expenses pursuant to s. 112.061.

(5) REPORTS.—By January 1, 2023 ~~September 1, 2022~~, the commission shall submit an interim report to the President of the Senate, the Speaker of the House of Representatives, and the Governor containing its findings and recommendations on how to best provide and facilitate mental health and substance abuse services in the state. The commission shall submit its final report to the President of the Senate, the Speaker of the House of Representatives, and the Governor by September 1, 2023.

Section 8. Subsection (5) is added to section 397.601, Florida Statutes, to read:

397.601 Voluntary admissions.—

(5) A service provider must document that, within 24 hours of admission, individuals admitted on a voluntary basis have been provided with the option to authorize the release of information from their clinical record to the individual's health care surrogate or proxy, attorney, representative, or other known emergency contact.

Section 9. Section 397.6772, Florida Statutes, is amended to read:

397.6772 Protective custody without consent.—

(1) If a person in circumstances which justify protective custody as described in s. 397.677 fails or refuses to consent

to assistance and a law enforcement officer has determined that a hospital or a licensed detoxification or addictions receiving facility is the most appropriate place for the person, the officer may, after giving due consideration to the expressed wishes of the person:

(a) Take the person to a hospital or to a licensed detoxification or addictions receiving facility against the person's will but without using unreasonable force. The officer shall use the standard form developed by the department pursuant to s. 397.321 to execute a written report detailing the circumstances under which the person was taken into custody. The report must include all emergency contact information for the person that is readily accessible to the law enforcement officer, including information available through electronic databases maintained by the Department of Law Enforcement or by the Department of Highway Safety and Motor Vehicles. Such emergency contact information may be used by a hospital or licensed detoxification or addictions receiving facility only for the purpose of informing listed emergency contacts of a patient's whereabouts and shall otherwise remain confidential and exempt pursuant to s. 119.0712(2)(d). The written report shall be included in the patient's clinical record; or

(b) In the case of an adult, detain the person for his or her own protection in any municipal or county jail or other appropriate detention facility.

Such detention is not to be considered an arrest for any purpose, and no entry or other record may be made to indicate that the person has been detained or charged with any crime. The







officer in charge of the detention facility must notify the nearest appropriate licensed service provider within the first 8 hours after detention that the person has been detained. It is the duty of the detention facility to arrange, as necessary, for transportation of the person to an appropriate licensed service provider with an available bed. Persons taken into protective custody must be assessed by the attending physician within the 72-hour period and without unnecessary delay, to determine the need for further services.

(2) The law enforcement officer must notify the nearest relative of a minor in protective custody and ~~must be notified by the law enforcement officer, as~~ must notify the nearest relative or other known emergency contact of an adult, unless the adult requests that there be no notification. The law enforcement officer must document such notification, and any attempts at notification, in the written report detailing the circumstances under which the person was taken into custody as required under paragraph (1)(a).

Section 10. Paragraph (b) of subsection (1) of section 409.972, Florida Statutes, is amended to read:

409.972 Mandatory and voluntary enrollment.—

(1) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:

(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or a treatment facility as defined in s. 394.455(49) ~~s. 394.455(48)~~.

Section 11. Subsection (7) of section 744.2007, Florida Statutes, is amended to read:

744.2007 Powers and duties.—

(7) A public guardian may not commit a ward to a treatment facility, as defined in s. 394.455(49) ~~s. 394.455(48)~~, without an involuntary placement proceeding as provided by law.

Section 12. This act shall take effect July 1, 2022.

The Florida Senate

# Committee Agenda Request

**To:** Senator Aaron Bean, Chair
Appropriations Subcommittee on Health and Human Services

**Subject:** Committee Agenda Request

**Date:** January 26, 2022

---

I respectfully request that **Senate Bill # 1262**, relating to Mental Health & Substance Abuse, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Danny Burgess
Florida Senate, District 20

File signed original with committee office

S-020 (03/2004)

The Florida Senate

# APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

Tab 3

| 2/16/2022 | SB 1262 |
|---|---|
| Meeting Date | Bill Number or Topic |
| Senate Appropriations Sucommittee on HHS | |
| Committee | Amendment Barcode (if applicable) |

Name Shane Messer Phone 850-322-6693

Address 316 East Park Ave Email shane@floridabha.org

Street

Tallahassee FL 32301

City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

**PLEASE CHECK ONE OF THE FOLLOWING:**

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

Florida Council for Behavioral Healthcare

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

*While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)*

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

# APPEARANCE RECORD

Deliver both copies of this form to Senate professional staff conducting the meeting

2/16/22
Meeting Date

CS/SB 1262
Bill Number or Topic

Appropriations Subcommittee on Health/Human Services
Committee

Amendment Barcode (if applicable)

Name Natalie Kelly

Phone 850 570 5747

Address 122 S Calhoun St.
Street

Email natalie@flmanagingentities.com

Tallahassee FL 32301
City State Zip

**Speaking:** ☐ For ☐ Against ☐ Information **OR** **Waive Speaking:** ☑ In Support ☐ Against

**PLEASE CHECK ONE OF THE FOLLOWING:**

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

Florida Association of Managing Entities

*While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)*

**This form is part of the public record for this meeting.**

S-001 (08/10/2021)

**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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 1436 |
| INTRODUCER: | Children, Families, and Elder Affairs Committee and Senator Garcia |
| SUBJECT: | Human Trafficking |
| DATE: | February 15, 2022 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Moody | Cox | CF | **Fav/CS** |
| 2. | Sneed | Money | AHS | **Recommend: Favorable** |
| 3. | | | AP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:


CS/SB 1436 amends section 16.617, Florida Statutes, to add the following additional duties to the Statewide Council on Human Trafficking (Council):

- Assess the frequency and extent to which social media platforms are used to assist, facilitate, or support human trafficking within the state;
- Establish a process to detect such use on a consistent basis; and
- Make recommendations on how to stop, reduce, or prevent social media platforms from being used for such purpose.

The Council must implement without undue delay a system to stop, reduce, or prevent social media platforms from being used to assist, facilitate, or support human trafficking within the state to the extent these objectives can be achieved under existing laws.

The bill requires the Florida Alliance to End Human Trafficking (FAEHT), who is the direct support-organization (DSO) of the Council, to develop training on the recognition and reporting of human trafficking for firesafety inspectors, which is eligible for continuing education credit under section 633.216(4), Florida Statutes.

The bill also requires foster parents, as a condition of licensure, and agency staff to successfully complete preservice training related to human trafficking which must be uniform statewide and must include, but need not be limited to:

- Basic information on human trafficking;

- Factors and knowledge on identifying children at risk of human trafficking; and
- Steps that should be taken to prevent at-risk youths from becoming victims of human trafficking.

The bill provides that foster parents, before licensure renewal, and agency staff, during each full year of employment, must complete training related to human trafficking to satisfy the inservice training requirement under current law.

Section 63.092, Florida Statutes, is reenacted for the purpose of incorporating the amendment made to section 409.175, Florida Statutes, by the act.

The bill has no fiscal impact on state government. However, it may have an indeterminate fiscal impact on the DSO by requiring the development of new training for firesafety inspectors. See Section V. Fiscal Impact Statement.

The bill takes effect July 1, 2022.

## II. Present Situation:

Human trafficking is modern day slavery which involves the transporting, soliciting, recruiting, harboring, providing, enticing, maintaining, purchasing, patronizing, procuring, or obtaining another person for the purpose of exploiting that person.[1] A person may not knowingly, or in reckless disregard of the facts, engage in human trafficking, attempt to engage in human trafficking, or benefit financially by receiving anything of value from participating in a venture that has subjected a person to human trafficking for commercial sexual activity,[2] labor, or services:

- By using coercion;[3]
- Of a child younger than 18 years old or an adult believed by the person to be a child younger than 18 years old;[4] or
- With a mentally defective or mentally incapacitated person, if for commercial sexual activity.[5, 6]

[1] Section 787.06(2)(d), F.S.

[2] Commercial sexual activity means any prostitution, lewdness, or assignation offense or attempt to commit such an offense, and includes a sexually explicit performance and the production of pornography. Section 787.06(2)(b), F.S.

[3] Section 787.06(3)(a)2., (b), (c)2., (d), (e)2., and (f)2., F.S. Section 787.06(2)(a), F.S., defines coercion to include using or threatening to use force against a person; restraining, isolating, or confining a person without lawful authority and against his or her will, or threatening to do so; using lending or other credit methods to establish a debt by a person when labor or services are pledged as a security for the debt, if the reasonably assessed value of the labor or services is not applied toward the liquidation of the debt; destroying, concealing, removing, confiscating, withholding, or possessing any actual or purported passport, visa, other immigration document, or government identification document; causing or threatening to cause financial harm; enticing or luring a person by fraud or deceit; or providing a Schedule I or II controlled substance to a person for the purpose of exploiting that person.

[4] Section 787.06(3)(a)1., (c)1., (e)1., (f)1., and (g), F.S.

[5] Section 787.06(3)(g), F.S., which also specifies that for purposes of this offense, the terms mentally defective and mentally incapacitated person mean the same as defined in s. 794.011(1), F.S.

[6] Section 794.011(1)(a), F.S., defines "mentally defective" to mean a mental disease or defect which renders a person temporarily or permanently incapable of appraising the nature of his or her conduct. Section 794.011(1)(b), F.S., defines "mentally incapacitated" to mean temporarily incapable of appraising or controlling a person's own conduct due to the

According to the United States Department of State, traffickers in the United States compel victims to engage in commercial sex and to work in both legal and illicit industries, including in hospitality, traveling sales crews, agriculture, janitorial services, construction, landscaping, restaurants, factories, care for persons with disabilities, salon services, massage parlors, retail services, fairs and carnivals, peddling and begging, drug smuggling and distribution, religious institutions, child care, and domestic work.[7] In 2020, the National Human Trafficking Hotline received a total of 51,667 substantive tip reports regarding human trafficking nationwide.[8] Of these reported tips, a total of 2,539 were reported from Florida.[9]

Social Media is used to recruit victims of human trafficking and increase their operations.[10] In particular, sex trafficking recruitment on social media is increasing especially since the beginning of the pandemic.[11] Recruiting victims online is typically considered less risky than recruiting victims in person.[12] Children and youth are being contacted, recruited, and sold for sex on social media.[13] Traffickers lure them in with online friendships and then manipulate them into becoming victims.[14] In 2019, Psychology Today reported that a recent survey found that 70% of more than 1,000 American children between the ages of 13 and 17 used social media several times per day.[15] The National Human Trafficking Hotline also notes that in the same year there were 447 (5.8%) situations where the venue/industry of potential trafficking was online ads,[16] 24 (3%) of which were received from Florida.[17]

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influence of a narcotic, anesthetic, or intoxicating substance administered without his or her consent or due to any other act committed upon that person without his or her consent.

[7] These reports were made by phone calls, texts, webchats, emails, or online. U.S. Department of State, Federal Response to Human Trafficking, *About Human Trafficking*, available at https://www.state.gov/humantrafficking-about-human-trafficking/#profile (last visited Feb. 2, 2022).

[8] National Human Trafficking Hotline, *2020 National Hotline Annual Report*, available at https://humantraffickinghotline.org/resources/2020-national-hotline-annual-report (last visited Feb. 2, 2022) (hereinafter cited as "2020 National Hotline Annual Report").

[9] National Human Trafficking Hotline, *National Human Trafficking Hotline Data Report, Florida State Report: 1/1/2020 – 12/31/2020*, July 1. 2021, available at Florida State Report For 2020.docx (humantraffickinghotline.org) (last visited Feb. 2, 2022) (hereinafter cited as "2020 National Human Trafficking Hotline Report for Florida").

[10] Polaris, *Human Trafficking and Social Media*, available at Human Trafficking and Social Media | Polaris (polarisproject.org) (last visited Feb. 2, 2022).

[11] Anderson, M., & Thompson, R., *Danger Warning! Social Media Sex Trafficking Recruitment is on the Rise since COVID Pandemic*, the DCF & Survive and Thrive Advocacy Center, Feb. 19, 2021, available at Danger Warning! Social Media Sex Trafficking Recruitment is on the Rise since COVID 19 Pandemic (Training Video) (usf.edu) (last visited Feb. 2, 2022) (hereinafter cited as ".

[12] Withers, M., Social Media Platforms Help Promote Human Trafficking, How Sex Trafficking is Bolstered by Social Media, and What to Do about It, Nov. 22, 2019, available at Social Media Platforms Help Promote Human Trafficking | Psychology Today (last visited Feb. 2, 2022) (hereinafter cited as "Psychology Today Article").

[13] *Id*.

[14] *Id*.

[15] *Id*.

[16] 2020 National Hotline Annual Report.

[17] 2020 National Human Trafficking Hotline Report for Florida.

**Statewide Council on Human Trafficking**

The Statewide Council on Human Trafficking (Council), established within the Department of Legal Affairs (DLA), is tasked with:

- Developing recommendations for human trafficking victim programs and services, including certification criteria for safe houses and foster homes.
- Making recommendations for apprehending and prosecuting traffickers.
- Annually holding a statewide policy summit.
- Working with the Department of Children and Families (DCF) to create and maintain an inventory of human trafficking programs and services in each county.
- Developing policy recommendations that advance the duties of the council and further the efforts to combat human trafficking in Florida.[18]

Membership on the Council includes:

- The Attorney General, or a designee, serving as chair.
- The Secretary of the DCF, or a designee, serving as vice chair.
- The State Surgeon General, or a designee.
- The Secretary of the Agency for Health Care Administration, or a designee.
- The executive director of the Department of Law Enforcement (FDLE), or a designee.
- The Secretary of the Department of Juvenile Justice, or a designee.
- The Commissioner of Education, or a designee.
- One member of the Senate appointed by the President of the Senate.
- One member of the House of Representatives appointed by the Speaker of the House of Representatives.
- An elected sheriff appointed by the Attorney General.
- An elected state attorney appointed by the Attorney General.
- Two members appointed by the Governor, and two members appointed by the Attorney General, who have professional experience to assist the Council in the development of care and treatment options for human trafficking victims.[19]

**Direct-Support Organizations**

A direct-support organization (DSO) is a non-profit organization authorized by statute to carry out specific tasks in support of a public entity or public cause. The function and purpose of a DSO is detailed in its enacting statute and the contract with the agency the DSO was created to support.[20]

In 2014, the Legislature created s. 20.058, F.S., establishing transparency and reporting requirements for DSOs.[21] Each DSO is required to submit, by August 1 of each year, specified

[18] Section 16.617, F.S.
[19] *Id*.
[20] Some examples of other DSOs may be found in ss. 14.29(9)(a), 267.1732, and 258.015(1), F.S. *See also* Rules of the Florida Auditor General, *Audits of Certain Nonprofit Organizations* (effective June 30, 2021), Rule 10.720(1)(b) and (d), available at https://flauditor.gov/pages/pdf_files/10_700.pdf (last visited Feb. 2, 2022).
[21] Chapter 14-96, s. 3, L.O.F.

information to the agency it was created to support.[22] A contract between an agency and a DSO must be contingent upon the DSO submitting the required information to the agency and posting the information on the agency's website. The contract must include a provision for ending operations and returning state-issued funds if the authorizing statute is repealed, the contract is terminated, or the organization is dissolved. If a DSO fails to submit the required information to the agency for two consecutive years, the agency head must terminate its contract with the DSO.[23] By August 15 of each year, the agency must report to the Governor, President of the Senate, Speaker of the House of Representatives, and the Office of Program Policy Analysis and Government Accountability the information submitted by each DSO, along with the agency's recommendation and supporting rationale to continue, terminate, or modify the agency's association with the DSO.[24] Any law creating or authorizing a DSO must provide that the authorization is repealed on October 1 of the fifth year after enactment, unless reviewed and reenacted by the Legislature.[25]

***DSO Supporting the Council – Florida Alliance to End Human Trafficking***

In 2019, the Legislature required the DLA to establish a DSO, the Florida Alliance to End Human Trafficking (FAEHT), to provide assistance, funding, and support to the Council, and to assist in the fulfillment of the Council's purposes.[26] The DSO met for the first time in August 2019,[27] and it is statutorily required to be:

- A Florida not for profit corporation, incorporated under ch. 617, F.S., and approved by the Secretary of State;
- Organized and operated exclusively to solicit funds; request and receive grants, gifts, and bequests of money; acquire, receive, hold, invest, and administer, in its own name, property and funds; and make expenditures in support of the purposes specified under s. 16.618, F.S.; and
- Certified by the DLA, after review, to be operating in a manner consistent with its purposes and in the best interests of the state.[28]

The FAEHT's board of directors must be thirteen members, including:

- Two members appointed by the executive director of the FDLE, both of whom must have experience and knowledge in the area of human trafficking.
- Three members appointed by the Attorney General, one of whom must be a human trafficking survivor and one of whom must be a mental health expert.
- Four members appointed by the President of the Senate.
- Four members appointed by the Speaker of the House of Representatives.[29]

The FAEHT is authorized to contract with Florida Forensic Institute for Research, Security, and Tactics (FIRST) to develop required training. The contract with FIRST must provide that the

[22] Section 20.058(1), F.S.
[23] Section 20.058(4), F.S.
[24] Section 20.058(3), F.S.
[25] Section 20.058(5), F.S.
[26] Ch. 2019-152, L.O.F., codified as s. 16.618, F.S.
[27] Office of the Attorney General, *Statewide Council on Human Trafficking*, available at http://myfloridalegal.com/pages.nsf/main/8aea5858b1253d0d85257d34005afa72 (last visited Feb. 2, 2022).
[28] Section 16.618(1), F.S.
[29] Section 16.618(3), F.S.

DSO may terminate the contract if FIRST fails to meet its obligations under s. 16.618(4), F.S. In addition, if FIRST ceases to exist, or if the contract between the FAEHT and FIRST is terminated, DLA must contract with another organization to develop the required training and information.[30]

FIRST, which is managed by the Pasco County Sheriff's Office, is designed to train public safety leaders.[31] Section 16.618(4), F.S., requires FIRST to develop training focused on detecting human trafficking, best practices for reporting human trafficking, and the interventions and treatment for human trafficking survivors. In developing the training, FIRST must consult with law enforcement agencies, human trafficking survivors, industry representatives, tourism representatives, and other interested parties and conduct research to determine the reduction in recidivism attributable to the education of the harms of human trafficking for first-time offenders.[32] The training has been developed and can currently be accessed online.[33]

**Firesafety Inspectors**

In Florida, a firesafety inspector is a person who holds a current and valid Fire Safety Inspector Certificate of Compliance issued by the Division of State Fire Marshal within the Department of Financial Services (DFS) under s. 633.216, F.S., and who is officially assigned the duties of conducting firesafety inspections of buildings and facilities on a recurring or regular basis on behalf of Florida or any county, municipality, or special district with fire safety responsibilities.[34]

Subject to a person meeting minimum qualifications, the Division of State Fire Marshal, Bureau of Firefighter Standards and Training issues certifications for Firesafety Inspector I and Firesafety Inspector II.[35] A Firesafety Inspector Certificate of Compliance is valid for four years from the date of its issuance, and certification renewal is subject to completing an application for renewal and meeting the requirements for renewal as established or adopted by the DFS rule or under ch. 633, F.S., which must include completion of at least 54 hours of continuing education during the preceding four year period or successfully passing an examination established by the DFS.[36]

Firesafety inspectors are typically responsible for inspections, re-inspections, and change-of-occupancy inspections in both new building construction and existing building construction for a variety of buildings and structures. Other duties may include, but are not limited to, ensuring fire safety equipment is installed and maintained properly and that firefighting, fire protection, and

[30] Section 16.618(4)(a), F.S.
[31] F1RST, Florida's Forensic Institute for Research, Security, & Tactics, available at https://www.floridafirsttraining.org/#/home (last visited Feb. 1, 2022).
[32] Section 16.618(4)(b), F.S.
[33] Section 16.618(4)(b), F.S. *See also* Florida Alliance to End Human Trafficking, available at https://fateht.vidcert.com/register (last visited Feb. 1, 2022).
[34] Section 633.102(12), F.S.
[35] *See* s. 633.216(2), F.S.; Bureau of Fire Standards and Training, Division of State Fire Marshal, *Firesafety Inspector I Certification* (Jun. 8, 2021), available at https://www.myfloridacfo.com/division/sfm/bfst/Documents/FiresafetyInspectorI.pdf; and Bureau of Fire Standards and Training, Division of State Fire Marshal, *Firesafety Inspector II Certification* (Sept. 26, 2012), available at https://www.myfloridacfo.com/division/sfm/bfst/Documents/FiresafetyInspectorII.pdf (all sites last visited on Feb. 2, 2022).
[36] Section 633.216(4), F.S., and Rules 69A-39.003, 69A-39.005, and 69A-39.009, F.A.C.

all other fire safety requirements are fulfilled in accordance with the Florida Fire Prevention Code, Florida Administrative Codes, county ordinances, and other adopted standards.[37] Due to their unique position of regularly inspecting buildings, firesafety inspectors may be able to detect and report human trafficking if properly trained in recognizing common indicators of human trafficking.

**Licensed Foster Care**

Foster home placements are intended to provide a temporary, safe place to live until a child can be reunited with his or her family, an adoptive family is identified, or other permanency is achieved. Section 409.175(2)(e), F.S., defines a "family foster home" as a private residence in which children who are unattended by a parent or legal guardian are provided 24-hour care. Such homes include emergency shelter family homes and specialized foster homes for children with special needs. A family foster home does not include an adoptive home which has been approved by the DCF or by a licensed child-placing agency for children placed for adoption.[38]

The recruitment, training, and licensing of foster parents is conducted by 18 community-based care agencies that maintain contracts with the DCF.[39] The total number of children placed in a family foster home must be based on the needs of each child in care; the ability of the foster family to meet the individual needs of each child, including any adoptive or biological children or young adults remaining in foster care living in the home; the amount of safe physical plant space; the ratio of active and appropriate adult supervision; and the background, experience, and skill of the family foster parents.[40] Foster parents are responsible for the care and well-being of the child, including maintaining their health, safety, and best interests and encouraging emotional and developmental growth. Following placement, a foster child should be closely monitored by a case worker, who provides support and additional training related to special needs.[41]

In 2019, Florida moved to a system of foster home licensing that consisted of five distinct levels:
- Level I: Child-Specific Foster Home.
- Level II: Non-Child Specific Foster Home.[42]
- Level III: Safe Foster Home for Victims of Human Trafficking.
- Level IV: Therapeutic Foster Home.

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[37] *See* Orange County Government Fire Rescue Department, *Fire Inspector I Fire Inspector Recruit*, available at https://www.orangecountyfl.net/Portals/0/Library/Employment-Volunteerism/docs/Fire%20Inspector%20I-CERT.pdf; *See also* the Villages Fire Rescue Department, *Currently Recruiting for Fire Inspector*, https://www.myfloridacfo.com/campaigns/firecollege/VillagesInsp.pdf (all sites last visited Feb. 2, 2022).

[38] Section 409.175(2)(e), F.S.

[39] The DCF, *Lead Agency Map*, available at https://www.myflfamilies.com/service-programs/community-based-care/lead-agency-map.shtml. The DCF terminated the contract with Eckerd Connects for Circuit 6 and Family Support Services of North Florida took over on January 1, 2022. Eckerd Connects will carry out its contract until it expires June 30, 2022. WFLA, *DCF, Eckerd Connects ending child welfare services contracts in 3 Tampa Bay counties*, available at https://www.wfla.com/news/local-news/dcf-eckerd-connects-end-child-welfare-services-in-3-tampa-bay-counties/; WUSF Public Media, *Family Support Services of North Florida will fully take over on January 1, 2022, Nov. 30, 2021*, available at https://wusfnews.wusf.usf.edu/health-news-florida/2021-11-29/state-selects-replacement-for-eckerd-connects-to-run-foster-care-in-pinellas-pasco| (all sites last visited Feb. 2, 2022).

[40] Section 409.175(3)(a) and (b), F.S., provides that the DCF may grant a capacity waiver in certain instances.

[41] *See* s. 409.1415(2), F.S., for specific roles and responsibilities of foster parents.

[42] Previously "Traditional" foster homes are now Level II.

- Level V: Medical Foster Home.[43]

Level I: Child-Specific Foster Home

A child specific licensed foster home is a new licensure type designed for relatives and nonrelatives who have an existing relationship with the child for whom they are seeking licensure. When a child is not able to safely remain at home with their parents, a family or like-family member who is willing and able to provide care for the child, is the next best alternative.[44]

Level II: Non-Child Specific Foster Home

A non-child specific licensed foster home is identified when placement with a relative or nonrelative caregiver is not possible. This licensure type is available to individuals in the community who may be interested in fostering.[45]

Level III: Safe Foster Home for Victims of Human Trafficking

Safe foster home means a foster home certified by the DCF to care for sexually exploited children.[46] This level of licensure is for individuals interested in providing a safe and stable environment for victims of human trafficking.[47] Florida law defines "human trafficking" as transporting, soliciting, recruiting, harboring, providing, enticing, maintaining,[48] purchasing, patronizing, procuring, or obtaining[49] another person for the purpose of exploitation of that person.[50] In Florida, any person who knowingly, or in reckless disregard of the facts, engages in human trafficking, or attempts to engage in human trafficking, or benefits financially by receiving anything of value from participation in a venture that has subjected a person to human trafficking for labor or services, or commercial sexual activity, commits a crime.[51]

In addition to meeting standard licensing requirements, safe foster homes meet certification requirements which include, in summary:

- Use strength-based and trauma-informed approaches to care;
- Serve exclusively one sex;
- Group child victims of commercial sexual exploitation by age or maturity level;
- Care for child victims of commercial sexual exploitation in a matter that separates those children from children with other needs;

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[43] The DCF, *Levels of Foster Care Licensure*, available at https://www.myflfamilies.com/service-programs/foster-care/levels.shtml (hereinafter cited as "Levels of Foster Care Licensure"); Florida FAPA, *Become a Foster Parent*, available at https://floridafapa.org/become-a-foster-parent/ (all sites last visited Feb. 2, 2022).
[44] *Id*.
[45] *Id*.
[46] Section 409.1678(1), F.S.
[47] Levels of Foster Care Licensure.
[48] Section 787.06(2)(f), F.S., provides "maintain" means, in relation to labor or services, to secure or make possible continued performance thereof, regardless of any initial agreement on the part of the victim to perform such type service. Section 787.06(2)(h), F.S., defines "services" as any act committed at the behest of, under the supervision of, or for the benefit of another, including forced marriage, servitude, or the removal of organs.
[49] Section 787.06(2)(g), F.S., provides "obtain" means, in relation to labor, commercial sexual activity, or services, to receive, take possession of, or take custody of another person or secure performance thereof. Section 787.06(2)(e), F.S., provides "labor" means work of economic or financial value.
[50] Section 787.06(2)(d), F.S.
[51] Section 787.06(3), F.S

- Have awake staff on duty 24 hours a day;
- Provide appropriate security though facility design, hardware, technology, staffing, and sitting; and
- Meet other criteria established by DCF rule.

There are currently 18 children who are placed in a safe foster home.

Level IV: Therapeutic Foster Home

This level of licensure is for caregivers who have received specialized training to care for a wide variety of children and adolescents who may have significant emotional, behavioral, or social needs. As a therapeutic foster parent, individualized care is provided in the home by the foster parent to ensure a child receives the appropriate level of care in the least restrictive setting.[52]

Level V: Medical Foster Home

This licensure type is for caregivers who have received specialized training to provide care for children and adolescents with chronic medical conditions. Medical foster parents enable children from birth through age 20 with medically-complex conditions whose parents are unable to care for them in their own homes, to live and receive care in a foster home rather than in hospitals or other facility settings.[53]

***Training Requirements for Foster Placement***

Under s. 409.175, F.S., in order to provide improved services to children, the DCF is required to provide or cause to be provided preservice training for prospective foster parents and inservice training for foster parents who are licensed and supervised by the DCF.[54]

Except in limited circumstances,[55] as a condition of licensure, foster parents are required to successfully complete preservice training. The preservice training must be uniform statewide and include, but not be limited to, such areas as:

- Orientation regarding agency purpose, objectives, resources, policies, and services;
- Role of the foster parent as a treatment team member;
- Transition of a child into and out of foster care;
- Management of difficult child behavior that can be intensified by placement, by prior abuse or neglect, and by prior placement disruptions;
- Prevention of placement disruptions;
- Care of children at various developmental levels;
- Effects of foster parenting on the family of the foster parent; and
- Information about and contact information for the local mobile response team as a means for addressing a behavioral health crisis or preventing placement disruption.[56]

[52] *Id*.
[53] *Id*.
[54] Section 409.175(14), F.S.
[55] Rule 65C-45.002, F.A.C. provides that, in limited instances, applicants who have completed a DCF approved preservice training curriculum within the last 5 years or who completed training in another state are exempt from completing certain pre-training requirements.
[56] Section 409.175(14)(b), F.S.

Rule 65C-45.002, F.A.C., provides for additional training topics, including:

- The reasonable and prudent parenting standards, pursuant to ss. 39.4091 and 409.145, F.S., and the balance of normalcy for children in care and their safety;
- Legal rights, roles, responsibilities, and expectations of foster parents;
- The social and emotional development of children and youth;
- Agency policies, services, laws, and regulations;
- Development of life skills for teens in care;
- The caregiver's role in supporting and promoting the educational progress of the child;
- Trauma-informed care, including recognizing the signs, symptoms, and triggers of trauma;
- The Multiethnic Placement Act and the Americans with Disabilities Act; and
- The administration of psychotropic Medication.

In addition, foster parents must receive 24 hours of specialized training in commercial sexual exploitation prior to receiving certification to care for sexually exploited children or young adults,[57] which includes, but is not limited to:

- The needs of child victims of commercial sexual exploitation;
- The effects of trauma and sexual exploitation; and
- How to address those needs using strength-based and trauma-informed approaches.[58]

Specifically, the intensive training on commercially exploited children must include:

- Distinctions between sexual abuse, sexual exploitation, and sexual trafficking;
- Language and sensitivity;
- Pathways to entry into sexual exploitation and sexual trafficking;
- Exploiters;
- Tactics of coercion and control;
- Impact of sexual exploitation;
- Stockholm Syndrome and trauma bonding;
- Identifying victims;
- Meeting the needs of victims;
- Trauma triggers;
- Trauma-informed care;
- Vicarious trauma and self-care strategies;
- Behavior management activities; and
- Intersection of labor trafficking and commercial sexual exploitation.[59]

In consultation with foster parents, each region or lead agency is required to develop a plan for making the completion of the required training as convenient as possible for potential foster parents that includes strategies such as providing training in nontraditional locations and at nontraditional times. The plan must be revised at least annually and must be included in the information provided to each person applying to become a foster parent.[60]

[57] Rule 65C-45.004(2), F.A.C.
[58] Section 409.1678(2)(e), F.S.
[59] Rule 65C-45.004(4), F.A.C.
[60] *Id*.

Before licensure renewal, each foster parent must successfully complete inservice training. Periodic time-limited training courses must be made available for selective use by foster parents. Such inservice training must include subjects affecting the daily living experiences of foster parenting as a foster parent. For a foster parent participating in the required inservice training, the DCF is required to reimburse such parent for travel expenditures and, if both parents in a home are attending training or if the absence of the parent would leave the children without departmentally approved adult supervision, the DCF is required to provide for child care or reimburse the foster parents for child care costs incurred by the parents for children in their care.[61]

**Agency Staff**

The term "agency" means a residential child-caring agency or child placing agency.[62] A "residential child-caring agency" means that any person, corporation, or agency, public or private, other than the child's parent or legal guardian, that provides staffed 24-hour care for children in facilities maintained for that purpose, regardless of whether operated for profit or whether a fee is charged.[63] A "child-placing agency" means any person, corporation, or agency, public or private, other than the parent or legal guardian of the child or an intermediary acting pursuant to ch. 63, F.S., that receives a child for placement and places or arranges for the placement of a child in a family foster home, residential child-caring agency, or adoptive home.[64]

***Training for Agency Staff***

Currently, only selected agency staff receives training on human trafficking. Child protective investigators and case managers, and their supervisors, must receive a minimum of six hours of specialized training on human trafficking approved by the DCF prior to accepting cases with children or young adult victims of human trafficking.[65] The specialized training in human trafficking is required to be conducted by a DCF-approved trainer and consist of:

- Three hours of live training pertaining to human trafficking;
- One hour of live training pertaining to Legislative language addressing human trafficking; and
- Two hours of additional live training on specialized topics related to human trafficking of children.

Each year child protective investigators and case managers must receive a minimum of one hour of ongoing training per quarter on human trafficking or related topics in order to continue receiving cases with child or young adult victims of human trafficking.

[61] *Id*.
[62] Section 409.175(2)(a), F.S.
[63] Section 409.175(2)(l), F.S.
[64] Section 409.175(2)(d), F.S.
[65] Rule 65C-43.005, F.A.C.

Any professional administering the Human Trafficking Screening Tool (HTST) must meet the training requirements set forth in Rule 65C-43.005, F.A.C., and must have completed the DCF approved training for the HTST prior to administering the tool.[66]

Similar to foster parents of safe foster homes, staff of safe houses must also complete intensive training.[67]

## III. Effect of Proposed Changes:

The bill adds the following duties to the Statewide Council on Human Trafficking (Council) to:

- Assess the frequency and extent to which social media platforms are used to assist, facilitate, or support human trafficking within the state;
- Establish a process to detect such use on a consistent basis; and
- Make recommendations on how to stop, reduce, or prevent social media platforms from being used for such purpose.

The Council must implement a system to achieve these objectives without undue delay to the extent they can be achieved under existing laws.

The bill requires the Florida Alliance to End Human Trafficking (FAEHT) to develop training specifically for firesafety inspectors related to recognizing and reporting human trafficking, and allows for such training to be eligible for the continuing education credits required under s. 633.216(4), F.S., for a firesafety inspector to renew his or her certification.

The bill also amends s. 16.618, F.S., to remove obsolete language which requires FIRST to develop human trafficking training for statewide dissemination no later than October 1, 2019, as such training has been developed and is currently available online. Under the bill, FIRST is still required to make such training available for statewide dissemination.

The bill also amends s. 409.175, F.S., to require foster parents and all agency staff to complete preservice and inservice training related to recognizing, preventing, and reporting human trafficking. The preservice training must cover the following topics, at a minimum:

- Basic information on human trafficking, such as understanding relevant terminology and different types of human trafficking;
- Information on children who are at risk of human trafficking; and
- Actions that may be taken to prevent children from becoming victims of domestic violence.

The bill requires the above-described inservice training to be completed by foster parents before licensure renewal and by agency staff during each full year of employment. The DCF will be required to develop the relevant training materials or outsource to an agency approved trainer.

Section 63.092, F.S., is reenacted for the purpose of incorporating the amendment made to s. 409.175, F.S., by the act.

[66] Rule 65C-45.001, F.A.C.
[67] Section 409.1678(2)(e), F.S.

The bill provides an effective date of July 1, 2022.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CS/SB 1436 may have an indeterminate fiscal impact on the DSO by requiring it to develop new training specifically for firesafety inspectors.

C. Government Sector Impact:

None.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 16.617, 16.618, and 409.175.

This bill reenacts section 63.092 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.)

**CS by Children, Families, and Elder Affairs on February 1, 2022:**
The Committee Substitute:

- Modifies the duties of the Council in relation to human trafficking on social media;
- Requires the Council to implement a system to eliminate or prevent social media platforms from being used to assist, facilitate, or support human trafficking to the extent these objectives can be achieved under existing laws;
- Requires the FAEHT to develop the required training for firesafety inspectors, instead of FIRST; and
- Makes a technical change which recognizes that the FIRST has already developed certain training material that is available for dissemination.

### B. Amendments:

None.

**By** the Committee on Children, Families, and Elder Affairs; and Senator Garcia

586-02600-22 20221436c1

A bill to be entitled

An act relating to human trafficking; amending s. 16.617, F.S.; providing the Statewide Council on Human Trafficking with an additional duty; amending s. 16.618, F.S.; deleting an obsolete provision; requiring the direct support organization of the Statewide Council on Human Trafficking to develop certain training for firesafety inspectors; providing that such training is eligible for continuing education credits; amending s. 409.175, F.S.; requiring foster parents and agency staff to complete preservice and inservice training related to human trafficking; reenacting s. 63.092(3)(e), F.S., relating to reports to the court of intended placement by an adoption entity, to incorporate the amendment made to s. 409.175, F.S., in a reference thereto; providing an effective date.

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

Section 1. Present paragraphs (b) through (e) of subsection (4) of section 16.617, Florida Statutes, are redesignated as paragraphs (c) through (f), respectively, and a new paragraph (b) is added to that subsection, to read:

16.617 Statewide Council on Human Trafficking; creation; membership; duties.—

(4) DUTIES.—The council shall:

(b) Assess the frequency and extent to which social media platforms are used to assist, facilitate, or support human







586-02600-22 20221436c1

trafficking within this state, establish a process to detect such use on a consistent basis, and make recommendations on how to stop, reduce, or prevent social media platforms from being used for such purposes. To the extent that these objectives can be achieved under existing laws, the council must implement a system to do so without undue delay.

Section 2. Paragraph (b) of subsection (4) of section 16.618, Florida Statutes, is amended, and paragraph (f) is added to that subsection, to read:

16.618 Direct-support organization.—

(4)

(b) Recognizing that this state hosts large-scale events, including sporting events, concerts, and cultural events, which generate significant tourism to this state, produce significant economic revenue, and often are conduits for human trafficking, the institute must develop training that is available ~~ready~~ for statewide dissemination ~~by not later than October 1, 2019~~.

1. Training must focus on detecting human trafficking, best practices for reporting human trafficking, and the interventions and treatment for survivors of human trafficking.

2. In developing the training, the institute shall consult with law enforcement agencies, survivors of human trafficking, industry representatives, tourism representatives, and other interested parties. The institute also must conduct research to determine the reduction in recidivism attributable to the education of the harms of human trafficking for first-time offenders.

(f) The direct-support organization shall develop training for firesafety inspectors in the recognition and reporting of

human trafficking. Such training is eligible for continuing education credit under s. 633.216(4).

Section 3. Paragraph (e) is added to subsection (14) of section 409.175, Florida Statutes, to read:

409.175 Licensure of family foster homes, residential child-caring agencies, and child-placing agencies; public records exemption.—

(14)

(e)1. In addition to any other preservice training required by law, foster parents, as a condition of licensure, and agency staff must successfully complete preservice training related to human trafficking which must be uniform statewide and must include, but need not be limited to:

a. Basic information on human trafficking, such as an understanding of relevant terminology, and the differences between sex trafficking and labor trafficking;

b. Factors and knowledge on identifying children at risk of human trafficking; and

c. Steps that should be taken to prevent at-risk youths from becoming victims of human trafficking.

2. Foster parents, before licensure renewal, and agency staff, during each full year of employment, must complete inservice training related to human trafficking to satisfy the training requirement under subparagraph (5)(b)7.

Section 4. For the purpose of incorporating the amendment made by this act to section 409.175, Florida Statutes, in a reference thereto, paragraph (e) of subsection (3) of section 63.092, Florida Statutes, is reenacted to read:

63.092 Report to the court of intended placement by an







adoption entity; at-risk placement; preliminary study.—

(3) PRELIMINARY HOME STUDY.—Before placing the minor in the intended adoptive home, a preliminary home study must be performed by a licensed child-placing agency, a child-caring agency registered under s. 409.176, a licensed professional, or an agency described in s. 61.20(2), unless the adoptee is an adult or the petitioner is a stepparent or a relative. If the adoptee is an adult or the petitioner is a stepparent or a relative, a preliminary home study may be required by the court for good cause shown. The department is required to perform the preliminary home study only if there is no licensed child-placing agency, child-caring agency registered under s. 409.176, licensed professional, or agency described in s. 61.20(2), in the county where the prospective adoptive parents reside. The preliminary home study must be made to determine the suitability of the intended adoptive parents and may be completed before identification of a prospective adoptive minor. If the identified prospective adoptive minor is in the custody of the department, a preliminary home study must be completed within 30 days after it is initiated. A favorable preliminary home study is valid for 1 year after the date of its completion. Upon its completion, a signed copy of the home study must be provided to the intended adoptive parents who were the subject of the home study. A minor may not be placed in an intended adoptive home before a favorable preliminary home study is completed unless the adoptive home is also a licensed foster home under s. 409.175. The preliminary home study must include, at a minimum:

(e) Documentation of counseling and education of the intended adoptive parents on adoptive parenting, as determined

by the entity conducting the preliminary home study. The training specified in s. 409.175(14) shall only be required for persons who adopt children from the department.

If the preliminary home study is favorable, a minor may be placed in the home pending entry of the judgment of adoption. A minor may not be placed in the home if the preliminary home study is unfavorable. If the preliminary home study is unfavorable, the adoption entity may, within 20 days after receipt of a copy of the written recommendation, petition the court to determine the suitability of the intended adoptive home. A determination as to suitability under this subsection does not act as a presumption of suitability at the final hearing. In determining the suitability of the intended adoptive home, the court must consider the totality of the circumstances in the home. A minor may not be placed in a home in which there resides any person determined by the court to be a sexual predator as defined in s. 775.21 or to have been convicted of an offense listed in s. 63.089(4)(b)2.

Section 5. This act shall take effect July 1, 2022.

The Florida Senate

# APPEARANCE RECORD

Deliver both copies of this form to
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2/16
Meeting Date

Appr. Health & Human Services
Committee

1436 Tab 4
Bill Number or Topic

Amendment Barcode (if applicable)

Name AUSTIN STOWERS

Phone austin.stowers@myfloridacfo.com

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Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

**PLEASE CHECK ONE OF THE FOLLOWING:**

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
CFO & State Fire Marshal Jimmy Patronis

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

*While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)*

**This form is part of the public record for this meeting.**

S-001 (08/10/2021)

2/16/24

Meeting Date

The Florida Senate

# APPEARANCE RECORD

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1436

Bill Number or Topic

App S.C. Health & Human Ser.

Committee

Amendment Barcode (if applicable)

**Name** Jon Pasqualone **Phone** 772-932-1555

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City State Zip

**Speaking:** ☐ For ☐ Against ☐ Information **OR** **Waive Speaking:** ☒ In Support ☐ Against

**PLEASE CHECK ONE OF THE FOLLOWING:**

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☒ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

FL. Fire Marshals & Inspectors Assoc.

*While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)*

**This form is part of the public record for this meeting.**

S-001 (08/10/2021)

**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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | PCS/CS/SB 1600 (534076) |
| INTRODUCER: | Appropriations Subcommittee on Health and Human Services; Children, Families, and Elder Affairs Committee; and Senator Bradley |
| SUBJECT: | Treatment of Defendants Adjudicated Incompetent to Stand Trial |
| DATE: | February 18, 2022 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Delia | Cox | CF | **Fav/CS** |
| 2. | Gerbrandt | Money | AHS | **Recommend: Fav/CS** |
| 3. | | | AP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

PCS/CS/SB 1600 authorizes the Secretary of the Department of Children and Families (the DCF) to designate facilities where the DCF may provide competency restoration treatment to criminal defendants who:

- Have been charged with a felony;
- Have been deemed incompetent to stand trial due to a mental illness and committed to the DCF;
- Are being held in a jail awaiting admission to a DCF-run facility; and
- Are likely to regain competence to proceed in the foreseeable future.

The bill revises the definition of "forensic facility" to include separate and secure facilities contracted using DCF funding, and to include a mental health facility operated by a community mental health provider that may be co-located in a county jail and is deemed appropriate by the DCF."

The bill is likely to have a negative yet indeterminate fiscal impact on the DCF and may have a positive fiscal impact on private sector entities. See Section V. Fiscal Impact Statement.

The bill takes effect on July 1, 2022.

## II. Present Situation:

### Competency Restoration Treatment and Forensic Facilities

Chapter 916, F.S., governs the state forensic system, which is a network of state facilities and community services for persons who have mental health issues, an intellectual disability, or autism and who are involved with the criminal justice system. Offenders who are charged with a felony and adjudicated incompetent to proceed[1] and offenders who are adjudicated not guilty by reason of insanity may be involuntarily committed to state civil and forensic treatment facilities by the circuit court,[2] or in lieu of such commitment, may be released on conditional release[3] by the circuit court if the person is not serving a prison sentence.[4] Conditional release is release into the community accompanied by outpatient care and treatment. The committing court retains jurisdiction over the defendant while the defendant is under involuntary commitment or conditional release.[5]

A civil facility is, in part, a mental health facility established within the DCF or by contract with the DCF to serve individuals committed pursuant to ch. 394, F.S., and defendants pursuant to ch. 916, F.S., who do not require the security provided in a forensic facility.[6]

A forensic facility is a separate and secure facility established within the DCF or the APD to service forensic clients committed pursuant to ch. 916, F.S.[7] A separate and secure facility means a security-grade building for the purposes of separately housing individuals with mental illness from persons who have intellectual disabilities or autism and separately housing persons who have been involuntarily committed from non-forensic residents.[8]

### State Forensic System – Mental Health Treatment for Criminal Defendants

If a defendant is suspected of being incompetent, the court, counsel for the defendant, or the state may file a motion for examination to have the defendant's cognitive state assessed.[9] If the motion is well-founded, the court will appoint experts to evaluate the defendant's cognitive state. The defendant's competency is then determined by the judge in a subsequent hearing.[10] If the defendant is found to be competent, the criminal proceeding resumes.[11] If the defendant is found to be incompetent to proceed, the proceeding may not resume unless competency is restored.[12]

---

[1] "Incompetent to proceed" means "the defendant does not have sufficient present ability to consult with her or his lawyer with a reasonable degree of rational understanding" or "the defendant has no rational, as well as factual, understanding of the proceedings against her or him." Section 916.12(1), F.S.
[2] Sections 916.13, 916.15, and 916.302, F.S.
[3] Conditional release is release into the community accompanied by outpatient care and treatment. Section 916.17, F.S.
[4] Section 916.17(1), F.S.
[5] Section 916.16(1), F.S.
[6] Section 916.106(4), F.S.
[7] Section 916.106(10), F.S. A separate and secure facility means a security-grade building for the purpose of separately housing persons who have mental illness from persons who have intellectual disabilities or autism and separately housing persons who have been involuntarily committed pursuant to chapter 916, F.S., from non-forensic residents.
[8] *Id.*
[9] Rule 3.210, Fla.R.Crim.P.
[10] *Id.*
[11] Rule 3.212, Fla.R.Crim.P.
[12] *Id.*

Sections 916.13 and 916.15, F.S., set forth the criteria under which a court may involuntarily commit a defendant charged with a felony who has been adjudicated incompetent to proceed due to a mental illness, or who has been found not guilty by reason of insanity. If a person is committed pursuant to either statute, the administrator at the commitment facility must submit a report to the court:

- No later than 6 months after a defendant's admission date and at the end of any period of extended commitment; or
- At any time the administrator has determined that the defendant has regained competency or no longer meets the criteria for involuntary commitment.[13]

***State Treatment Facilities***

State treatment facilities are the most restrictive settings for forensic services. The forensic facilities provide assessment, evaluation, and treatment to the individuals who have mental health issues and who are involved with the criminal justice system.[14] In addition to general psychiatric treatment approaches and environment, specialized services include:

- Psychosocial rehabilitation;
- Education;
- Treatment modules such as competency, anger management, mental health awareness, medication, and relapse prevention;
- Sexually transmitted disease education and prevention;
- Substance abuse awareness and prevention;
- Vocational training;
- Occupational therapies; and
- Full range of medical and dental services.[15]

***Mental Health Treatment Facilities***

The DCF runs three mental health treatment facilities: the Florida State Hospital (FSH), the Northeast Florida State Hospital (NEFSH), and the North Florida Evaluation and Treatment Center (NFETC).[16] The DCF also contracts with a private provider, Wellpath Recovery Solutions (Wellpath), to operate three additional facilities that provide competency restoration training. The facilities are the South Florida Evaluation and Treatment Center, South Florida State Hospital, and Treasure Coast Treatment Facility.[17]

The FSH, located in Chattahoochee, Florida, is a state psychiatric hospital that provides civil and forensic services.[18] The hospital's civil services are comprised of the following three units with a total of 490 beds:

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[13] Section 916.13(2)-(3), F.S.
[14] The DCF, *About Adult Forensic Mental Health (AFMH)*, available at https://www.myflfamilies.com/service-programs/samh/adult-forensic-mental-health/forensic-facilities.shtml (last visited January 28, 2022).
[15] Id.
[16] The DCF, *State Mental Health Treatment Facilities*, available at https://www.myflfamilies.com/service-programs/mental-health/state-mental-health-treatment-facilities.shtml (last visited January 28, 2022).
[17] *Id*.
[18] The DCF, *Florida State Hospital Services and Programs*, available at https://www.myflfamilies.com/service-programs/mental-health/fsh/services-programs.shtml (last visited January 28, 2022).

- Civil Admissions evaluates and provides psychiatric services primarily for newly admitted acutely ill male and female civil residents between the ages of 18 and 64;
- Civil Transition Program serves civil residents and individuals previously in a forensic setting who no longer need that level of security and with court approval, may reside in a less restrictive civil environment; and
- Specialty Care Program serves a diverse population of individuals requiring mental health treatment and services, including civil and forensic step downs.[19]

The hospital's forensic services section evaluates and treats persons with felony charges who have been adjudicated incompetent to stand trial or not guilty by reason of insanity. Forensic services is comprised of the following two units;

- Forensic Admission is a maximum security facility that assesses new admissions, provides short-term treatment and competency restoration for defendants found incompetent to stand trial, and behavior stabilization for persons committed as not guilty by reason of insanity; and
- Forensic Central provides longer-term treatment and serves a seriously and persistently mentally ill population who are incompetent to proceed or not guilty by reason of insanity.[20]

The NEFSH, located in Macclenny, Florida, is a state psychiatric hospital that provides civil services.[21] The facility operates 633 beds and is the largest state-owned provider of psychiatric care and treatment to civilly committed individuals in Florida. Referrals are based upon community and regional priorities for admission.[22]

The NFETC, located in Gainesville, Florida, is an evaluation and treatment center for people with mental illnesses who are involved in the criminal justice system.[23] The center has 193 beds open for the evaluation and treatment of residents who have major mental disorders. These residents are either incompetent to proceed to trial or have been judged to be not guilty by reason of insanity.[24]

As of January 13, 2022, there are a total of 548 individuals on the waitlist for forensic beds at the state's mental health facilities.[25] Of these, 492 individuals have been on the waitlist for more than 15 days.[26] Individuals spend 59 days on the waitlist on average.[27]

**Jail-Based Forensic Diversion**

In addition to state-run forensic facilities, some other states currently operate jail-based treatment programs for individuals deemed incompetent to proceed.

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[19] *Id*.
[20] *Id*.
[21] The DCF, *State Mental Health Treatment Facilities North Florida Evaluation and Treatment Center, About the Center*, available at http://www.myflfamilies.com/service-programs/mental-health/nefsh/about.shtml (last visited January 28, 2022).
[22] *Id*.
[23] *See* the DCF, *State Mental Health Treatment Facilities North Florida Evaluation and Treatment Center (NFETC)*, available at https://www.myflfamilies.com/service-programs/mental-health/nfetc/about.shtml (last visited January 28, 2022).
[24] *Id*.
[25] E-mail from John Paul Fiore, Legislative Affairs Director, the DCF (January 29, 2022) (on file with the Senate Committee on Children, Families, and Elder Affairs).
[26] *Id*.
[27] *Id*.

In 2011, the state of Georgia contracted with a university forensic program to develop a 16-bed, jail-based diversion pilot program.[28] The program was developed as a means of addressing a waitlist for admission to a state hospital forensic unit which had grown to more than 60 days.[29] The program opened in October 2011, and 16 defendants were admitted to the unit, immediately shortening the wait time for inpatient hospitalization to less than 20 days.[30] Because almost all competency evaluations were performed by the university forensic service, once an evaluator deemed a defendant incompetent to proceed, that defendant could be transferred to the unit and restoration services initiated before the court made a formal finding of incompetence.[31] As a result, restoration could often be accomplished without the court ever making a formal finding of incompetence.[32]

Since 2013, Colorado's Office of Behavioral Health[33] has contracted with Wellpath to operate a jail-based diversion program, known as the RISE Program, in addition to mental health treatment facilities.[34] Wellpath was awarded the initial contract through a competitive procurement process in 2013 and subsequent contract expansions in 2015 and 2018.[35] The program is divided between a county detention facility and a jail and currently provides 114 total patient beds.[36]

Wellpath also operates the Kern County Admission, Evaluation, and Stabilization Center (AES) in Bakersfield, California.[37] The Kern County AES is a 60-bed jail-based competency evaluation and restoration program established through a collaboration between the Kern County Sheriff's Office, California Department of State Hospitals (DSH), and Wellpath.[38] Wellpath was awarded the contract through a competitive procurement process in 2018.[39]

## III. Effect of Proposed Changes:

The bill amends s. 916.13, F.S., permitting a forensic client who has been deemed incompetent to proceed due to a mental illness and committed to the DCF, and who is being held in a jail awaiting admission to a facility of the DCF, to obtain restoration treatment at any facility the DCF Secretary deems appropriate. The bill limits treatment at such facilities to defendants who are likely to regain competence in the foreseeable future.

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[28] The Journal of the American Academy of Psychiatry and the Law, *A Jail-Based Competency Restoration Unit as a Component of a Continuum of Restoration Services*, November 2019, available at http://jaapl.org/content/early/2019/11/21/JAAPL.003893-20#sec-1 (last visited January 29, 2022).
[29] *Id*.
[30] *Id*.
[31] *Id*.
[32] *Id*.
[33] The Office of Behavioral Health is Colorado's state agency handling behavioral health matters.
[34] The Colorado Department of Human Services, *Request for Applications: Jail-Based Program for Individuals Court Ordered to Forensic Evaluation and Treatment*, p. 3-5 (on file with the Senate Committee on Children, Families, and Elder Affairs) (hereinafter, "The Colorado RFP).
[35] Wellpath Recovery Solutions, *RISE Program at Arapahoe County Detention Center*, available at https://wellpathcare.com/rise-program-at-arapahoe-county-detention-center/ (last visited January 28, 2022).
[36] The Colorado RFP at p. 4.
[37] Wellpath Recovery Solutions, *Kern County AES Center*, available at https://wellpathcare.com/kern-county-aes-center/ (last visited January 28, 2022).
[38] *Id*.
[39] *Id*.

The bill also amends s. 916.106, F.S., revising the definition of "forensic facility" to include separate and secure facilities contracted using DCF funding, and to include a mental health facility operated by a community mental health provider that may be co-located in a county jail and is deemed appropriate by the DCF.

The bill may alleviate the waitlist for forensic treatment beds at existing DCF-run facilities by creating additional venues where individuals deemed incompetent to stand trial due to a mental illness, but who are likely to regain competence to proceed in the foreseeable future, can receive restoration treatment.

The DCF anticipates that the proposed language would also provide flexibility in identifying and securing community-based or jail-based competency restoration treatment, for individuals who can be served in a less restrictive environment.[40]

The bill is effective July 1, 2022.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

[40] The DCF, *Agency Analysis of SB 1600*, p. 2, January 8, 2022 (on file with the Senate Committee on Children, Families, and Elder Affairs).

B. Private Sector Impact:

PCS/CS/SB 1600 may have a positive fiscal impact on private entities with whom the DCF contracts to operate jail-based treatment programs under the bill.

C. Government Sector Impact:

The bill is likely to have significant yet indeterminate fiscal impact on the DCF. Currently, if a person is adjudicated incompetent to proceed they are provided competency training at one of DCF's forensic or civil state mental health treatment facilities. There is a waitlist to receive services at one of DCF's mental health treatment facilities, and on average an individual spends 59 days awaiting services. The bill creates additional venues where certain individuals can receive restoration treatment and therefore may alleviate the waitlist. To the extent that the DCF would need an appropriation to cover the restoration services provided at the additional venues, as opposed to diverting the current budget for restoration services to the additional venues, the bill will have a significant yet, indeterminate fiscal impact on the DCF. The fiscal impact is indeterminate because it is unclear how many individuals will receive treatment at the newly designated facilities.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

The bill substantially amends the following sections of the Florida Statutes: 916.106 and 916.13.

## IX. Additional Information:

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

**Recommended CS/CS by Appropriations Subcommittee on Health and Human Services on February 16, 2022:**
The committee substitute:

- Modifies the definition of "forensic facility" under s. 916.106, F.S., to include a facility contracted using DCF funds.
- Clarifies that restoration treatment can be provided at any forensic facility deemed appropriate by the DCF Secretary to clients who have been committed to the DCF.

**CS by Children, Families, and Elder Affairs on February 1, 2022:**
The committee substitute:

- Modifies the existing definition of "forensic facility" under s. 916.106, F.S., to provide that "the term includes a mental health facility operated by a community

mental health provider which may be co-located in a county jail and which is deemed appropriate by the department."

- Requires facilities designated for jail-based diversion programs to be operated by a community mental health provider.
- Provides that such facilities may be co-located in a county jail.

B. Amendments:

None.

774274

LEGISLATIVE ACTION

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Appropriations Subcommittee on Health and Human Services (Bradley) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 20 - 43

and insert:

facility established within the department or agency, or contracted using department funding, to serve forensic clients. A separate and secure facility means a security-grade building for the purpose of separately housing persons who have mental illness from persons who have intellectual disabilities or autism and separately housing persons who have been

774274

involuntarily committed pursuant to this chapter from nonforensic residents. The term includes a mental health facility operated by a community mental health provider which may be colocated in a county jail and which is deemed appropriate by the department.

Section 2. Subsection (2) of section 916.13, Florida Statutes, is amended to read:

916.13 Involuntary commitment of defendant adjudicated incompetent.—

(2) A defendant who has been charged with a felony and who has been adjudicated incompetent to proceed due to mental illness, and who meets the criteria for involuntary commitment under this chapter, may be committed to the department, and the department shall retain and treat the defendant. Restoration treatment for a forensic client who has been committed to the department, who is held in a jail awaiting admission to a forensic facility, and who is likely to regain competence to proceed in the foreseeable future may be provided at any forensic facility deemed appropriate by the department secretary.

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

And the title is amended as follows:

Delete lines 5 - 10

and insert:

facility"; amending s. 916.13, F.S.; providing that restoration treatment for a forensic client who meets certain criteria may receive treatment at any facility designated by the department; providing an effective

118168

LEGISLATIVE ACTION

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| 02/16/2022 | . | |
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Appropriations Subcommittee on Health and Human Services (Farmer) recommended the following:

**Senate Amendment to Amendment (774274) (with title amendment)**

Between lines 15 and 16
insert:

(13) "Intellectual disability" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior which manifests before the age of 18, or significantly deficient adaptive functioning resulting from a traumatic brain injury, and which



can reasonably be expected to continue indefinitely. For the purposes of this definition, the term:

(a) "Adaptive behavior" means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age, cultural group, and community.

(b) "Significantly deficient adaptive functioning" means the extreme limitation of one, or marked limitation of two, of the following areas of mental functioning:

1. Understanding, remembering, or applying information;

2. Interacting with others;

3. Concentrating, persisting, or maintaining pace; or

4. Adapting or managing oneself.

(c) "Significantly subaverage general intellectual functioning" means performance that is two or more standard deviations from the mean score on a standardized intelligence test specified in the rules of the agency.

(d) "Traumatic brain injury" means a disruption in the normal function of the brain which can be caused by a bump, blow, or jolt to the head or a penetrating head injury ~~has the same meaning as in s. 393.063~~.

Section 2. Subsection (4) is added to section 916.303, Florida Statutes, to read:

916.303 Determination of incompetency; dismissal of charges.—

(4) If the charges are dismissed and the defendant has been found incompetent to proceed due to an intellectual disability caused by a traumatic brain injury, the agency must assist the defendant with application to the long-term care managed care

118168

program described in ss. 409.978-409.985.

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

And the title is amended as follows:

Delete line 35

and insert:

facility"; redefining the term "intellectual disability" as it relates to defendants who have been found to be incompetent to proceed by adding the terms "significantly deficient adaptive functioning" and "traumatic brain injury"; amending s. 916.303, F.S.; requiring the Agency for Persons with Disabilities to assist certain defendants found incompetent to proceed with application to the long-term care managed care program; amending s. 916.13, F.S.; providing that

735792

LEGISLATIVE ACTION

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| 02/16/2022 | . | |
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| | . | |

Appropriations Subcommittee on Health and Human Services (Farmer) recommended the following:

**Senate Amendment (with directory and title amendments)**

Between lines 29 and 30

insert:

(13) "Intellectual disability" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior which manifests before the age of 18, or significantly deficient adaptive functioning resulting from a traumatic brain injury, and which can reasonably be expected to continue indefinitely. For the

735792

purposes of this definition, the term:

(a) "Adaptive behavior" means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age, cultural group, and community.

(b) "Significantly deficient adaptive functioning" means the extreme limitation of one, or marked limitation of two, of the following areas of mental functioning:

1. Understanding, remembering, or applying information;

2. Interacting with others;

3. Concentrating, persisting, or maintaining pace; or

4. Adapting or managing oneself.

(c) "Significantly subaverage general intellectual functioning" means performance that is two or more standard deviations from the mean score on a standardized intelligence test specified in the rules of the agency.

(d) "Traumatic brain injury" means a disruption in the normal function of the brain which can be caused by a bump, blow, or jolt to the head or a penetrating head injury ~~has the same meaning as in s. 393.063~~.

Section 2. Subsection (4) is added to section 916.303, Florida Statutes, to read:

916.303 Determination of incompetency; dismissal of charges.—

(4) If the charges are dismissed and the defendant has been found incompetent to proceed due to an intellectual disability caused by a traumatic brain injury, the agency must assist the defendant with application to the long-term care managed care program described in ss. 409.978-409.985.

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====== D I R E C T O R Y  C L A U S E  A M E N D M E N T ======
And the directory clause is amended as follows:
Delete lines 15 - 16
and insert:
Section 1. Subsections (10) and (13) of section 916.106, Florida Statutes, are amended to read:

================ T I T L E  A M E N D M E N T ================
And the title is amended as follows:
Delete line 5
and insert:
facility"; redefining the term "intellectual disability" as it relates to defendants who have been found to be incompetent to proceed by adding the terms "significantly deficient adaptive functioning" and "traumatic brain injury"; amending s. 916.303, F.S.; requiring the Agency for Persons with Disabilities to assist certain defendants found incompetent to proceed with application to the long-term care managed care program; amending s. 916.13, F.S.; providing that a

**By** the Committee on Children, Families, and Elder Affairs; and Senator Bradley

586-02591-22 20221600c1

A bill to be entitled

An act relating to treatment of defendants adjudicated incompetent to stand trial; amending s. 916.106, F.S.; revising the definition of the term "forensic facility"; amending s. 916.13, F.S.; providing that a forensic client who is being held in a jail awaiting admission to a Department of Children and Families facility and who is likely to regain competence to proceed may receive treatment at any facility designated by the department; providing an effective date.

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

Section 1. Subsection (10) of section 916.106, Florida Statutes, is amended to read:

916.106 Definitions.—For the purposes of this chapter, the term:

(10) "Forensic facility" means a separate and secure facility established within the department or agency to serve forensic clients. A separate and secure facility means a security-grade building for the purpose of separately housing persons who have mental illness from persons who have intellectual disabilities or autism and separately housing persons who have been involuntarily committed pursuant to this chapter from nonforensic residents. The term includes a mental health facility operated by a community mental health provider which may be colocated in a county jail and which is deemed appropriate by the department.







586-02591-22 20221600c1

Section 2. Subsection (2) of section 916.13, Florida Statutes, is amended to read:

916.13 Involuntary commitment of defendant adjudicated incompetent.—

(2) A defendant who has been charged with a felony and who has been adjudicated incompetent to proceed due to mental illness, and who meets the criteria for involuntary commitment under this chapter, may be committed to the department, and the department shall retain and treat the defendant. For a forensic client who is held in a jail awaiting admission to a facility of the department, and who is likely to regain competence to proceed in the foreseeable future, restoration treatment may be provided at any facility deemed appropriate by the department secretary.

(a) Immediately after receipt of a completed copy of the court commitment order containing all documentation required by the applicable Florida Rules of Criminal Procedure, the department shall request all medical information relating to the defendant from the jail. The jail shall provide the department with all medical information relating to the defendant within 3 business days after receipt of the department's request or at the time the defendant enters the physical custody of the department, whichever is earlier.

(b) Within 6 months after the date of admission and at the end of any period of extended commitment, or at any time the administrator or his or her designee determines that the defendant has regained competency to proceed or no longer meets the criteria for continued commitment, the administrator or designee shall file a report with the court pursuant to the

applicable Florida Rules of Criminal Procedure.

(c) A competency hearing must be held within 30 days after the court receives notification that the defendant is competent to proceed or no longer meets the criteria for continued commitment. The defendant must be transported to the committing court's jurisdiction for the hearing. If the defendant is receiving psychotropic medication at a mental health facility at the time he or she is discharged and transferred to the jail, the administering of such medication must continue unless the jail physician documents the need to change or discontinue it. The jail and department physicians shall collaborate to ensure that medication changes do not adversely affect the defendant's mental health status or his or her ability to continue with court proceedings; however, the final authority regarding the administering of medication to an inmate in jail rests with the jail physician.

Section 3. This act shall take effect July 1, 2022.

**THE FLORIDA SENATE**

Tallahassee, Florida 32399-1100

**SENATOR JENNIFER BRADLEY**
5th District

**COMMITTEES:**
Community Affairs, *Chair*
Agriculture, *Vice Chair*
Appropriations Subcommittee on Agriculture, Environment, and General Government
Education
Ethics and Elections
Judiciary
Reapportionment

**SELECT SUBCOMMITTEE:**
Select Subcommittee on Congressional Reapportionment, *Chair*

**JOINT COMMITTEES:**
Joint Legislative Auditing Committee
Joint Select Committee on Collective Bargaining

February 5, 2022

Senator Aaron Bean, Chair
Senate Appropriations Subcommittee on Health and Human Services
404 Senate Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chairman Bean:

I respectfully request that Senate Bill 1600 be placed on the committee's agenda at your earliest convenience. This bill relates to treatment of defendants adjudicated incompetent to stand trial.

Thank you for your consideration.

Sincerely,

Jennifer Bradley

cc: Tonya Money, Staff Director
Robin Jackson, Administrative Assistant

REPLY TO:
❒ 1279 Kingsley Avenue, Kingsley Center, Suite 117, Orange Park, Florida 32073 (904) 278-2085
❒ 324 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5005

Senate's Website: *www.flsenate.gov*

**WILTON SIMPSON**
**President of the Senate**

**AARON BEAN**
**President Pro Tempore**

**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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | SB 1712 |
| INTRODUCER: | Senators Burgess and Rodrigues |
| SUBJECT: | Veteran Suicide Prevention Training Pilot Program |
| DATE: | February 15, 2022 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Brown | Caldwell | MS | **Favorable** |
| 2. | Gerbrandt | Money | AHS | **Recommend: Favorable** |
| 3. | | | AP | |

## I. Summary:

SB 1712 requires the Department of Veterans' Affairs (department) to establish and oversee the Veteran Suicide Prevention Training Pilot Program (program). The purpose of the program is to provide training and certification in preventing veteran suicide to department claims examiners and county and city veteran service officers. The bill requires the department to contract with an organization to develop the training curriculum.

The bill requires the department to adopt rules, and submit a report to the President of the Senate and the Speaker of the House of Representatives by June 30 of each year. The report must provide information on the pilot program and recommend whether changes should be made to increase its effectiveness. In the report to be submitted by June 30, 2026, the department must recommend whether the pilot program should be continued.

A non-recurring appropriation of $500,000 is provided in the bill.

The bill takes effect on July I, 2022.

## II. Present Situation:

### Veteran Population and Suicide

#### *Veteran Population and Demographics*

As of 2017, 20 million veterans live in the United States, of which nearly 2 million are women.[1] Only about half of veterans nationally receive or access at least one benefit from the U.S.

[1] U.S. Dep't of Veterans Affairs, *National Strategy for Preventing Veteran Suicide, 2018-2028*, available at https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf (pg. 5).

Department of Veteran Affairs (VA).[2] Third in veteran population to California and Texas, Florida has more than 1.5 million veterans.[3] Of these:

- 1.17 million are wartime veterans;
- 350,000 are peacetime veterans;
- 31,000 are World War II veterans;
- 105,000 are Korean War veterans;
- 498,000 are Vietnam-era veterans;
- 188,000 are Gulf War veterans; and
- 177,494 are Post-9/11 veterans.[4]

***Mental Health of Veterans***

Veterans are known to have higher levels of mental distress than non-veterans. In a 2014 study, almost 1 in 4 veterans showed symptoms of mental illness.[5] Predominant mental health diagnoses among veterans are:

- Post-traumatic Stress Disorder (PTSD) at a rate of 15 times that of the general population;
- Depression at a rate of 5 times that of the general population; and
- Traumatic Brain Injury (TBI).[6]

Veterans who have a diagnosed mental health illness or substance use disorder are at a much higher risk of suicide than veterans without these diagnoses.[7]

***Substance Use Disorder by Veterans***

Substance use is considered to constitute a substance use disorder if the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.[8]

Substance use disorder is marked among veterans, the most prevalent being alcohol binge drinking by younger veterans and at a higher rate of misuse than by non-veterans. [9] The rate of illegal drug use, primarily marijuana (marijuana use for recreational purposes is still illegal in most states) is about the same for veterans and the general population.[10] Additionally,

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[2] *Id*.
[3] Florida Dep't of Veterans' Affairs, *Fast Facts*, available at https://www.floridavets.org/our-veterans/profilefast-facts/ (last visited Jan. 13, 2022).
[4] *Id*.
[5] National Institute on Mental Illness (NAMI); *Veterans & Active Duty* (pg. 1), available at https://www.nami.org/Your-Journey/Veterans-Active-Duty (last visited Jan. 14, 2022).
[6] *Id*.
[7] The rate of suicide among VHA patients with a mental health illness or a substance use disorder was 57.2 patients per 100,000 population, more than double the rate amount those without these diagnoses. Ramchand, Rajeev, Suicide Among Veterans: Veterans' Issues in Focus. Santa Monica, CA: RAND Corporation, 2021 available at: https://www.rand.org/pubs/perspectives/PEA1363-1.html (last visited Feb. 8, 2022).
[8] Substance Abuse and Mental Health Services Administration, U.S. Dep't of Health and Human Services, *Mental Health and Substance Use Disorders*, available at https://www.samhsa.gov/find-help/disorders (last visited Oct. 25, 2021).
[9] National Center for Biotechnology Information (NCBI), U.S. National Library of Medicine, *Substance Use Disorders in Military Veterans: Prevalence and Treatment Challenges*, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5587184/ (pg. 3).
[10] *Id*. at 4.

prescription drugs, such as opioids are being prescribed to veterans at increasing rates. Despite efforts by the VA and other agencies in recent decades to reduce substance use disorder among veterans, rates continue to increase.[11] Veterans with substance use disorders often have co-occurring medical conditions, other psychiatric disorders, poorer quality relationships, lower overall quality of life, and increased rates of suicidal ideation, attempts, and completion.[12]

***Military Sexual Trauma***

Military sexual trauma is an occurrence or occurrences of sexual harassment or sexual assault that has taken place during military service. Researchers have found a clear association between military sexual trauma and suicide. Early data finds that 1 out of 4 survivors of military sexual trauma report non-suicidal self-injury. Relatedly, non-suicidal self-injury correlates to suicidal ideation, planning, and attempts.[13]

***Suicide Rates Attributed to Service During Post 9/11 Conflicts***

An estimated 30,177 active duty service members and veterans of the post 9/11 wars have died by suicide, significantly more than the 7,057 service members that died in the post 9/11 war operations.[14] Identified causes vary.

> There are clear contributors to suicidal ideation like high exposure to trauma [(mental, physical, moral, and sexual),] stress and burnout, the influence of the military's hegemonic masculine culture, continued access to guns, and the difficulty of reintegrating into civilian life. … [W]e must also examine unique elements of the U.S. post-9/11 wars. … [W]e have seen a tremendous rise of improvised explosive devices (IEDs) in warfare, significantly increasing the number of traumatic brain injuries (TBIs), and polytrauma cases among service members.[15]

As many as 20 percent of post-9/11 service members have experienced a TBI, with many exposed to repetitive damage.[16]

***Suicide Rates between Veterans and Non-Veterans***

From the latest data reported for 2019, 553 veterans died by suicide in Florida, 524 men and 29 women, while nationally, 6,261 veterans died by suicide.[17] Nationally, suicide rates are highest

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[11] *Id*. at 2.
[12] *Id*. at 2.
[13] U.S. Dep't of Veterans Affairs, *Military Sexual Trauma -- A Risk Factor for Suicide*, available at https://www.mentalhealth.va.gov/suicide_prevention/docs/Literature-Review-Military-Sexual-Trauma-CLEARED-3-5-19.pdf.
[14] Thomas Howard Suitt, III, Watson Institute, International & Public Affairs, Brown University, *High Suicide Rates among United States Service Members and Veterans of the Post-9/11 Wars*, available at https://watson.brown.edu/costsofwar/files/cow/imce/papers/2021/Suitt_Suicides_Costs%20of%20War_June%2021%202021.pdf (June 21, 2021) (pgs. 1, 3).
[15] *Id*. at 3-4.
[16] *Id*. at 4.
[17] U.S. Dep't of Veterans Affairs, *Florida Veteran Suicide Data Sheet, 2019*, available at https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019-State-Data-Sheet-Florida-508.pdf.

among young veterans, aged 18-29 years of age.[18] In comparing suicide death rates between the veteran and non-veteran population, in 2019 the rate of suicide by the general population in Florida was 19.6 per 100,000 persons while that for Florida veterans, was 35.7.[19] A similar disparity exists at the national level, 18.0 suicide deaths per 100,000 for the general population and 31.6 for veterans.[20] More than 70 percent of the time, a firearm was used to die by suicide.[21]

It is well-documented that the Covid-19 pandemic has contributed to a significant increase in feelings of loss, anxiety, and depression.[22] However, the impact of the pandemic on suicide is unknown. Also, unknown at this time is whether the disparity in suicide rates between veterans and non-veterans will trend differently in coming years.

**Suicide Intervention Programs**

***Federal Programs***

Suicide prevention is a top clinical priority of the U.S. Department of Veterans Affairs (VA). In 2018, the department implemented a 10-year strategy for preventing veteran suicide.[23] This approach to suicide prevention involves a veteran's family, peers, and community and includes specific outreach to veterans who do not access services of the VA.[24]

VA suicide prevention initiatives include:
- Enhancing mental health services for veterans who are women.
- Broadening telehealth.
- Developing free-of-charge mobile applications for veterans and their families.
- Improving access to mental health care.
- Helping families of veterans by telephone.[25]

In implementing its suicide prevention strategy, the VA partners with other government agencies and organizations at both the national and local level to share information and training on suicide prevention.[26] To impact suicide prevention at the state level, the VA along with the Substance Abuse and Mental Health Service Administration (SAMHSA), initiated the "Governor's

[18] U.S. Dep't of Veterans Affairs, *National Strategy for Preventing Veteran Suicide, 2018-2028*, available at https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.
[19] U.S. Dep't of Veterans Affairs, *Florida Veteran Suicide Data Sheet, 2019*, available at https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019-State-Data-Sheet-Florida-508.pdf.
[20] *Id*.
[21] *Id*.
[22] *See* KFF, *The Implications of COVID-19 for Mental Health and Substance Use* (Feb. 10, 2021), available at https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/ (last visited Nov. 3, 2021).
[23] U.S. Dep't of Veterans Affairs, *National Strategy for Preventing Veteran Suicide, 2018-2028*, available at https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.
[24] *Id*. at 1.
[25] *Id*. at 11.
[26] *Id*.

Challenge to Prevent Suicide Among Service Members, Veterans, and their Families."[27] The goal of this initiative is to develop and implement a state-wide suicide prevention plan. To date, 35 states have joined the challenge, including Florida.[28,29]

The Veterans COMPACT Act of 2020 (Act) enables the VA to implement programs, policies, and reports related to transition assistance, suicide care, mental health education and treatment, health care, and women veteran care. The Act also requires the VA to pay for providing veteran emergent suicide care at VA and non-VA facilities.[30]

Most recently, in November 2021, the White House unveiled a plan to advance a comprehensive, cross-sector, evidence-based strategy for reducing suicide rates among service members and veterans.[31] This plan has several priority goals:

- Improve lethal means safety by inserting time and distance between a person in crisis and access to lethal means, such as a firearm or medication.
- Enhance crisis care and facilitating care transitions, including stabilization services.
- Increase access to and delivery of evidence-based treatment.
- Address upstream risk (leading up to crisis) and protective factors in furthering prevention efforts.
- Bridge interagency coordination.[32]

***State Programs***

The 2021 Legislature created the Florida Veterans' Care Coordination Program (program), to be established by the Department of Veterans' Affairs (department).[33] To provide services, the department is authorized to contract with a nonprofit, accredited entity to provide dedicated behavioral health care referral services, through the state's 211 Network.[34] A key goal of the program is to prevent suicide by veterans.[35]

**County and City Veteran Service Officers and Department Claims Examiners**

County and city veteran service officers are responsible for assisting Veterans and their dependents in securing all entitled benefits earned through honorable military service and to

[27] U.S. Dep't of Veterans Affairs, *2021 National Veteran Suicide Prevention Report* (Sept. 2021) (pg. 13), available at https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf.
[28] *Id.* at 14.
[29] Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Dep't of Health & Human Services, *Governor's and Mayor's Challenges to Prevent Suicide Among Service members, Veterans, and their Families*, available at https://www.samhsa.gov/smvf-ta-center/mayors-governors-challenges (last visited Jan. 14, 2022).
[30] Veterans COMPACT Act of 2020 (Pub. L. No. 116-214).
[31] The White House, *Reducing Military and Veteran Suicide: Advancing a Comprehensive, Cross-sector, Evidence-informed Public Health Strategy*, available at https://www.whitehouse.gov/wp-content/uploads/2021/11/Military-and-Veteran-Suicide-Prevention-Strategy.pdf
[32] *Id*. at 8-9.
[33] Chapter 2021-198, Laws of Fla.; s. 394.9087, F.S.
[34] Section 394.9087(1), F.S. The Florida 211 network, established in s. 408.918, F.S., operates as the single point of coordination for information and referral of health and human services (s. 408.918(1), F.S.)
[35] Section 394.9087(2)(a), F.S.

advocate for Veteran's interest in their community.[36] Current law authorizes each board of county commissioners to employ a county veteran service officer.[37] Likewise, the governing body of a city may employ a city veteran service officer.[38]

The department provides the training program for county and city veteran service officers.[39] Every county or city veteran service officer must attend the training and successfully complete a test administered by the department. The department is required to further establish periodic training refresher courses, which must be completed as a condition of continued employment.[40]

Similarly, the department employs veteran claims examiners to assist with questions and connect veterans with their earned benefits. Veteran Claims Examiners are co-located at each VA Medical Center and many VA outpatient clinics. To date, the department has on staff 89 veteran claims examiners statewide.[41]

## III. Effect of Proposed Changes:

The bill requires the Department of Veterans' Affairs (department) to establish and oversee the Veteran Suicide Prevention Training Pilot Program (program). The purpose of the program is to provide training and certification in preventing veteran suicide to agency claims examiners and county and city veteran service officers. To provide training curriculum, the bill requires the department to contract with an organization that has experience in developing and implementing veteran-relevant and evidence-based suicide prevention training.

Program participants must be trained in identifying indicators of elevated suicide risk and providing emergency crisis referrals for veterans in emotional or psychological distress.

The bill requires the department to adopt rules, and submit a report to the President of the Senate and the Speaker of the House of Representatives by June 30 of each year. The report will provide information on the pilot program and recommend whether changes should be made to increase its effectiveness. In the report to be submitted by June 30, 2026, the department must recommend whether the pilot program should be continued.

A non-recurring appropriation of $500,000 is provided in the bill.

The bill takes effect on July 1, 2022.

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[36] Leon County Government, Veterans Services, available at https://cms.leoncountyfl.gov/Home/Departments/Office-of-Human-Services-and-Community-Partnership/Veterans-Services (last visited Jan. 26, 2022).
[37] Section 292.11(1), F.S.
[38] *Id*.
[39] Section 292.11(4), F.S.
[40] *Id*.
[41] Dep't of Veterans Affairs, *2022 Agency Legislative Bill Analysis, SB 1712* (Jan. 14, 2022) (on file with the Senate Committee on Military and Veterans Affairs, Space, and Domestic Security). A veteran service officer at the city level may be found in a city such as Jacksonville, which is consolidated with Duval County. Email from Christian Cochran, Department of Veterans Affairs (Jan. 14, 2022) (on file with the Senate Committee on Military and Veterans Affairs, Space, and Domestic Security).

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

SB 1712 includes a non-recurring appropriation of $500,000 from the General Revenue Fund to the Department of Veterans' Affairs.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill creates section 394.9088 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.

**By** Senator Burgess

20-01740B-22 20221712__

A bill to be entitled

An act relating to the Veteran Suicide Prevention Training Pilot Program; creating s. 394.9088, F.S.; requiring the Department of Veterans' Affairs to establish the pilot program; providing the purpose of the pilot program; requiring pilot program participants to receive certain training; requiring the department to contract with an organization to develop the curriculum for such training; requiring the department to establish and oversee the participant certification process; requiring the department to adopt rules; requiring the department to submit an annual report to the Legislature by a specified date; providing an appropriation; providing an effective date.

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

Section 1. Section 394.9088, Florida Statutes, is created to read:

394.9088 Veteran Suicide Prevention Training Pilot Program.—

(1) The Department of Veterans' Affairs shall establish the Veteran Suicide Prevention Training Pilot Program. The purpose of the pilot program is to offer to each Department of Veterans' Affairs claims examiner and each county and city veteran service officer, as described in s. 292.11, specialized training and certification in the prevention of veteran suicide.

(2) Individuals electing to participate in the pilot







20-01740B-22 20221712__

program must be trained to identify indicators of elevated suicide risk and provide emergency crisis referrals for veterans expressing or exhibiting symptoms of emotional or psychological distress. The Department of Veterans' Affairs shall contract with an organization having proven experience developing and implementing veteran-relevant and evidence-based suicide prevention training to develop the curriculum for such training. The department shall establish and oversee the process for certifying program participants who successfully complete such training.

(3) The Department of Veterans' Affairs shall adopt rules necessary to implement the pilot program.

(4) The Department of Veterans' Affairs shall submit a report to the President of the Senate and the Speaker of the House of Representatives by June 30 of each year which includes information concerning the pilot program and whether any changes should be made to the pilot program which would increase its effectiveness. In its report submitted by June 30, 2026, the department shall include a recommendation of whether the pilot program should be continued.

Section 2. The sum of $500,000 in nonrecurring funds is appropriated from the General Revenue Fund to the Department of Veterans' Affairs for the purpose of implementing this act.

Section 3. This act shall take effect July 1, 2022.

The Florida Senate

# Committee Agenda Request

**To:** Senator Aaron Bean, Chair
Appropriations Subcommittee on Health and Human Services

**Subject:** Committee Agenda Request

**Date:** January 26, 2022

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I respectfully request that **Senate Bill #1712**, relating to Veterans Suicide Prevention Training Pilot Program, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Danny Burgess
Florida Senate, District 20

File signed original with committee office

S-020 (03/2004)

2/16/22
Meeting Date

HEAS
Committee

# The Florida Senate
# APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

SB 1712 T6
Bill Number or Topic

Amendment Barcode (if applicable)

Name MAJOR GENERAL HARTSELL FDVA Phone (850)487-1533

Address 400 S. MONROE ST Suite 2105 Email HARTSELLJC@FDVA.State.FL
Street

TALLAHASSEE FL 32399
City State Zip

**Speaking:** ☐ For ☐ Against ☐ Information **OR** **Waive Speaking:** ☑ In Support ☐ Against

**PLEASE CHECK ONE OF THE FOLLOWING:**

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: FDVA

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

*While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)*

**This form is part of the public record for this meeting.**

S-001 (08/10/2021)

**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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | PCS/SB 1770 (860032) |
| INTRODUCER: | Appropriations Subcommittee on Health and Human Services and Senator Book |
| SUBJECT: | Donor Human Milk Bank Services |
| DATE: | February 18, 2022 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Smith | Brown | HP | **Favorable** |
| 2. | McKnight | Money | AHS | **Recommend: Fav/CS** |
| 3. | | | AP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

PCS/SB 1770 authorizes the Florida Medicaid program to reimburse for donor human milk for hospital inpatient use. The Medicaid coverage would be for infants who are medically or physically unable to receive maternal breast milk or whose mother is medically or physically unable to produce maternal breast milk or breastfeed, and who also meet specified eligibility factors. The bill also requires the Agency for Health Care Administration (AHCA) to establish provider eligibility, by rule, and authorizes the AHCA to seek any necessary federal approvals to implement the new coverage benefit.

The bill has a significant negative fiscal impact to the Florida Medicaid program. *See* Section V of this analysis.

The bill takes effect on July 1, 2022.

## II. Present Situation:

### Donor Human Breast Milk

According to the federal Centers for Disease Control and Prevention (CDC), breast milk is the best source of nutrition for most infants.[1] Ideally, an infant should be fed his or her own mother's

[1] Centers for Disease Control and Prevention, *Frequently Asked Questions* (FAQ) (Aug. 10, 2021) *available at* https://www.cdc.gov/breastfeeding/faq/index.htm (last visited Jan. 22, 2022).

breast milk because nutritional components within the mother's breast milk change to meet the infant's needs as he or she ages.[2] Mothers of infants born prematurely are sometimes unable to produce milk because their bodies are not ready, they too are sick, or they are affected by the stress of having their premature infant in intensive care.[3] Breast milk donated by nursing mothers provides an option for infants who are unable to receive adequate nutrition from their mother's own milk or from commercial infant formulas. Very few illnesses are transmitted via breast milk, even in cases where someone else's breast milk is given to another child.[4]

The American Academy of Pediatrics notes that human donor breast milk can be effective for high-risk and very low birthweight infants if the child's mother is unable to provide enough milk.[5] Additionally, the World Health Organization (WHO) indicates that human donor breast milk can prevent some digestive disorders but specifies that any donor milk must come from safe facilities and is not recommended for sick infants or those weighing less than 1000 grams.[6, 7] In the absence of a mother's milk, the WHO notes that standard formula is also an acceptable alternative.[8]

Currently, the federal Food and Drug Administration (FDA) considers human donor breast milk a "food" source rather than a medical product. The FDA does not have established guidelines or standards for human donor breast milk or milk banks, although it does recommend consulting with a health care provider before feeding it to an infant.[9] Additionally, the FDA recommends that the caregiver only feed an infant milk from a source that has screened its donors and has taken precautions to ensure milk safety, such as a milk bank.[10]

***The Human Milk Banking Association of North America (HMBANA)***

Founded in 1985, the Human Milk Banking Association of North America (HMBANA) serves as the professional organization that accredits nonprofit milk banks in the United States and Canada.[11] The HMBANA is funded by membership fees from its 31 member nonprofit milk banks, foundation funds, and individual donors.[12] There is one HMBANA-accredited location in

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[2] *Id.*
[3] Naseem S. Miller, *Bill aims to get Medicaid coverage for donor breast milk: 'Something like this makes smart policy'*, Orlando Sentinel (Mar. 15, 2019) *available at* https://www.orlandosentinel.com/health/os-ne-mothers-milk-bank-bill-20190315-story.html (last visited Jan. 22, 2022).
[4] Centers for Disease Control and Prevention, *Frequently Asked Questions* (FAQ) (Aug. 10, 2021) *available at* https://www.cdc.gov/breastfeeding/faq/index.htm (last visited Jan. 22, 2022).
[5] American Academy of Pediatrics Committee on Nutrition, Section on Breastfeeding and Committee on Fetus and Newborn, Policy Statement, *Donor Human Milk for the High-Risk Infant: Preparation, Safety, and Usage Options in the United States* (Jan. 2017) *available at* https://publications.aap.org/pediatrics/article/139/1/e20163440/52000/Donor-Human-Milk-for-the-High-Risk-Infant (last visited Jan. 22, 2022).
[6] Agency for Health Care Administration, *Senate Bill 240 Fiscal Analysis* (Dec. 28, 2020) (on file with Senate Committee on Health Policy).
[7] World Health Organization, *Recommendations for the Feeding of low-birth-weight infants in low- and middle-income countries, available at* https://www.who.int/elena/titles/full_recommendations/feeding_lbw/en/ (last visited Jan. 22, 2022).
[8] *Id.*
[9] U.S. Food and Drug Administration, *Use of Donor Human Milk* (Mar. 22, 2018) *available at* https://www.fda.gov/science-research/pediatrics/use-donor-human-milk (last visited Jan. 22, 2022).
[10] *Id.*
[11] Human Milk Banking Association of North America, *About Us*, *available at* https://www.hmbana.org/about-us/ (last visited Jan. 22, 2022).
[12] *Id.*

Florida – the Mother's Milk Bank of Florida located in Orlando.[13] The Mother's Milk Bank of Florida supplies pasteurized donor human milk to 38 of the 68[14] neonatal intensive care units (NICUs) in Florida, as well as to medically fragile babies at home.[15]

***HMBANA Safety Guidelines[16]***

The HMBANA reports that its member milk banks follow guidelines that were developed by the HMBANA in consultation with the CDC and the FDA. The FDA reports that it has not been involved in establishing these voluntary guidelines.[17] According to the AHCA, no federal or state regulations are in place to oversee the Mother's Milk Bank of Florida.[18]

Under the HMBANA's guidelines, before milk is collected, each donor is strictly screened for medical and lifestyle risk factors and serum is screened for HIV, HTLV, syphilis, and Hepatitis B and C.[19] After the milk is collected, it is mixed and pooled so that each pool includes human milk from three to five donors. This is done to ensure an even distribution of nutritional components. Bottles are filled with the pooled milk and then the milk is pasteurized to eliminate potentially harmful bacteria while retaining the majority of the milk's beneficial nutrients. Milk samples are taken during the pasteurization process and cultured to check for bacterial growth. Any contaminated milk is discarded. No milk is dispensed after pasteurization until a culture is found to be negative for bacteriological growth. After pasteurization, the milk is frozen and shipped to hospitals and outpatient families.

**AHCA Report on Donor Human Milk[20]**

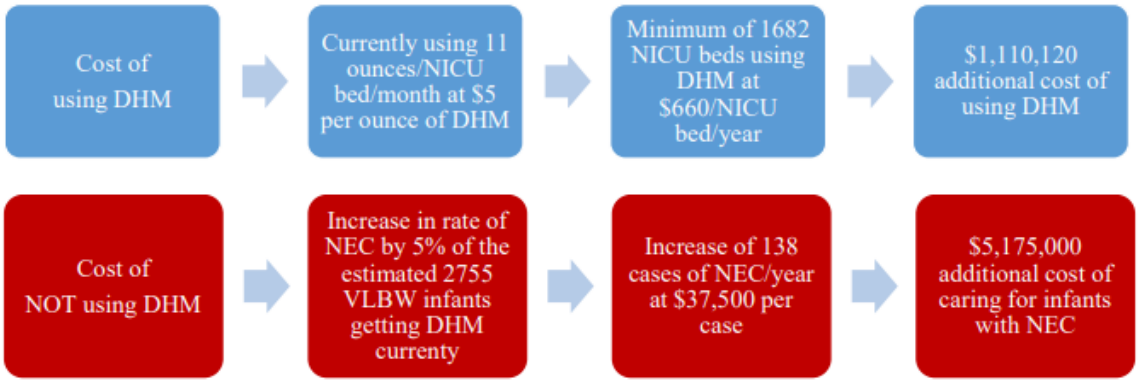
In 2021, the Legislature required the Agency for Health Care Administration (AHCA), in consultation with the Department of Health (DOH), to study and report on the use of donor human milk as a supplement to newborn care and health specific to newborn infants born prematurely and hospitalized within the NICU.[21] On November 1, 2021, the report was published. The study reports that a survey of Florida NICUs in 2021 determined that 86 percent of them use pasteurized donor human milk (PDHM). The most common reasons for administering PDHM were prematurity (92 percent), birth weight threshold (76 percent), and

[13] *Id.*
[14] Naseem S. Miller, *Bill aims to get Medicaid coverage for donor breast milk: 'Something like this makes smart policy'*, Orlando Sentinel (Mar. 15, 2019) *available at* https://www.orlandosentinel.com/health/os-ne-mothers-milk-bank-bill-20190315-story.html (last visited Jan. 22, 2022).
[15] Mothers' Milk Bank of Florida, *Covid-19 Update*, *available at* https://milkbankofflorida.org/covid-19-update/ (last visited Jan. 22, 2022).
[16] Human Milk Banking Association of North America, *Milk Processing and Safety*, *available at* https://www.hmbana.org/our-work/milk-processing-safety.html (last visited Jan. 22, 2022).
[17] U.S. Food and Drug Administration, *Use of Donor Human Milk* (Mar. 22, 2018) *available at* https://www.fda.gov/science-research/pediatrics/use-donor-human-milk (last visited Jan. 22, 2022).
[18] Agency for Health Care Administration, *Senate Bill 240 Fiscal Analysis* (Dec. 28, 2020) (on file with Senate Committee on Health Policy).
[19] Human Milk Banking Association of North America, *Milk Banking and COVID-19* (Apr. 2, 2020) *available at* https://www.hmbana.org/file_download/inline/a04ca2a1-b32a-4c2e-9375-44b37270cfbd (last visited Jan. 22, 2022).
[20] Agency for Health Care Administration, Donor Human Milk Legislative Report (Nov. 1, 2021) (on file with Senate Committee on Health Policy).
[21] Chapter 2021-36, s. 3, Laws of Fla.

medical necessity (71 percent) determined by the attending physician based on diagnosis and symptoms.
The report includes recommendations of best practices for the oversight of milk banks and their staff, operating procedures, standards for donor screening, and recommendations for the collection, storage, handling, processing, and dispending of donor human milk. In addition, the report addresses the need for high-quality clinical studies to quantify the efficacy and cost-effectiveness of donor human milk derivatives.

The AHCA report also conducted an economic analysis on the impact of inpatient feeding of PDHM. While PDHM use is not currently reimbursable by the Florida Medicaid program or commercial health insurance companies, some Florida hospitals have earned grant funding or donations to support the provision of PDHM, and most large facilities using PDHM have chosen to do so knowing that the cost will not be reimbursed. These facilities balance the direct costs of PDHM use with better outcomes, in hopes that improved outcomes will ultimately decrease total cost of care by reducing risk and severity of necrotizing enterocolitis (NEC), a severe and lethal complication affecting premature and low birth weight infants, and other illnesses associated with prematurity.

In Florida, approximately 3,500 infants are born with a very low birth weight (VLBW) (birth weight less than 1,500 grams or 3.5 pounds) annually. The AHCA report found that if Florida NICUs were to stop using PDHM, there would be a 5 percent increase in the number NEC cases from the 2,755 VLBW infants born annually in Florida. As illustrated in the chart below, when comparing costs of providing PDHM ($1.1 million) to estimated costs of not using PDHM ($5.2 million), there is an estimated $4.1 million cost avoidance statewide among all payers.




The report finds that the avoided cost is largely predicated on the management of NEC. This cost-avoidance is among all payers; however, it is particularly relevant to the Florida Medicaid program given its coverage of over 50 percent of births in the State of Florida. Furthermore, the report states that this cost-avoidance with PDHM is an underestimate, as it does not factor in additional benefits after the birth hospitalization with respect to readmissions, home nursing, and emergency room visits.

**Florida Medicaid Program**

The Medicaid program is a joint federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults and persons with disabilities.[22] The Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for administering the federal Medicaid program. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the AHCA and financed through state and federal funds.[23]

A Medicaid state plan is an agreement between a state and the federal government describing how the state administers its Medicaid programs. The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements.

In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives states the flexibility to cover other population groups (optional eligibility groups). States set individual eligibility criteria within federal minimum standards. The AHCA may seek an amendment to the state plan as necessary to comply with federal or state laws or to implement program changes. States send state plan amendments to the federal CMS for review and approval.[24]

Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, the AHCA contracts with private managed care plans for the coordination and payment of services for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan.

In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program.[25] The SMMC program has two components, the Managed Medical Assistance (MMA) program and the Long-Term Care program. Florida's SMMC offers a health care package covering both acute and long-term care.[26] The SMMC benefits are authorized by federal authority and are specifically required in ss. 409.973 and 409.98, F.S.

The AHCA contracts with managed care plans on a regional basis to provide services to eligible recipients. The MMA program, which covers most medical and acute care services for managed care plan enrollees, was fully implemented in August 2014, and was re-procured for a period beginning December 2018 and ending in 2023.[27] In 2020, the Legislature extended the allowable

[22] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid/index.html (last visited Jan. 22, 2022).
[23] Section 20.42, F.S.
[24] Medicaid.gov, *Medicaid State Plan Amendments, available at* https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html (last visited Jan. 22, 2022).
[25] *Id.*
[26] *Id.*
[27] *Id.*

term of the SMMC contracts from five to six years.[28] As a result, the AHCA's current contracts will end in December 2024.

***Medical Necessity Requirements***

Florida Medicaid covers services that are medically necessary, as defined in its Medicaid state plan pursuant to Rule 59G-1.010 of the Florida Administrative Code. The AHCA routinely reviews new health services, products, and supplies to assess potential coverage under Florida Medicaid which depends on whether that service, product, or supply is medically necessary.[29] Care, goods, and services are deemed medically necessary if they are:

- Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Reflective of the level of service that can be safely furnished, and *for which no equally effective and more conservative or less costly treatment is available statewide*; and
- Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.[30]

Under federal law, Medicaid states must have a process in place to pay for services that are medically necessary but are not covered for recipients under the age of 21.[31] This is often referred to as the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) guidelines. Health plans participating in the SMMC program must also adhere to EPSDT guidelines.[32]

**Coverage of Nutritional Supplements for Infants in Florida[33]**

Florida Medicaid covers prescription enteral and parenteral commercial formulas under the Durable Medical Equipment and Supplies benefit, when medically necessary. Commercial formula would be considered medically necessary for infants diagnosed with conditions such as metabolic disorders or who are unable to accept nutrition orally. In addition, if an infant needs commercial formula during an inpatient hospital stay, it would be covered as part of the all-inclusive payment to the hospital, just as needed food or medicine would be covered for a patient of any age.

The Women, Infants, and Children (WIC) program is a federally funded program that provides nutritional support for women and children. Administered by the DOH, WIC provides food assistance such as milk and infant and toddler formulas. If a child is not able to consume a

[28] Chapter 2020-156, s. 44, Laws of Fla.
[29] Agency for Health Care Administration, *Senate Bill 240 Fiscal Analysis* (Dec. 28, 2020) (on file with Senate Committee on Health Policy).
[30] 59G-1.010, F.A.C.
[31] 42 C.F.R. s. 441 Subpart B.
[32] *Id.*
[33] *Supra* note 30.

contract formula,[34] WIC can make exceptions and provide non-contract formulas with appropriate medical documentation. Contract formulas currently available through WIC include: Enfamil, Enfagrow, Gerber Good Start Soy 1, and Gerber Good Start Soy 3. WIC does not provide human donor breast milk to program participants.

Florida Medicaid does not reimburse separately for human donor breast milk or contract formulas covered through WIC. If an infant needed human donor breast milk outside of the hospital setting, a request would need to be made through the EPSDT coverage process. The AHCA reports that it is not aware of any such requests being made for infants in fee-for-service or Medicaid managed care.[35]

Most private insurers do not cover donor human breast milk, which costs approximately $4 an ounce and can add up to over $1,000 per month per infant.[36] Through donations and fundraisers, the Mother's Milk Bank of Florida provides grants to low-income families to make donor human breast milk more affordable.[37]

**Medicaid Coverage of Human Donor Breast Milk in Other States**

Currently nine states (California, Connecticut, Iowa, Kansas, Missouri, New Jersey, New York, Texas, and Utah) and the District of Columbia, provide coverage for human donor milk under their state Medicaid programs.[38]

**State Medicaid Coverage Policies for Donor Human Milk[39]**

| State/Territory | Description of Coverage | HMBANA Bank in State |
|---|---|---|
| California | Coverage when mother's own milk is insufficient, or infant cannot breastfeed, or contraindication to formula. Cover for inpatient and outpatient. | Yes |
| Connecticut | Coverage when medically necessary, infant unable to breastfeed, or mother unable to produce insufficient milk. | No |
| Iowa | Coverage for infants in the inpatient setting. | Yes |

[34] Commercial infant formula manufacturers provide substantial discounts, in the form of rebates, to state WIC programs in return for the exclusive right to provide their products to the state's WIC participants. Commercial formulas whose manufacturers have those exclusive rights are considered "contract formulas." *See* Steven Carlson, Robert Greenstein, and Zoe Neuberger, Center on Budget and Policy Priorities, *WIC's Competitive Bidding Process for Infant Formula Is Highly Cost-Effective* (Feb. 17, 2017) *available at* https://www.cbpp.org/sites/default/files/atoms/files/6-26-15fa.pdf (last viewed Mar. 4, 2021).
[35] Agency for Health Care Administration, *Senate Bill 240 Fiscal Analysis* (Dec. 28, 2020) (on file with Senate Committee on Health Policy).
[36] Naseem S. Miller, *Bill aims to get Medicaid coverage for donor breast milk: 'Something like this makes smart policy'*, Orlando Sentinel (Mar. 15, 2019) *available at* https://www.orlandosentinel.com/health/os-ne-mothers-milk-bank-bill-20190315-story.html (last visited Jan. 22, 2022).
[37] *Id*.
[38] Agency for Health Care Administration, Donor Human Milk Legislative Report (Nov. 1, 2021) (on file with Senate Committee on Health Policy).
[39] *Id*.

| | | |
|---|---|---|
| Kansas | Coverage for infants under 3 months of age who are critically ill and have medical necessity. Coverage for NICU only. Prior authorization required. | No |
| Missouri | Coverage for infants under 3 months of age who are critically ill and have medical necessity for human milk diet. Coverage for NICU only. | Yes |

| **State Medicaid Coverage Policies for Donor Human Milk[40]** | | |
|---|---|---|
| New Jersey | Coverage for infants under 6 months of age, infant unable to breastfeed, mother unable to produce sufficient milk, infant body weight below healthy level, or medically necessary. Coverage for inpatient and outpatient. | No |
| New York | Coverage for infants with birth weights less than 1,500 grams, infant unable to breastfeed, mother unable to produce sufficient milk, or medical necessity. Coverage for inpatient. Prior authorization required. | Yes |
| Texas | Coverage for inpatient infants at or under six months of age with medical necessity. Coverage for outpatient infants at or under 11 months of age but may be extended through 20 years with inability to tolerate formula and medical necessity. Prior authorization for outpatient. Subsequent reauthorization for both inpatient and outpatient. | Yes |
| Utah | Coverage for infants under 11 months of age with medical necessity. Cover for outpatient only. Prior authorization with reauthorization. | Yes |
| District of Columbia | Coverage of infants under 11 months of age who are unable to tolerate formula and have medical necessity. Coverage for inpatient and outpatient. Prior authorization and reauthorization required. | No |

## III. Effect of Proposed Changes:

**Section 1** amends s. 409.906, F.S., to authorize the Agency for Health Care Administration (AHCA) to reimburse through Florida Medicaid for the cost of donor human milk for inpatient use as ordered by a licensed physician, nurse practitioner, physician assistant, or dietician.

To be eligible, the infant's mother must be medically or physically unable to produce breastmilk or breastfeed; the infant must be medically unable to receive maternal breast milk or breastfeed, or physically unable to receive maternal milk or breastfeed. In addition, the infant must have a documented birth weight of 1,800 grams or less, and:

[40] Agency for Health Care Administration, Donor Human Milk Legislative Report (Nov. 1, 2021) (on file with Senate Committee on Health Policy).

- Have a congenital or acquired condition and be at high risk for developing a feeding intolerance, necrotizing enterocolitis, or an infection; or
- Otherwise have a medical indication for a human milk diet.

**Section 2** amends s. 409.908, F.S., to authorize Florida Medicaid to pay for donor human milk bank services as an optional covered service in the fee-for service delivery system.

**Section 3** amends s. 409.973, F.S., to require health plans participating in the Statewide Medicaid Managed Care program to cover donor human milk bank services.

**Section 4** provides an effective date of July 1, 2022.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact[41]:

Because human donor milk is not currently a covered service, PCS/SB 1770 would have a significant negative fiscal impact on the Florida Medicaid program. Based on data provided by the Agency for Health Care Administration (AHCA), the maximum estimated cost to the Florida Medicaid program in Fiscal Year 2022-2023 is a recurring $4.1 million, of which $1.6 million is general revenue.

The AHCA's estimate assumes 50 percent of infants with birth weights of 1,999 grams or less are eligible for Florida Medicaid, even though the bill would only reimburse for infants weighing 1,800 grams or less. The AHCA utilizes diagnosis codes for birth weights of up to 1,749 grams and up to 1,999 grams; there is no code tied to a birth weight of 1,800 grams. Therefore, the AHCA used the code associated with 1,999 grams to ensure infants weighing 1,800 grams or less are included in the estimate.

| | Infants Eligible for Donor Milk | Estimated Total Fiscal Impact | General Revenue | Trust Fund |
|---|---|---|---|---|
| Infants born <1500g | 843 | $ 2,758,806 | $ 1,095,246 | $ 1,663,560 |
| Infants born 1500g-1999g | 1009 | $ 1,300,690 | $ 516,374 | $ 784,316 |
| **Total** | **1852** | **$ 4,059,496** | **$ 1,611,620** | **$ 2,447,876** |

It is unknown how many infants would satisfy the health conditions specified in the bill and meet Medicaid's medical necessity criteria. However, taking into consideration the cost comparison of providing donor human milk to estimated costs of not using donor human as reported in the AHCA's Donor Human Milk Legislative Report to the Florida Legislature and highlighted in Section 2 of this bill analysis, there is a possible cost avoidance statewide among all payers particularly relevant to the Florida Medicaid program, given its coverage of over 50 percent of births in the State of Florida. Furthermore, the AHCA report states that this cost-avoidance with donor human milk is an underestimate, as it does not factor in additional benefits after the birth hospitalization with respect to readmissions, home nursing, and emergency room visits. Without additional data on the additional benefits, any potential savings that would offset costs realized from a policy change are indeterminate at this time.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

[41] Email from the Agency for Health Care Administration to the Senate Appropriations Subcommittee on Health and Human Services (Feb. 15, 2022) (on file with the Senate Appropriations Subcommittee on Health and Human Services).

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.906, 409.908, and 409.973.

## IX. Additional Information:

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

**Recommended CS by Appropriations Subcommittee on Health and Human Services on February 16, 2022:**
The committee substitute:

- Permits the Medicaid program to pay only for inpatient use of donor human milk and products.
- Adds physician assistants and dieticians to the list of approved health care providers who may order such products for payment by Medicaid.
- Increases the infant maximum documented birth weight from 1,500 grams or less, to 1,800 grams or less, for eligibility for payment of donor human or donor human milk products.
- Removes the requirement that donor human milk or donor human milk products be obtained from a nonprofit milk bank certified by the Human Milk Banking Association of North America.
- Removes the cost reimbursement floor for donor human milk or donor human milk products.
- Requires the Agency for Health Care Administration (AHCA) to establish provider eligibility, by rule, and authorizes the AHCA to seek any necessary federal approvals to implement the new coverage benefit.

B. Amendments:

None.

272010

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 02/16/2022 | . | |
| | . | |
| | . | |
| | . | |

Appropriations Subcommittee on Health and Human Services (Book) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 41 - 56

and insert:

(28) DONOR HUMAN MILK BANK SERVICES.—The agency may pay for the provision of donor human milk and human milk products derived therefrom for inpatient use, for which a licensed physician, nurse practitioner, physician assistant, or dietitian has issued an order for an infant who is medically or physically unable to receive maternal breast milk or to breastfeed or whose

272010

mother is medically or physically unable to produce maternal breast milk or breastfeed. Such infant must have a documented birth weight of 1,800 grams or less; have a congenital or acquired condition and be at high risk for developing a feeding intolerance, necrotizing enterocolitis, or an infection; or otherwise have a medical indication for a human milk diet. The agency shall adopt rules that include, but are not limited to, eligible providers of donor human milk and donor human milk derivates. The agency may seek federal approval necessary to implement this subsection.

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

And the title is amended as follows:

Delete line 7

and insert:

requirements; requiring the agency to adopt rules; authorizing the agency to seek federal approval; amending s. 409.908, F.S.; adding donor

**By** Senator Book

32-00150-22 20221770__

A bill to be entitled

An act relating to donor human milk bank services; amending s. 409.906, F.S.; authorizing the Agency for Health Care Administration to pay for donor human milk bank services as an optional Medicaid service if certain conditions are met; specifying coverage requirements; amending s. 409.908, F.S.; adding donor human milk bank services to the list of Medicaid services authorized for reimbursement on a fee-for-service basis; amending s. 409.973, F.S.; adding donor human milk bank services to the list of minimum benefits required to be covered by Medicaid managed care plans; providing an effective date.

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

Section 1. Subsection (28) is added to section 409.906, Florida Statutes, to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees,







32-00150-22 20221770__

reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(28) DONOR HUMAN MILK BANK SERVICES.—The agency may pay for the cost of donor human milk, for home and inpatient use, for which a licensed physician or nurse practitioner has issued an order for an infant who is medically or physically unable to receive maternal breast milk or breastfeed or whose mother is medically or physically unable to produce maternal breast milk or breastfeed. Such infant must have a documented birth weight of 1,500 grams or less; have a congenital or acquired intestinal condition and be at high risk for developing a feeding intolerance, necrotizing enterocolitis, or an infection; or otherwise require nourishment by breast milk. The donor human milk must be procured from a nonprofit milk bank certified by the Human Milk Banking Association of North America (HMBANA). Coverage for donor human milk may not be less than the reasonable cost of such milk procured from an HMBANA-certified milk bank, plus reasonable processing and handling fees.

Section 2. Present paragraphs (f) through (t) of subsection (3) of section 409.908, Florida Statutes, are redesignated as

paragraphs (g) through (u), respectively, and a new paragraph (f) is added to that subsection, to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid-eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the





adjustment is consistent with legislative intent.

(3) Subject to any limitations or directions provided for in the General Appropriations Act, the following Medicaid services and goods may be reimbursed on a fee-for-service basis. For each allowable service or goods furnished in accordance with Medicaid rules, policy manuals, handbooks, and state and federal law, the payment shall be the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the agency, whichever amount is less, with the exception of those services or goods for which the agency makes payment using a methodology based on capitation rates, average costs, or negotiated fees.

(f) Donor human milk bank services.

Section 3. Present paragraphs (e) through (bb) of subsection (1) of section 409.973, Florida Statutes, are redesignated as paragraphs (f) through (cc), respectively, and a new paragraph (e) is added to that subsection, to read:

409.973 Benefits.—

(1) MINIMUM BENEFITS.—Managed care plans shall cover, at a minimum, the following services:

(e) Donor human milk bank services.

Section 4. This act shall take effect July 1, 2022.

The Florida Senate

# APPEARANCE RECORD

Deliver both copies of this form to Senate professional staff conducting the meeting

2/6/22
Meeting Date

HHS Appropriations
Committee

1770T1
Bill Number or Topic

Amendment Barcode (if applicable)

Name Teye Carmichael

Phone 8507285490

Address 311 E. Park Ave.
Street

Email tcarmichael@smithbryanandmyers.com

Tallahassee FL 32301
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

**PLEASE CHECK ONE OF THE FOLLOWING:**

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: FANA

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

*While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)*

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

# APPEARANCE RECORD

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02/16/2022
Meeting Date

Appropriations Subcommittee on Health & Human Services
Committee

1770
Bill Number or Topic

272010
Amendment Barcode (if applicable)

Name Jason Rodriguez

Phone (727)6564256

Address 2985 Drew Street
*Street*

Email jason.rodriguez@baycare.org

Clearwater — *City*
FL — *State*
33759 — *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

**PLEASE CHECK ONE OF THE FOLLOWING:**

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
BayCare

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

*While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)*

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

# APPEARANCE RECORD

2/16/2022
Meeting Date

Sub Health & Human Servic
Committee

Deliver both copies of this form to
Senate professional staff conducting the meeting

1770 Tab 7
Bill Number or Topic

Amendment Barcode (if applicable)

Name Kandis Natoli PhD, RN, IBCLC

Phone 407-248-9505 0

Address 8669 Commodity Cir Suite 490
Street

Email Knatoli@milkbankofflorida.org

Orlando FL 32819
City State Zip

Speaking: ☒ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

**PLEASE CHECK ONE OF THE FOLLOWING:**

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

*While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)*

This form is part of the public record for this meeting.

S-001 (08/10/2021)

**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 Appropriations Subcommittee on Health and Human Services

| | |
|---|---|
| BILL: | PCS/CS/SB 1950 (625186) |
| INTRODUCER: | Appropriations Subcommittee on Health and Human Services; Health Policy Committee; and Senator Brodeur |
| SUBJECT: | Statewide Medicaid Managed Care Program |
| DATE: | February 18, 2022 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Smith | Brown | HP | **Fav/CS** |
| 2. | McKnight | Money | AHS | **Recommend: Fav/CS** |
| 3. | | | AP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:


PCS/CS/SB 1950 makes changes to the Statewide Medicaid Managed Care (SMMC) program in anticipation of the next competitive procurement for the 2025 plan year. The bill:

- Requires provider service networks (PSNs) to be reimbursed on a prepaid basis.
- Authorizes the Agency for Health Care Administration (AHCA) to select eligible managed care plans to provide services through a single statewide procurement and deletes the requirement that the AHCA conduct separate and simultaneous procurements for each Medicaid region.
- Authorizes the AHCA to award contracts to managed care plans on a regional or statewide basis.
- Outlines a new regional structure for plan selection under the SMMC program's Managed Medical Assistance (MMA) and Long-Term Care (LTC) programs with a minimum and maximum number of plans designated for each region. The bill provides for eight regions named by letters (Regions A-H), rather than the 11 regions named by numbers (Regions 1-11) in current law.
- Requires the AHCA to award a contract to at least one PSN in each of the eight regions under the MMA program and under the LTC program.
- Requires managed care plans to include Florida cancer hospitals that meet specified federal criteria in their networks as essential providers.

- Revises MMA plan healthy behaviors program requirements to include tobacco cessation programs, rather than smoking cessation programs, and to clarify that substance abuse programs must include opioid abuse recovery.
- Authorizes an MMA Child Welfare Specialty Plan to serve a child in a permanent guardianship situation whose parents receive payments through the Guardianship Assistance Program.
- Deletes obsolete language.

The bill has a significant negative fiscal impact to the Florida Medicaid program. *See* Section V of this analysis.

The bill takes effect on July 1, 2022.

## II. Present Situation:

### Florida Medicaid Program

The Medicaid program is a joint federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults, and persons with disabilities.[1] The Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for administering the federal Medicaid program. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the Agency for Health Care Administration (AHCA) and financed through state and federal funds.[2]

A Medicaid state plan is an agreement between a state and the federal government describing how the state administers its Medicaid programs. The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements.

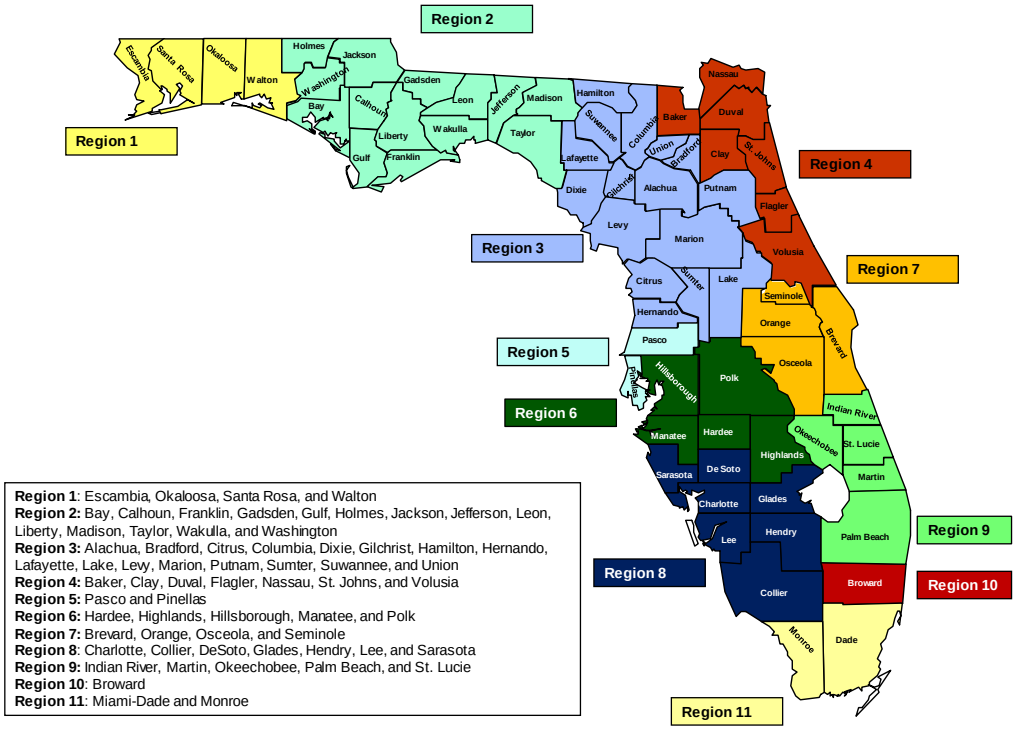
In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives states the flexibility to cover other population groups (optional eligibility groups). States set individual eligibility criteria within federal minimum standards. The AHCA may seek an amendment to the state plan as necessary to comply with federal or state laws or to implement program changes. States send state plan amendments to the federal CMS for review and approval.[3]

Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service or managed care. Under fee-for-service, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, the state contracts with private managed care plans for the coordination and payment of services for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan.

[1] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid/index.html (last visited Jan. 23, 2022).
[2] Section 20.42, F.S.
[3] Medicaid.gov, *Medicaid State Plan Amendments, available at* https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html (last visited Jan. 23, 2022).

**Statewide Medicaid Managed Care (SMMC) Program**

In 2011, the Legislature established the Medicaid program as a statewide, integrated managed care program for all covered services, and directed the AHCA to create the Statewide Medicaid Managed Care (SMMC) program and contract with managed care plans on a regional basis to provide services to eligible recipients.[4] The SMMC minimum benefits are authorized by federal authority and are specifically required in s. 409.973, F.S., for Managed Medical Assistance (MMA) plans and s. 409.98, F.S., for Long-Term Care (LTC) plans.




Today, the majority of Florida Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the SMMC program. The SMMC program has three components:

- MMA: provides Medicaid covered medical services like doctor visits, hospital care, prescribed drugs, mental health care, and transportation to these services.[5]
- LTC: provides Medicaid LTC services like care in a nursing facility, assisted living, or at home. To get LTC you must be at least 18 years old and meet nursing home level of care (or meet hospital level of care if you have Cystic Fibrosis).[6]
- Dental: provides all Medicaid dental services for children and adults. All individuals on Medicaid must enroll in a dental plan.[7]

[4] Chapter 2011-134, Laws of Fla.
[5] Agency for Health Care Administration, *Statewide Medicaid Managed Care, Health Plans and Programs, available at* https://www.flmedicaidmanagedcare.com/health/comparehealthplans (last visited Feb. 9, 2022).
[6] *Id.*
[7] *Id.*

***Eligible Plan Selection***

The SMMC program was fully implemented in August 2014. During the initial SMMC procurement, the AHCA awarded contracts to 18 plans, including seven provider service networks (PSNs). By the end of the first contract period, due to various mergers, acquisitions, and conversions to HMO status, only one PSN remained.[8]

During the second procurement, beginning December 2018 and ending in December 2023, the AHCA awarded contracts to 16 plans, including five PSNs, but only three of the PSNs currently remain in the program due to mergers and acquisitions with a total of 10 health plans.[9] In 2020, the Legislature extended the allowable term of the SMMC contracts from five to six years.[10] As a result, the AHCA's current contracts will end in December 2024. The AHCA will conduct its next procurement in Fiscal Year 2022-2023 for implementation in the 2025 plan year.

Various mergers and acquisitions have occurred during the lifecycle of each SMMC contract, resulting in a situation where a majority of enrollees are receiving services from statewide plans that operate in all 11 regions. As of October 1, 2021, 40 percent of the SMMC population, including those enrolled in a specialty plan, were enrolled in a plan operating statewide and 79 percent were enrolled in a plan that operates in at least eight of the 11 regions. The chart below reflects the current operational SMMC plans in their designated regions as of October 1, 2021:[11]

| **SMMC Health Plans by Region (2018-2024)** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** |
| **MMA Health Plans** | | | | | | | | | | | |
| *AmeriHealth* | | | | | | | | | ✓ | | ✓ |
| *Community Care Plan* | | | | | | | | | | ✓ | |
| *Simply Healthcare* | ✓ | ✓ | | | | | | | ✓ | | |
| *Vivida Health* | | | | | | | | ✓ | | | |
| **Comprehensive Plans (MMA & LTC Combined)** | | | | | | | | | | | |
| *Aetna Better Health* | | | | | | ✓ | ✓ | | | | ✓ |
| *Humana Medical Plan* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| *Molina Healthcare* | | | | | | | | ✓ | | | ✓ |
| *Simply Healthcare* | | | | | ✓ | ✓ | ✓ | | | ✓ | ✓ |
| *Sunshine Health* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| *United Healthcare* | | | ✓ | ✓ | | ✓ | | | | | ✓ |
| **Specialty Plans** | | | | | | | | | | | |
| *CMS Plan* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| *Clear Health Alliance* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| *Molina SMI Specialty* | | | | ✓ | ✓ | | ✓ | | | | |
| *Sunshine SMI Specialty* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| *Sunshine Child Welfare* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

[8] Agency for Health Care Administration, 2022 Agency Legislative Bill Analysis for SB 1950, Jan. 19, 2022 (on file with the Senate Committee on Health Policy).
[9] *Id.*
[10] Chapter 2020-156, s. 44, Laws of Fla.
[11] Agency for Health Care Administration, *Statewide Medicaid Managed Care, available at* https://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/SMMC_Plans_by_Region.pdf (last visited Feb. 9, 2022).

***Provider Service Networks (PSNs)***

A PSN in the Medicaid program is a managed care plan established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions.[12] The health care providers must have a controlling interest in the governing body of the PSN. The AHCA is authorized to contract with PSNs under s. 409.912(1), F.S., and may currently reimburse PSNs on a fee-for-service basis with a shared savings settlement or on a prepaid basis with per-member, per-month payments. A PSN may be reimbursed on a fee-for-service basis for only the first two years of the plan's operation.[13]

***Specialty Plans[14]***

An MMA managed care plan can participate in the MMA program as a standard plan or as a specialty plan. A specialty plan is a managed care plan that serves Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis.[15] Under federal Medicaid law and the SMMC waiver, each recipient has a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient.[16] If a specialty plan is available to accommodate a specific condition or diagnosis of a Medicaid recipient, the AHCA must automatically enroll the recipient in that plan unless the recipient chooses a different plan.[17] MMA specialty plans cover the same health care services as the standard MMA plans, and in addition, they must maintain a care coordination program tailored to the special needs of the plan's enrollees.

When a recipient is eligible for more than one MMA specialty plan, the AHCA uses a ranking to determine which MMA specialty plan to assign. Unless the recipient chooses to enroll in another MMA specialty plan for which he or she is eligible, or in a standard MMA plan offered in his or her region, the recipient is automatically assigned to the specialty plan listed highest on the ranking. The AHCA has awarded specialty plan contracts to serve enrollees with specialty conditions including severe mental illness, HIV/AIDS, as well as children with special health care needs, and those involved with Florida's child welfare system.

[12] Section 409.912(1)(b), F.S.
[13] *Id.*
[14] Agency for Health Care Administration, *Medicaid Managed Medical Assistance Specialty Plans available at* https://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/Specialty_Plans_110316.pdf (last visited Jan. 23, 2022).
[15] Section 409.962(18), F.S.
[16] Section 409.969(1), F.S.
[17] Section 409.977(1), F.S.

## III. Effect of Proposed Changes:

**Section 1** amends s. 409.912(1), F.S., to eliminate fee-for-service (FFS) reimbursement of provider service networks (PSNs) in conjunction with changes made to s. 409.968(2), F.S., in section 6 of the bill. Under these changes, PSNs must be reimbursed on a prepaid basis, receiving a per-member, per-month payment. This section of the bill prohibits the Agency for Health Care Administration (AHCA) from contracting with a PSN outside of the procurement process in s. 409.966, F.S., as amended by section 4 of the bill.

Changes to this subsection relocate, but do not substantively change, language exempting PSNs from parts I and III of ch. 643, F.S.

**Section 2** repeals obsolete language in s. 409.9124, F.S., relating to managed care plan reimbursement.

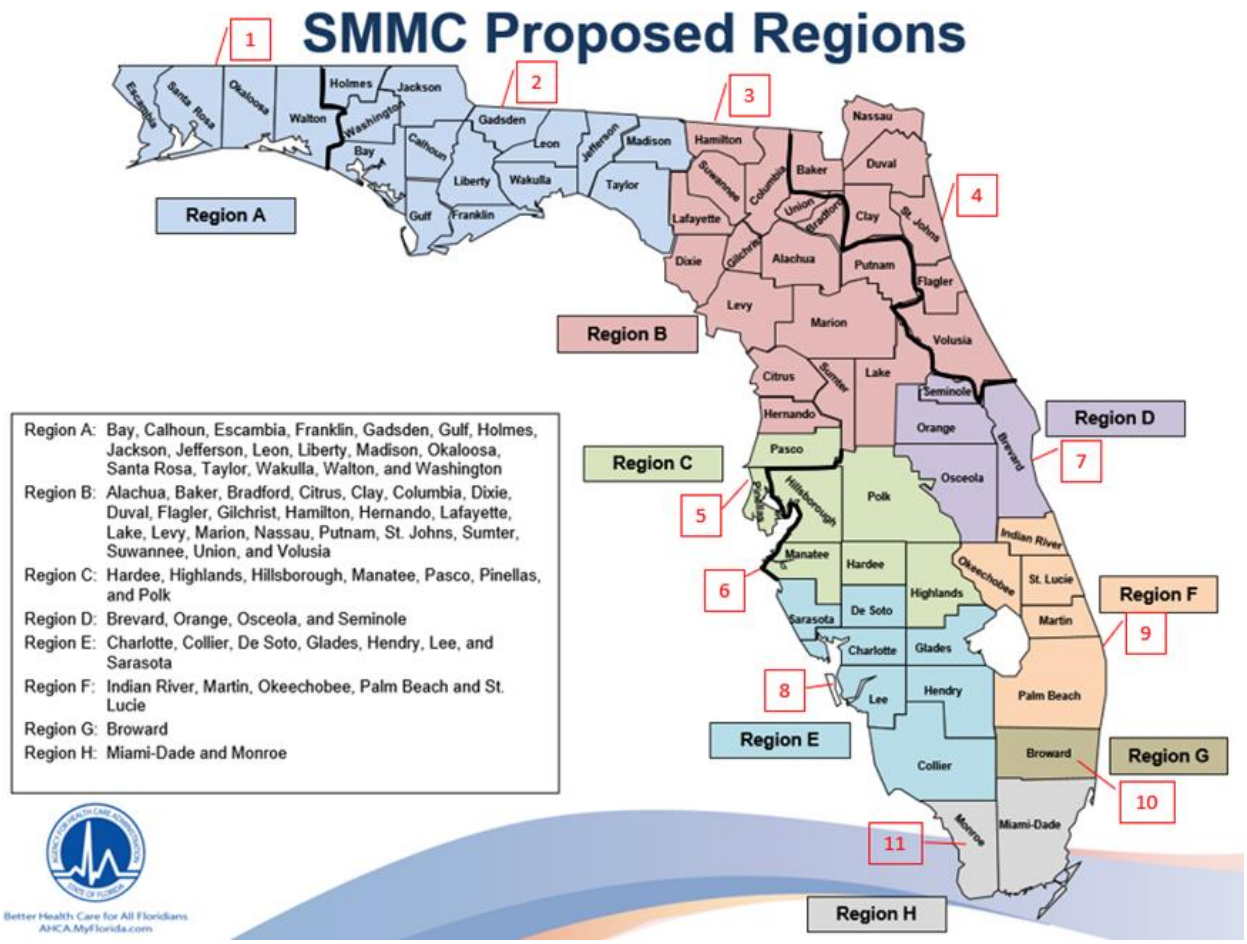
**Section 3** amends s. 409.964, F.S., to eliminate an obsolete requirement that the AHCA provide public notice and the opportunity for public comment before seeking a waiver to implement the Statewide Medicaid Managed Care (SMMC) program. This language is obsolete as the public notice and public meeting requirements were met prior to the AHCA seeking federal authority to implement the SMMC program in 2011 and 2012.

**Section 4** amends s. 409.966(2), F.S., to require the AHCA's databook consisting of Medicaid utilization and spending data (which must be published 90 days before issuing an invitation to negotiate) to include at least the 24 most recent months of data from the Medicaid Encounter Data System. This removes the requirement that the databook consist of data for the three most recent contract years, include historic fee-for-service claims, and delineate utilization by age, gender, eligibility group, geographic area, and aggregate clinical risk score.

This section of the bill deletes the requirement for the AHCA to conduct separate and simultaneous procurements for each Medicaid region and outlines a new structure for regional awards. The new structure includes eight regions named by letters (Regions A-H), rather than the 11 regions named by numbers (Regions 1-11) included in the original statute.

The following map and chart outline the eight regions proposed in the bill:[18]

[18] Agency for Health Care Administration, 2022 Agency Legislative Bill Analysis for SB 1950, Jan. 19, 2022 (on file with the Senate Committee on Health Policy).




| Current | Counties | Proposed |
|---|---|---|
| **Region 1** | Escambia, Okaloosa, Santa Rosa, and Walton | **Region A** |
| **Region 2** | Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington | |
| **Region 3** | Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union | **Region B** |
| **Region 4** | Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia | |
| **Region 5** | Pasco and Pinellas | **Region C** |
| **Region 6** | Hardee, Highlands, Hillsborough, Manatee, and Polk | |
| **Region 7** | Brevard, Orange, Osceola, and Seminole | **Region D** |
| **Region 8** | Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota | **Region E** |
| **Region 9** | Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie | **Region F** |
| **Region 10** | Broward | **Region G** |
| **Region 11** | Miami-Dade and Monroe | **Region H** |

This section of the bill also deletes obsolete language in s. 409.966(3)(d), F.S., that required the AHCA to negotiate capitation rates for the first year of the first contract term and in s. 409.966(3)(e), F.S., that awarded additional contracts to plans who are awarded contracts in

Regions 1 and 2. The AHCA indicates that due to the merger of Regions 1 and 2 into a single Region A, and because the bill provides for the award of statewide contracts, this provision is no longer needed.[19]

**Section 5** amends s. 409.967, F.S., to delete obsolete language relating to plans contracting with hospital facilities that became licensed and operational before January 1, 2013. This section of the bill also deletes obsolete language requiring the AHCA to issue a request for information to determine whether cost savings could be achieved through oversight and management by the end of the fourth year of the first contract term.

**Section 6** amends s. 409.968(2), F.S., to delete language allowing PSNs to receive fee-for-service rates with a shared savings settlement. In conjunction with changes made to s. 409.912. F.S., in section 1 of this bill, the bill requires all PSNs to be prepaid plans, receiving a per-member, per-month payment, and be negotiated pursuant to the procurement process in s. 409.966, F.S.

**Section 7** amends s. 409.973, F.S., to revise language related to Healthy Behaviors programs which Managed Medical Assistance (MMA) plans are required to establish to encourage and reward healthy behaviors. The bill requires each plan to establish a "tobacco cessation program" rather than a "smoking cessation program" to ensure that each program also includes smokeless tobacco products. It also requires an MMA plan's substance abuse recovery program to include opioid abuse recovery.

This section of the bill also deletes obsolete language in 409.97(4)(b), F.S., relating to the Primary Care Initiative, which requires the plans to schedule an appointment with a primary care provider for enrollees who became eligible for Medicaid between January 1, 2014 and December 31, 2015, within 6 months of enrollment in the plan.

**Section 8** amends s. 409.974(1), F.S., to outline the structure for plan selection under the MMA program. This section authorizes the AHCA to select eligible plans to provide services through a single statewide procurement and to award contracts to plans on a regional or statewide basis. It requires the AHCA to award a contract to at least one PSN in each of the 8 regions and to procure:

- 3-4 plans for Region A
- 3-6 plans for Region B
- 5-10 plans for Region C
- 3-6 plans for Region D
- 3-4 plans for Region E
- 3-5 plans for Region F
- 3-5 plans for Region G
- 5-10 plans for Region H

This section of the bill also amends s. 409.974(2), F.S., to eliminate the requirement that the AHCA exercise a preference for plans with a provider network in which over 10 percent of the

[19] Agency for Health Care Administration, 2022 Agency Legislative Bill Analysis for SB 1950, Jan. 19, 2022 (on file with the Senate Committee on Health Policy).

providers use electronic health records. It is estimated that 80 percent of providers currently use electronic health records.[20]

**Section 9** amends s. 409.975(1)(b), F.S., to expand the list of statewide essential providers to include Florida cancer hospitals that meet the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v). Currently, Moffitt Cancer Center in Tampa and Sylvester Comprehensive Cancer Center in Miami meet this criteria. Under the bill, managed care plans would be required to include these cancer hospitals in their networks as essential providers.

**Section 10** amends s. 409.977, F.S., to revise and relocate the requirement for the AHCA to maintain a recipient's enrollment in a plan if a recipient was enrolled in a plan immediately before the recipient's choice period and that plan is still available in the region, unless an applicable specialty plan is available from subsection (1) to subsection (2).

This section of the bill deletes the obsolete requirement in s. 409.977(4), F.S., for the AHCA to seek federal approval to develop and implement a process to enable a Medicaid recipient with access to employer-sponsored health care coverage to opt out of all managed care plans and to use Medicaid financial assistance to pay for the recipient's share of the cost in such employer-sponsored coverage. The AHCA has already obtained federal approval for what has come to be known as their Health Insurance Premium Payment (HIPP) program[21] and continues to implement this program.[22] As of August 2021, 53 recipients were participating in the HIPP program.[23]

This section of the bill also amends s. 409.977(5), F.S., to authorize a child welfare specialty managed care plan under contract with the MMA program to serve a child in a permanent guardianship situation.[24] Specifically, such a child must continue to be eligible for Medicaid and must receive guardianship assistance payments under the Guardianship Assistance Program. Currently, only children in foster care, extended foster care, or subsidized adoption are eligible for the child welfare specialty plan.

**Section 11** amends s. 409.981, F.S., to outline the structure for plan selection under the Long-Term Care program. Tracking the structure for MMA plan selection above in section 8 of this bill, except as noted, this section authorizes the AHCA to select eligible plans to provide services through a single statewide procurement and to award contracts to plans on a regional or

[20] Email from Legislative Affairs Director, Agency for Health Care Administration, to Senate Committee on Health Policy Staff (Jan. 24, 2022) (on file with the Senate Committee on Health Policy).
[21] *See* Rule 59G-7.007, F.A.C.
[22] The Agency for Health Care Administration reports that for the 2020 calendar year, $95,388.79 was spent on premium reimbursements through the HIPP program. From January to August of 2021, $912,363.87 was spent on premium reimbursements through the program. Agency for Health Care Administration, 2022 Agency Legislative Bill Analysis for SB 1950, Jan. 19, 2022 (on file with the Senate Committee on Health Policy).
[23] Email from Legislative Affairs Director, Agency for Health Care Administration, to Senate Committee on Health Policy Staff (Jan. 24, 2022) (on file with the Senate Committee on Health Policy).
[24] For more information on the Sunshine Health Child Welfare Specialty Plan and the Guardianship Assistance Program, *see* Florida Senate Bill Analysis and Fiscal Impact Statement for CS/SB 1080, Jan. 19, 2022 *available* at https://www.flsenate.gov/Session/Bill/2022/1080/Analyses/2022s01080.hp.PDF (last visited Jan. 23, 2022). The provisions of CS/SB 1080 are identical to the changes made to s. 409.977(5), F.S., in this bill.

statewide basis. It requires the AHCA to award a contract to at least one PSN in each of the eight regions and to procure:

- 3-4 plans for Region A
- 3-6 plans for Region B
- 5-10 plans for Region C
- 3-6 plans for Region D
- 3-4 plans for Region E
- 3-5 plans for Region F
- 3-4 plans for Region G[25]
- 5-10 plans for region H

**Section 12** amends s. 409.8132, F.S., to conform a cross-reference to changes made in bill section 2 which repeals s. 409.9124, F.S.

**Section 13** reenacts s. 409.962, F.S., to incorporate changes made by this act to s. 409.912, F.S., in bill section 1.

**Section 14** reenacts s. 641.19, F.S., to incorporate changes made by this act to s. 409.912, F.S., in bill section 1.

**Section 15** reenacts s. 430.2053, F.S., to incorporate changes made by this act to s. 409.981, F.S., in bill section 11.

**Section 16** provides an effective date of July 1, 2022.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

[25] Note that the Agency for Health Care Administration must award 3-5 MMA plans for Region G under bill section 8.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The capitation rate for children in the Child Welfare Specialty Plan is higher than the rates for most children in other plans. If children become eligible and receive services through the Child Welfare Specialty Plan as authorized in the bill, the bill will have a significant negative fiscal impact to the Florida Medicaid program. The AHCA estimates a maximum recurring fiscal impact of $12.2 million ($4.7 million General Revenue) based on a rate year 2020-2021 estimate of 4,120 children who currently would be eligible for the change in plans.[26]

The precise fiscal impact of children becoming newly eligible for the Child Welfare Specialty Plans cannot be calculated without knowing the Medicaid region in which an eligible child resides and the capitation rate category in which the child is currently categorized. This is because Medicaid capitation rates vary by region and children could be in different rate cells based on age, gender, Medicaid eligibility category, and other characteristics.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.912, 409.964, 409.966, 409.967, 409.968, 409.973, 409.974, 409.975, 409.977, 409.981, and 409.8132.

This bill repeals section 409.9124 of the Florida Statutes.

This bill reenacts the following sections of the Florida Statutes: 409.962, 641.19, and 430.2053.

[26] Agency for Health Care Administration, 2022 Agency Legislative Bill Analysis for SB 1950, Jan. 19, 2022 (on file with the Senate Committee on Health Policy).

## IX. Additional Information:

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

**Recommended CS/CS by Appropriations Subcommittee on Health and Human Services on February 16, 2022:**
The committee substitute removes the achieved savings rebate provisions from the bill and maintains current law.

**CS by Health Policy on January 26, 2022:**
The CS corrects a drafting error in the underlying bill that would have inadvertently deleted the AHCA's existing authority to implement the HIPP program. The amendment keeps the HIPP program intact and removes obsolete language from statute regarding already-obtained federal approval to implement the program.

B. Amendments:

None.

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 02/16/2022 | . | |
| | . | |
| | . | |
| | . | |

Appropriations Subcommittee on Health and Human Services (Brodeur) recommended the following:

**Senate Amendment (with directory and title amendments)**

Delete lines 503 - 629.

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======
And the directory clause is amended as follows:
Delete lines 401 - 402
and insert:
Section 5. Paragraphs (c) and (f) of subsection (2) of section 409.967, Florida Statutes, are amended

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11
12 ================= T I T L E  A M E N D M E N T ================
13 And the title is amended as follows:
14 Delete lines 29 - 32
15 and insert:
16 409.967, F.S.; deleting obsolete provisions; amending
17 s. 409.968, F.S.; conforming

**By** the Committee on Health Policy; and Senator Brodeur

588-02344-22 20221950c1

A bill to be entitled

An act relating to the statewide Medicaid managed care program; amending s. 409.912, F.S.; requiring, rather than authorizing, that the reimbursement method for provider service networks be on a prepaid basis; deleting the authority to reimburse provider service networks on a fee-for-service basis; conforming provisions to changes made by the act; providing that provider service networks are subject to and exempt from certain requirements; providing construction; repealing s. 409.9124, F.S., relating to managed care reimbursement; amending s. 409.964, F.S.; deleting a requirement that the Agency for Health Care Administration provide the opportunity for public feedback on a certain waiver application; amending s. 409.966, F.S.; revising requirements relating to the databook published by the agency consisting of Medicaid utilization and spending data; reallocating regions within the statewide managed care program; deleting a requirement that the agency negotiate plan rates or payments to guarantee a certain savings amount; deleting a requirement for the agency to award additional contracts to plans in specified regions for certain purposes; revising a limitation on when plans may begin serving Medicaid recipients to apply to any eligible plan that participates in an invitation to negotiate, rather than plans participating in certain regions; making technical changes; amending s. 409.967, F.S.; deleting obsolete provisions; revising





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provisions relating to agency-defined quality measures under the achieved savings rebate program for Medicaid prepaid plans; amending s. 409.968, F.S.; conforming provisions to changes made by the act; amending s. 409.973, F.S.; revising requirements for healthy behaviors programs established by plans; deleting an obsolete provision; amending s. 409.974, F.S.; requiring the agency to select plans for the managed medical assistance program through a single statewide procurement; authorizing the agency to award contracts to plans on a regional or statewide basis; specifying requirements for minimum numbers of plans which the agency must procure for each specified region; conforming provisions to changes made by the act; deleting a requirement for the agency to exercise a preference for certain plans; amending s. 409.975, F.S.; providing that cancer hospitals meeting certain criteria are statewide essential providers; amending s. 409.977, F.S.; revising the circumstances for maintaining a recipient's enrollment in a plan; deleting obsolete language; authorizing specialty plans to serve certain children who receive guardianship assistance payments under the Guardianship Assistance Program; amending s. 409.981, F.S.; requiring the agency to select plans for the long-term care managed medical assistance program through a single statewide procurement; authorizing the agency to award contracts to plans on a regional or statewide basis; specifying requirements for



**CODING:** Words ~~stricken~~ are deletions; words underlined are additions.

minimum numbers of plans which the agency must procure for each specified region; conforming provisions to changes made by the act; amending s. 409.8132, F.S.; conforming a cross-reference; reenacting ss. 409.962(1), (7), (13), and (14) and 641.19(22) relating to definitions, to incorporate the amendments made by this act to s. 409.912, F.S., in references thereto; reenacting s. 430.2053(3)(h), (i), and (j) and (11), relating to aging resource centers, to incorporate the amendments made by this act to s. 409.981, F.S., in references thereto; providing an effective date.

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

Section 1. Subsection (1) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. s. 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid





aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services

results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(1) The agency may contract with a provider service network, which must ~~may~~ be reimbursed on a ~~fee-for-service or~~ prepaid basis. ~~Prepaid~~ Provider service networks shall receive per-member, per-month payments. ~~A provider service network that does not choose to be a prepaid plan shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of the plan's operation or until the~~





~~contract year beginning September 1, 2014, whichever is later. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service in the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period shall be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation shall be considered final.~~

~~(a) A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641 but must comply with the solvency requirements in s. 641.2261(2) and meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency.~~

~~(b)~~ A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of

providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

(a) A provider service network is exempt from parts I and III of chapter 641 but must comply with the solvency requirements in s. 641.2261(2) and meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency.

(b) This subsection does not authorize the agency to contract with a provider service network outside of the procurement process described in s. 409.966.

Section 2. Section 409.9124, Florida Statutes, is repealed.

Section 3. Section 409.964, Florida Statutes, is amended to read:

409.964 Managed care program; state plan; waivers.—The Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care services. The agency shall apply for and implement state plan amendments or waivers of applicable federal laws and regulations necessary to implement the program. ~~Before seeking a waiver, the agency shall provide public notice and the opportunity for public comment and include public feedback in the waiver application. The agency shall hold one public meeting in each of the regions described in s. 409.966(2), and the time~~







~~period for public comment for each region shall end no sooner than 30 days after the completion of the public meeting in that region.~~

Section 4. Subsections (2), (3), and (4) of section 409.966, Florida Statutes, are amended to read:

409.966 Eligible plans; selection.—

(2) ELIGIBLE PLAN SELECTION.—The agency shall select a limited number of eligible plans to participate in the Medicaid program using invitations to negotiate in accordance with s. 287.057(1)(c). At least 90 days before issuing an invitation to negotiate, the agency shall compile and publish a databook consisting of a comprehensive set of utilization and spending data consistent with actuarial rate-setting practices and standards ~~for the 3 most recent contract years consistent with the rate-setting periods for all Medicaid recipients by region or county~~. The source of the data in the databook ~~report~~ must include, at a minimum, the 24 most recent months of ~~both historic fee-for-service claims and~~ validated data from the Medicaid Encounter Data System. The statewide managed care program includes ~~report must be available in electronic form and delineate utilization use by age, gender, eligibility group, geographic area, and aggregate clinical risk score. Separate and simultaneous procurements shall be conducted in each of~~ the following regions:

(a) Region A ~~1~~, which consists of Bay, Calhoun, Escambia, ~~Okaloosa, Santa Rosa, and Walton Counties.~~

~~(b) Region 2, which consists of Bay, Calhoun,~~ Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and

Washington Counties.

(b) ~~(c)~~ Region B ~~3~~, which consists of Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, ~~and~~ Union ~~Counties.~~

~~(d) Region 4, which consists of Baker, Clay, Duval, Flagler, Nassau, St. Johns~~, and Volusia Counties.

(c) ~~(e)~~ Region C ~~5~~, which consists of ~~Pasco and Pinellas Counties.~~

~~(f) Region 6, which consists of~~ Hardee, Highlands, Hillsborough, Manatee, Pasco, Pinellas, and Polk Counties.

(d) ~~(g)~~ Region D ~~7~~, which consists of Brevard, Orange, Osceola, and Seminole Counties.

(e) ~~(h)~~ Region E ~~8~~, which consists of Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota Counties.

(f) ~~(i)~~ Region F ~~9~~, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties.

(g) ~~(j)~~ Region G ~~10~~, which consists of Broward County.

(h) ~~(k)~~ Region H ~~11~~, which consists of Miami-Dade and Monroe Counties.

(3) QUALITY SELECTION CRITERIA.—

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

1. Accreditation by the National Committee for Quality





Assurance, the Joint Commission, or another nationally recognized accrediting body.

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

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

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

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

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

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

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

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

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

negotiate.

(b) An eligible plan must disclose any business relationship it has with any other eligible plan that responds to the invitation to negotiate. The agency may not select plans in the same region for the same managed care program that have a business relationship with each other. Failure to disclose any business relationship shall result in disqualification from participation in any region for the first full contract period after the discovery of the business relationship by the agency. For the purpose of this section, "business relationship" means an ownership or controlling interest, an affiliate or subsidiary relationship, a common parent, or any mutual interest in any limited partnership, limited liability partnership, limited liability company, or other entity or business association, including all wholly or partially owned subsidiaries, majority-owned subsidiaries, parent companies, or affiliates of such entities, business associations, or other enterprises, that exists for the purpose of making a profit.

(c) After negotiations are conducted, the agency shall select the eligible plans that are determined to be responsive and provide the best value to the state. Preference shall be given to plans that:

1. Have signed contracts with primary and specialty physicians in sufficient numbers to meet the specific standards established pursuant to s. 409.967(2)(c).

2. Have well-defined programs for recognizing patient-centered medical homes and providing for increased compensation for recognized medical homes, as defined by the plan.

3. Are organizations that are based in and perform





operational functions in this state, in-house or through contractual arrangements, by staff located in this state. Using a tiered approach, the highest number of points shall be awarded to a plan that has all or substantially all of its operational functions performed in the state. The second highest number of points shall be awarded to a plan that has a majority of its operational functions performed in the state. The agency may establish a third tier; however, preference points may not be awarded to plans that perform only community outreach, medical director functions, and state administrative functions in the state. For purposes of this subparagraph, operational functions include corporate headquarters, claims processing, member services, provider relations, utilization and prior authorization, case management, disease and quality functions, and finance and administration. For purposes of this subparagraph, the term "corporate headquarters" means the principal office of the organization, which may not be a subsidiary, directly or indirectly through one or more subsidiaries of, or a joint venture with, any other entity whose principal office is not located in the state.

4. Have contracts or other arrangements for cancer disease management programs that have a proven record of clinical efficiencies and cost savings.

5. Have contracts or other arrangements for diabetes disease management programs that have a proven record of clinical efficiencies and cost savings.

6. Have a claims payment process that ensures that claims that are not contested or denied will be promptly paid pursuant to s. 641.3155.

~~(d) For the first year of the first contract term, the agency shall negotiate capitation rates or fee-for-service payments with each plan in order to guarantee aggregate savings of at least 5 percent.~~

~~1. For prepaid plans, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid managed care plans for similar populations in the same areas in the prior year. In regions containing no prepaid plans in the prior year, determination of the amount of savings shall be calculated by comparison to the Medicaid rates established and certified for those regions in the prior year.~~

~~2. For provider service networks operating on a fee-for-service basis, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid on a fee-for-service basis for the same services in the prior year.~~

~~(e) To ensure managed care plan participation in Regions 1 and 2, the agency shall award an additional contract to each plan with a contract award in Region 1 or Region 2. Such contract shall be in any other region in which the plan submitted a responsive bid and negotiates a rate acceptable to the agency. If a plan that is awarded an additional contract pursuant to this paragraph is subject to penalties pursuant to s. 409.967(2)(i) for activities in Region 1 or Region 2, the additional contract is automatically terminated 180 days after the imposition of the penalties. The plan must reimburse the agency for the cost of enrollment changes and other transition activities.~~

(d)~~(f)~~ The agency may not execute contracts with managed







care plans at payment rates not supported by the General Appropriations Act.

(4) ADMINISTRATIVE CHALLENGE.—Any eligible plan that participates in an invitation to negotiate ~~in more than one region and is selected in at least one region~~ may not begin serving Medicaid recipients ~~in any region for which it was selected~~ until all administrative challenges to procurements required by this section to which the eligible plan is a party have been finalized. If the number of plans selected is less than the maximum amount of plans permitted in the region, the agency may contract with other selected plans in the region not participating in the administrative challenge before resolution of the administrative challenge. For purposes of this subsection, an administrative challenge is finalized if an order granting voluntary dismissal with prejudice has been entered by any court established under Article V of the State Constitution or by the Division of Administrative Hearings, a final order has been entered into by the agency and the deadline for appeal has expired, a final order has been entered by the First District Court of Appeal and the time to seek any available review by the Florida Supreme Court has expired, or a final order has been entered by the Florida Supreme Court and a warrant has been issued.

Section 5. Paragraphs (c) and (f) of subsection (2) and subsection (3) of section 409.967, Florida Statutes, are amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care

program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. ~~A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge.~~ Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider.





The agency shall conduct, or contract for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have access to behavioral health services.

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

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

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

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

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

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

2. Each plan must collect and report the Health Plan Employer Data and Information Set (HEDIS) measures, as specified by the agency. These measures must be published on the plan's website in a manner that allows recipients to reliably compare the performance of plans. The agency shall use the HEDIS measures as a tool to monitor plan performance.

3. Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body, or have initiated the accreditation process, within 1 year after the





contract is executed. For any plan not accredited within 18 months after executing the contract, the agency shall suspend automatic assignment under s. 409.977 and 409.984.

~~4. By the end of the fourth year of the first contract term, the agency shall issue a request for information to determine whether cost savings could be achieved by contracting for plan oversight and monitoring, including analysis of encounter data, assessment of performance measures, and compliance with other contractual requirements.~~

(3) ACHIEVED SAVINGS REBATE.—

(a) The agency is responsible for verifying the achieved savings rebate for all Medicaid prepaid plans. To assist the agency, a prepaid plan shall:

1. Submit an annual financial audit conducted by an independent certified public accountant in accordance with generally accepted auditing standards to the agency on or before June 1 for the preceding year; and

2. Submit an annual statement prepared in accordance with statutory accounting principles on or before March 1 pursuant to s. 624.424 if the plan is regulated by the Office of Insurance Regulation.

(b) The agency shall contract with independent certified public accountants to conduct compliance audits for the purpose of auditing financial information, including but not limited to: annual premium revenue, medical and administrative costs, and income or losses reported by each prepaid plan, in order to determine and validate the achieved savings rebate.

(c) Any audit required under this subsection must be conducted by an independent certified public accountant who

meets criteria specified by rule. The rules must also provide that:

1. The entity selected by the agency to conduct the audit may not have a conflict of interest that might affect its ability to perform its responsibilities with respect to an examination.

2. The rates charged to the prepaid plan being audited are consistent with rates charged by other certified public accountants and are comparable with the rates charged for comparable examinations.

3. Each prepaid plan audited shall pay to the agency the expenses of the audit at the rates established by the agency by rule. Such expenses include actual travel expenses, reasonable living expense allowances, compensation of the certified public accountant, and necessary attendant administrative costs of the agency directly related to the examination. Travel expense and living expense allowances are limited to those expenses incurred on account of the audit and must be paid by the examined prepaid plan together with compensation upon presentation by the agency to the prepaid plan of a detailed account of the charges and expenses after a detailed statement has been filed by the auditor and approved by the agency.

4. All moneys collected from prepaid plans for such audits shall be deposited into the Grants and Donations Trust Fund, and the agency may make deposits into such fund from moneys appropriated for the operation of the agency.

(d) At a location in this state, the prepaid plan shall make available to the agency and the agency's contracted certified public accountant all books, accounts, documents,





files, and information that relate to the prepaid plan's Medicaid transactions. Records not in the prepaid plan's immediate possession must be made available to the agency or the certified public accountant in this state within 3 days after a request is made by the agency or certified public accountant engaged by the agency. A prepaid plan has an obligation to cooperate in good faith with the agency and the certified public accountant. Failure to comply to such record requests shall be deemed a breach of contract.

(e) Once the certified public accountant completes the audit, the certified public accountant shall submit an audit report to the agency attesting to the achieved savings of the plan. The results of the audit report are dispositive.

(f) Achieved savings rebates validated by the certified public accountant are due within 30 days after the report is submitted. Except as provided in paragraph (h), the achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

1. One hundred percent of income up to and including 3 ~~5~~ percent of revenue shall be retained by the plan.

2. Fifty percent of income above 3 ~~5~~ percent and up to 10 percent shall be retained by the plan, and the other 50 percent refunded to the state and transferred to the General Revenue Fund, unallocated.

3. One hundred percent of income above 10 percent of revenue shall be refunded to the state and transferred to the General Revenue Fund, unallocated.

(g) A plan that exceeds agency-defined quality measures in

the reporting period may retain up to an additional 2 ~~1~~ percent of revenue. For the purpose of this paragraph, the quality measures must include two tiers and must include plan performance for preventing or managing complex, chronic conditions that are associated with an elevated likelihood of requiring high-cost medical treatments.

1. If the agency-defined quality or performance targets identified in tier one are met, the plan may retain up to 4 percent of revenue. Fifty percent of income above 4 percent and up to 10 percent must be retained by the plan, and the other 50 percent refunded to the state and transferred to the General Revenue Fund, unallocated.

2. If the agency-defined quality or performance targets identified in tier two are met, the plan may retain up to 5 percent of revenue. Fifty percent of income above 5 percent and up to 10 percent must be retained by the plan, and the other 50 percent refunded to the state and transferred to the General Revenue Fund, unallocated.

(h) The following may not be included as allowable expenses in calculating income for determining the achieved savings rebate:

1. Payment of achieved savings rebates.

2. Any financial incentive payments made to the plan outside of the capitation rate.

3. Any financial disincentive payments levied by the state or federal government.

4. Expenses associated with any lobbying or political activities.

5. The cash value or equivalent cash value of bonuses of





any type paid or awarded to the plan's executive staff, other than base salary.

6. Reserves and reserve accounts.

7. Administrative costs, including, but not limited to, reinsurance expenses, interest payments, depreciation expenses, bad debt expenses, and outstanding claims expenses in excess of actuarially sound maximum amounts set by the agency.

The agency shall consider these and other factors in developing contracts that establish shared savings arrangements.

(i) Prepaid plans that incur a loss in the first contract year may apply the full amount of the loss as an offset to income in the second contract year.

(j) If, after an audit, the agency determines that a prepaid plan owes an additional rebate, the plan has 30 days after notification to make the payment. Upon failure to timely pay the rebate, the agency shall withhold future payments to the plan until the entire amount is recouped. If the agency determines that a prepaid plan has made an overpayment, the agency shall return the overpayment within 30 days.

Section 6. Subsection (2) of section 409.968, Florida Statutes, is amended to read:

409.968 Managed care plan payments.—

(2) Provider service networks must ~~may~~ be prepaid plans and receive per-member, per-month payments negotiated pursuant to the procurement process described in s. 409.966. ~~Provider service networks that choose not to be prepaid plans shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider~~

~~service network only for the first 2 years of its operation. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service within the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period must be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation period for claims that could be received and paid by the agency after the 6 month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation is considered final.~~

Section 7. Subsections (3) and (4) of section 409.973, Florida Statutes, are amended to read:

409.973 Benefits.—

(3) HEALTHY BEHAVIORS.—Each plan operating in the managed medical assistance program shall establish a program to encourage and reward healthy behaviors. At a minimum, each plan must establish a medically approved tobacco ~~smoking~~ cessation program, a medically directed weight loss program, and a medically approved alcohol recovery program or substance abuse recovery program that must include, but may not be limited to, opioid abuse recovery. Each plan must identify enrollees who





smoke, are morbidly obese, or are diagnosed with alcohol or substance abuse in order to establish written agreements to secure the enrollees' commitment to participation in these programs.

(4) PRIMARY CARE INITIATIVE.—Each plan operating in the managed medical assistance program shall establish a program to encourage enrollees to establish a relationship with their primary care provider. Each plan shall:

(a) Provide information to each enrollee on the importance of and procedure for selecting a primary care provider, and thereafter automatically assign to a primary care provider any enrollee who fails to choose a primary care provider.

(b) If the enrollee was not a Medicaid recipient before enrollment in the plan, assist the enrollee in scheduling an appointment with the primary care provider. If possible the appointment should be made within 30 days after enrollment in the plan. ~~For enrollees who become eligible for Medicaid between January 1, 2014, and December 31, 2015, the appointment should be scheduled within 6 months after enrollment in the plan.~~

(c) Report to the agency the number of enrollees assigned to each primary care provider within the plan's network.

(d) Report to the agency the number of enrollees who have not had an appointment with their primary care provider within their first year of enrollment.

(e) Report to the agency the number of emergency room visits by enrollees who have not had at least one appointment with their primary care provider.

Section 8. Subsections (1) and (2) of section 409.974, Florida Statutes, are amended to read:

409.974 Eligible plans.—

(1) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans for the managed medical assistance program through the procurement process described in s. 409.966 through a single statewide procurement. The agency may award contracts to plans selected through the procurement process either on a regional or statewide basis. The awards must include at least one provider service network in each of the eight regions outlined in this subsection. The agency shall procure:

(a) At least 3 plans and up to 4 plans for Region A.

(b) At least 3 plans and up to 6 plans for Region B.

(c) At least 5 plans and up to 10 plans for Region C.

(d) At least 3 plans and up to 6 plans for Region D.

(e) At least 3 plans and up to 4 plans for Region E.

(f) At least 3 plans and up to 5 plans for Region F.

(g) At least 3 plans and up to 5 plans for Region G.

(h) At least 5 plans and up to 10 plans for Region H. ~~The agency shall notice invitations to negotiate no later than January 1, 2013.~~

~~(a) The agency shall procure two plans for Region 1. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.~~

~~(b) The agency shall procure two plans for Region 2. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.~~

~~(c) The agency shall procure at least three plans and up to five plans for Region 3. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~





~~(d) The agency shall procure at least three plans and up to five plans for Region 4. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(e) The agency shall procure at least two plans and up to four plans for Region 5. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(f) The agency shall procure at least four plans and up to seven plans for Region 6. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(g) The agency shall procure at least three plans and up to six plans for Region 7. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(h) The agency shall procure at least two plans and up to four plans for Region 8. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(i) The agency shall procure at least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(j) The agency shall procure at least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(k) The agency shall procure at least five plans and up to~~

~~10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

If no provider service network submits a responsive bid, the agency shall procure no more than one less than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in those regions where no provider service network has been selected.

(2) QUALITY SELECTION CRITERIA.—In addition to the criteria established in s. 409.966, the agency shall consider evidence that an eligible plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers before the plan submitting a response. The agency shall evaluate and give special weight to evidence of signed contracts with essential providers as defined by the agency pursuant to s. 409.975(1). ~~The agency shall exercise a preference for plans with a provider network in which over 10 percent of the providers use electronic health records, as defined in s. 408.051.~~ When all other factors are equal, the agency shall consider whether the organization has a contract to provide managed long-term care services in the same region and shall exercise a preference for such plans.

Section 9. Paragraph (b) of subsection (1) of section 409.975, Florida Statutes, is amended to read:

409.975 Managed care plan accountability.—In addition to





the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(c). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

2. Regional perinatal intensive care centers as defined in s. 383.16(2).

3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28).

4. Accredited and integrated systems serving medically complex children which comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

5. Florida cancer hospitals that meet the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v).

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of

recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Except for payments for emergency services, payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

Section 10. Subsections (1), (2), (4), and (5) of section 409.977, Florida Statutes, are amended to read:

409.977 Enrollment.—

(1) The agency shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. When a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign the recipient to that plan. ~~In the first year of the first contract term only, if a recipient was previously enrolled in a plan that is still available in the region, the agency shall automatically enroll the recipient in that plan unless an applicable specialty plan is available.~~ Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another.





(2) When automatically enrolling recipients in managed care plans, if a recipient was enrolled in a plan immediately before the recipient's choice period and that plan is still available in the region, the agency must maintain the recipient's enrollment in that plan unless an applicable specialty plan is available. Otherwise, the agency shall automatically enroll based on the following criteria:

(a) Whether the plan has sufficient network capacity to meet the needs of the recipients.

(b) Whether the recipient has previously received services from one of the plan's primary care providers.

(c) Whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

(4) The agency shall develop a process to enable a recipient with access to employer-sponsored health care coverage to opt out of all managed care plans and to use Medicaid financial assistance to pay for the recipient's share of the cost in such employer-sponsored coverage. ~~Contingent upon federal approval,~~ The agency shall also enable recipients with access to other insurance or related products providing access to health care services created pursuant to state law, including any product available under the Florida Health Choices Program, or any health exchange, to opt out. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient. The agency shall ~~seek federal approval to~~ require Medicaid recipients with access to employer-sponsored health care coverage to enroll in that coverage and

use Medicaid financial assistance to pay for the recipient's share of the cost for such coverage. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient.

(5) Specialty plans serving children in the care and custody of the department may serve such children as long as they remain in care, including those remaining in extended foster care pursuant to s. 39.6251, or are in subsidized adoption and continue to be eligible for Medicaid pursuant to s. 409.903, or are receiving guardianship assistance payments and continue to be eligible for Medicaid pursuant to s. 409.903.

Section 11. Subsection (2) of section 409.981, Florida Statutes, is amended to read:

409.981 Eligible long-term care plans.—

(2) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans for the long-term care managed care program through the procurement process described in s. 409.966 through a single statewide procurement. The agency may award contracts to plans selected through the procurement process on a regional or statewide basis. The awards must include at least one provider service network in each of the eight regions outlined in this subsection. The agency shall procure:

(a) At least 3 plans and up to 4 plans for Region A.

(b) At least 3 plans and up to 6 plans for Region B.

(c) At least 5 plans and up to 10 plans for Region C.

(d) At least 3 plans and up to 6 plans for Region D.

(e) At least 3 plans and up to 4 plans for Region E.

(f) At least 3 plans and up to 5 plans for Region F.





(g) At least 3 plans and up to 4 plans for Region G.

(h) At least 5 plans and up to 10 plans for Region H.

~~Two plans for Region 1. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(b) Two plans for Region 2. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(c) At least three plans and up to five plans for Region 3. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(d) At least three plans and up to five plans for Region 4. At least one plan must be a provider service network if any provider service network submits a responsive bid.~~

~~(e) At least two plans and up to four plans for Region 5. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(f) At least four plans and up to seven plans for Region 6. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(g) At least three plans and up to six plans for Region 7. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(h) At least two plans and up to four plans for Region 8. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(i) At least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(j) At least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(k) At least five plans and up to 10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

If no provider service network submits a responsive bid ~~in a region other than Region 1 or Region 2~~, the agency shall procure no more than one less than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in regions where no provider service network has been selected.

Section 12. Subsection (4) of section 409.8132, Florida Statutes, is amended to read:

409.8132 Medikids program component.—

(4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908, 409.912, 409.9121, 409.9122, 409.9123, ~~409.9124,~~ 409.9127, 409.9128, 409.913, 409.916, 409.919, 409.920, and 409.9205 apply to the administration of the Medikids program component of the Florida Kidcare program, except that s. 409.9122 applies to Medikids as modified by the provisions of subsection (7).

Section 13. For the purpose of incorporating the amendment made by this act to section 409.912, Florida Statutes, in references thereto, subsections (1), (7), (13), and (14) of section 409.962, Florida Statutes, are reenacted to read:





409.962 Definitions.—As used in this part, except as otherwise specifically provided, the term:

(1) "Accountable care organization" means an entity qualified as an accountable care organization in accordance with federal regulations, and which meets the requirements of a provider service network as described in s. 409.912(1).

(7) "Eligible plan" means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under s. 409.912(1) or an accountable care organization authorized under federal law. For purposes of the managed medical assistance program, the term also includes the Children's Medical Services Network authorized under chapter 391 and entities qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, Medicare Advantage Health Maintenance Organizations, Medicare Advantage Coordinated Care Plans, and Medicare Advantage Special Needs Plans, and the Program of All-inclusive Care for the Elderly.

(13) "Prepaid plan" means a managed care plan that is licensed or certified as a risk-bearing entity, or qualified pursuant to s. 409.912(1), in the state and is paid a prospective per-member, per-month payment by the agency.

(14) "Provider service network" means an entity qualified pursuant to s. 409.912(1) of which a controlling interest is owned by a health care provider, or group of affiliated providers, or a public agency or entity that delivers health services. Health care providers include Florida-licensed health

care professionals or licensed health care facilities, federally qualified health care centers, and home health care agencies.

Section 14. For the purpose of incorporating the amendment made by this act to section 409.912, Florida Statutes, in a reference thereto, subsection (22) of section 641.19, Florida Statutes, is reenacted to read:

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

(22) "Provider service network" means a network authorized under s. 409.912(1), reimbursed on a prepaid basis, operated by a health care provider or group of affiliated health care providers, and which directly provides health care services under a Medicare, Medicaid, or Healthy Kids contract.

Section 15. For the purpose of incorporating the amendments made by this act to section 409.981, Florida Statutes, in references thereto, paragraphs (h), (i), and (j) of subsection (3) and subsection (11) of section 430.2053, Florida Statutes, are reenacted to read:

430.2053 Aging resource centers.—

(3) The duties of an aging resource center are to:

(h) Assist clients who request long-term care services in being evaluated for eligibility for enrollment in the Medicaid long-term care managed care program as eligible plans become available in each of the regions pursuant to s. 409.981(2).

(i) Provide enrollment and coverage information to Medicaid managed long-term care enrollees as qualified plans become available in each of the regions pursuant to s. 409.981(2).

(j) Assist Medicaid recipients enrolled in the Medicaid long-term care managed care program with informally resolving grievances with a managed care network and assist Medicaid





recipients in accessing the managed care network's formal grievance process as eligible plans become available in each of the regions defined in s. 409.981(2).

(11) In an area in which the department has designated an area agency on aging as an aging resource center, the department and the agency shall not make payments for the services listed in subsection (9) and the Long-Term Care Community Diversion Project for such persons who were not screened and enrolled through the aging resource center. The department shall cease making payments for recipients in eligible plans as eligible plans become available in each of the regions defined in s. 409.981(2).

Section 16. This act shall take effect July 1, 2022.

The Florida Senate

# Committee Agenda Request

**To:** Senator Aaron Bean, Chair
Appropriations Subcommittee on Health and Human Services

**Subject:** Committee Agenda Request

**Date:** January 27, 2022

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I respectfully request that **Senate Bill 1950**, relating to **Statewide Medicaid Managed Care Program,** be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Jason Brodeur

Senator Jason Brodeur
Florida Senate, District 9

File signed original with committee office

The Florida Senate

# APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/16/22
Meeting Date

HHS Approps
Committee

1950 Tab 8
Bill Number or Topic

Amendment Barcode (if applicable)

**Name** Cody Farrill **Phone**

**Address** 2727 Mahan Dr. **Email**
*Street*

Tallahassee FL
*City* *State* *Zip*

**Speaking:** ☑ For ☐ Against ☐ Information **OR** **Waive Speaking:** ☐ In Support ☐ Against

**PLEASE CHECK ONE OF THE FOLLOWING:**

☐ **I am appearing without compensation or sponsorship.**

☑ **I am a registered lobbyist, representing:**

AHCA

☐ **I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:**

*While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)*

**This form is part of the public record for this meeting.**

S-001 (08/10/2021)

02/10/22
Meeting Date

The Florida Senate

# APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

SB 1950
Bill Number or Topic

Approps on Health/ Human Services
Committee

Amendment Barcode (if applicable)

Name Sarah Nemes, Embrace Families

Phone 407-592-1732

Address
Street

Email

Orlando, FL
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

**PLEASE CHECK ONE OF THE FOLLOWING:**

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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**This form is part of the public record for this meeting.**

S-001 (08/10/2021)

# CourtSmart Tag Report

**Room:** KB 412 **Case No.:** - **Type:**
**Caption:** Senate Appropriations Subcommittee on Health & Human Services **Judge:**

**Started: 2/16/2022 10:01:32 AM**
**Ends: 2/16/2022 10:52:09 AM** **Length: 00:50:38**

**10:04:12 AM** Sen. Bean (Chair)
**10:05:19 AM** S1600
**10:05:43 AM** Sen. Bradley
**10:06:21 AM** Sen. Bean
**10:06:45 AM** Sen. Bradley
**10:06:48 AM** Sen. Bean
**10:07:03 AM** Am. 774274
**10:07:07 AM** Sen. Bradley
**10:07:22 AM** Sen. Bean
**10:07:48 AM** Am. 735792
**10:08:17 AM** Sen. Farmer
**10:08:25 AM** Am. 118168
**10:09:30 AM** Sen. Farmer
**10:12:23 AM** Sen. Bean
**10:13:41 AM** Sen. Bradley
**10:15:02 AM** S1712
**10:15:24 AM** Sen. Burgess
**10:16:53 AM** Sen. Bean
**10:17:52 AM** Major General James Hartsell, Executive Director, Florida Department of Veterans' Affairs (waives in support)
**10:18:06 AM** Sen. Burgess
**10:18:40 AM** S768
**10:18:52 AM** Sen. Rodriguez
**10:19:20 AM** Melissa Villar, NORML Tallahassee
**10:21:41 AM** S1436
**10:21:58 AM** Sen. Garcia
**10:23:30 AM** Austin Stowers (waives in support)
**10:23:44 AM** Jon Pasqualone, Executive Director, FL Fire Marshals & Inspectors Association (waives in support)
**10:24:11 AM** Sen. Harrell
**10:24:58 AM** Sen. Garcia
**10:25:41 AM** S1770
**10:26:15 AM** Sen. Book
**10:26:49 AM** Am. 272010
**10:27:29 AM** Sen. Farmer
**10:28:15 AM** Sen. Book
**10:29:22 AM** Teye Carmichael, FANA (waives in support)
**10:30:04 AM** Dr. Kandis Natoli, PhD, RN, IBCLC
**10:31:18 AM** Jason Rodriguez, BayCare (waives in support)
**10:31:32 AM** Sen. Burgess
**10:32:06 AM** Sen. Book
**10:33:09 AM** S1120
**10:33:11 AM** Sen. Rodriguez
**10:33:45 AM** Sen. Bean
**10:33:58 AM** John Paul Fiore, Director of Legislative Affairs, DCF (waives in support)
**10:34:53 AM** S1262
**10:35:02 AM** Sen. Burgess
**10:36:29 AM** Am. 814364
**10:38:38 AM** Sen. Rouson
**10:39:39 AM** Shane Messer, Florida Council for Behavioral Healthcare (waives in support)
**10:39:49 AM** Natalie Kelly, Florida Association of Managing Entities (waives in support)
**10:40:13 AM** Sen. Harrell
**10:41:12 AM** Sen. Diaz

**10:41:27 AM** Sen. Bean
**10:41:44 AM** Sen. Burgess
**10:43:07 AM** S1950
**10:43:11 AM** Sen. Bean
**10:43:53 AM** Sen. Brodeur
**10:44:28 AM** Am. 702460
**10:44:34 AM** Sen. Brodeur
**10:45:43 AM** Sen. Rouson
**10:46:51 AM** Sen. Brodeur
**10:47:21 AM** Sen. Harrell
**10:47:39 AM** Sen. Brodeur
**10:48:05 AM** Sen. Brodeur
**10:48:51 AM** Sarah Nemes, Embrace Families (waives in support)
**10:49:16 AM** Cody Ferrill, Chief of Staff, AHCA (waives in support)
**10:49:41 AM** Sen. Brodeur
**10:50:46 AM** Sen. Bean
**10:51:19 AM** Sen. Harrell
**10:51:30 AM** Sen. Farmer
**10:51:39 AM** Sen. Jones