HOUSE OF REPRESENTATIVES STAFF FINAL BILL ANALYSIS

BILL #: HB 7089 PCB HHS 24-02 Health Care Expenses
SPONSOR(S): Health & Human Services Committee, Grant
TIED BILLS: **IDEN./SIM. BILLS:** SB 1502, CS/SB 1640

FINAL HOUSE FLOOR ACTION: 111 **Y's** 0 **N's** **GOVERNOR'S ACTION:** Pending

SUMMARY ANALYSIS

HB 7089 passed the House on March 4, 2024, as amended. The bill was amended in the Senate on March 8, 2024, and returned to the House. The House concurred in the Senate amendments and subsequently passed the bill as amended on March 8, 2024. The bill includes portions of CS/CS/CS/HB 1061 and CS/CS/CS/SB 536.

The bill establishes standards for medical billing and health care price transparency, and regulates contractual relationships between the Department of Children and Families (DCF) and community-based child welfare lead agencies (CBCs).

The bill requires hospitals and ambulatory surgical centers (ASCs) to publish the costs of at least 300 shoppable services or provide an internet-based tool which meets federal standards. The bill defers compliance for ASCs to January 1, 2026 for this provision. The bill requires hospitals and ASCs to establish an internal grievance process for patient billing disputes. Hospitals and ASCs must disclose when an insured patient's cost-sharing amount exceeds a non-insured person's cash price or pay a maximum fine of $500 per incident. The bill requires hospitals and ASCs to provide each patient with an estimate, and requires health plans to provide an advanced explanation of benefits on certain time lines. The bill requires health plans to count shared savings incentives as medical expenses for rate development and filing purposes.

The bill prohibits hospitals and ASCs from filing an extraordinary collection action for medical debt. The bill establishes a new three-year statute of limitation period for medical debt collections which begins on the date the hospital or ASC refers the medical debt to a third party. The bill exempts up to $10,000 of a debtor's property from attachment, garnishment, or other legal action by a hospital or ASC to recover a medical debt. The bill also prohibits a hospital or ASC from engaging in extraordinary action to collect a medical debt while a patient 's eligibility for, enrollment in, or grievance about other coverages are pending.

The bill reforms the contractual rights and obligations between DCF and CBCs. It establishes related party requirements to screen conflicts of interests before a CBC subcontracts or transacts with related parties, and subjects a CBC to a systematic approval process before DCF authorizes a CBC to exceed the direct services threshold limitation. The bill creates penalties and contractual remedies to address violations of procurement law, breach of contract, or deficient performance of contract.

The bill charges DCF to develop a new CBC funding methodology for the allocation of core service funds in collaboration with the CBCs and other child welfare service providers. DCF must submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2024, documenting the proposed funding methodology. In addition, the bill establishes a DCF working group to study, evaluate, and offer recommendations relating to contractual and funding matters in the child welfare system.

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

Subject to the Governor's veto powers, the effective date of the bill is July 1, 2024; except for the provisions related to good faith estimates and advanced explanations of benefits which are effective and contingent upon certain federal action.

I. SUBSTANTIVE INFORMATION

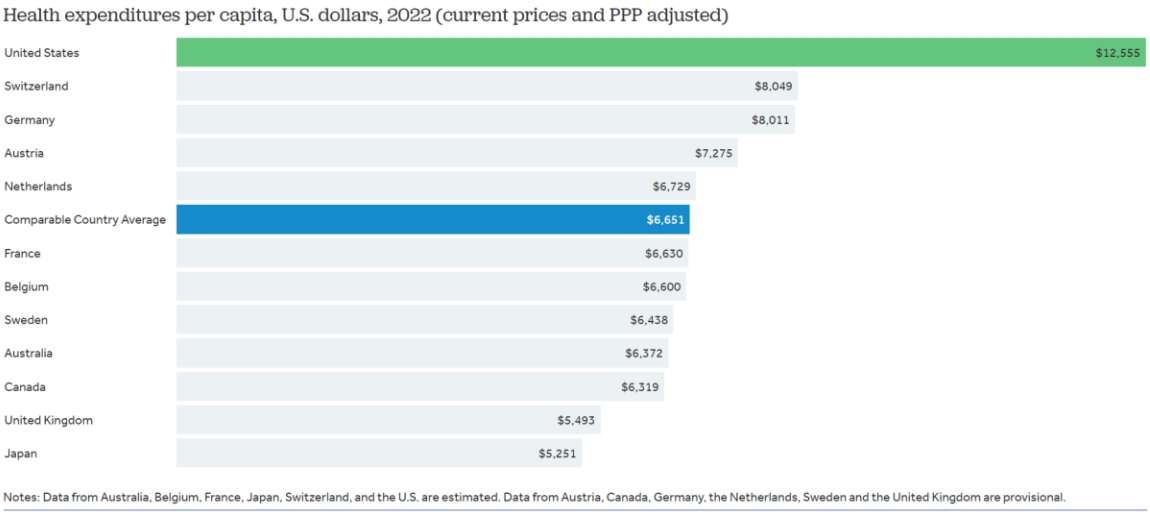
A. EFFECT OF CHANGES:

BACKGROUND

Health Care Spending

Health spending in the United States has exploded in the last 50 years, totaling $74.1 billion in 1970, increasing to $1.4 trillion by 2000, then tripling in 2021 to $4.3 trillion.[1] Total national health expenditures grew by $175 billion in 2022 from 2021 with hospital expenditures and retail prescription drugs accounting for approximately one-third of the spending growth.[2]

The United States spends more per person on health care than any other high-income country in the world and spending has continued to increase over the past few decades. As the chart below indicates, the United States far outspends other high-income countries on a per capita basis and exceeds the comparable country average by almost double.[3]



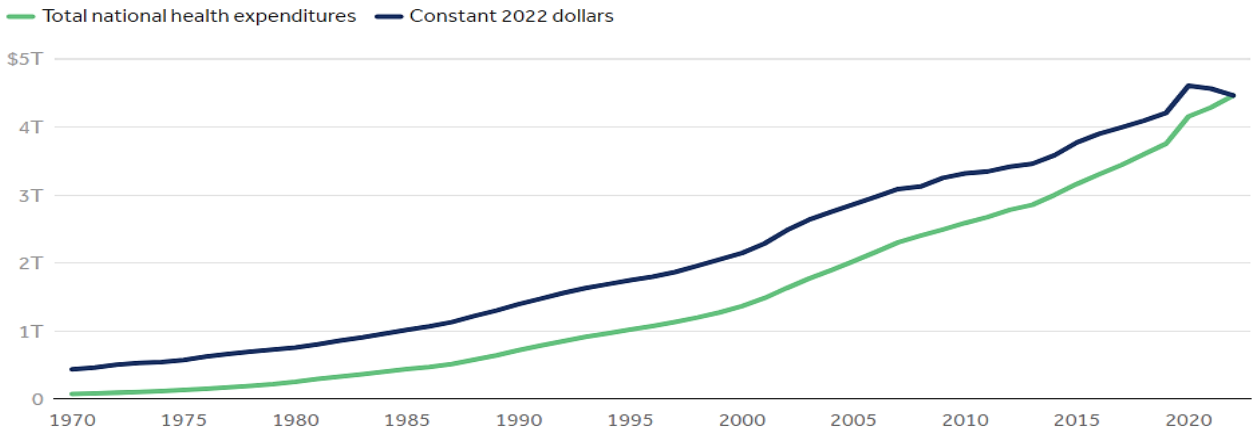
The Organization for Economic Cooperation Development estimated that total spending in 2019 in its member countries averaged 8.8 percent of their gross domestic product (GDP), compared with 16.8 percent in the United States.[4] One study found commercial health spending per enrollee in the United States increased by 61.6 percent from 2008 to 2022, faster than both Medicaid and Medicare which rose at 40.8 percent and 21.7 percent, respectively, for the same time period.[5]

The following chart illustrates the relative impact that each of the major service components contribute towards the country's total health care expenditures.[6]

---

[1] Peterson-Kaiser Family Foundation, Health System Tracker, *Health Spending – How has U.S. spending on healthcare changed over time?*, December 15, 2023, available at https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Total%20national%20health%20expenditures,%20US%20$%20Billions,%201970-2022 https://healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/ (last visited on February 18, 2024).
[2] *Id.*
[3] Emma Wagner, et. al., Peterson-KFF Health System Tracker, *How does health spending in the U.S. compare to other countries? (January 23, 2024),* available at https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/ (last visited March 26, 2024).
[4] *Id.*
[5] *Supra,* note 1.
[6] *Supra,* note 3.

In the chart below, the total of all health care expenditure categories is reflected and tracked since 1970 against the constant value of the United States dollar. The chart illustrates the rate of growth in total national health expenditures from 1970 to 2022.[7]

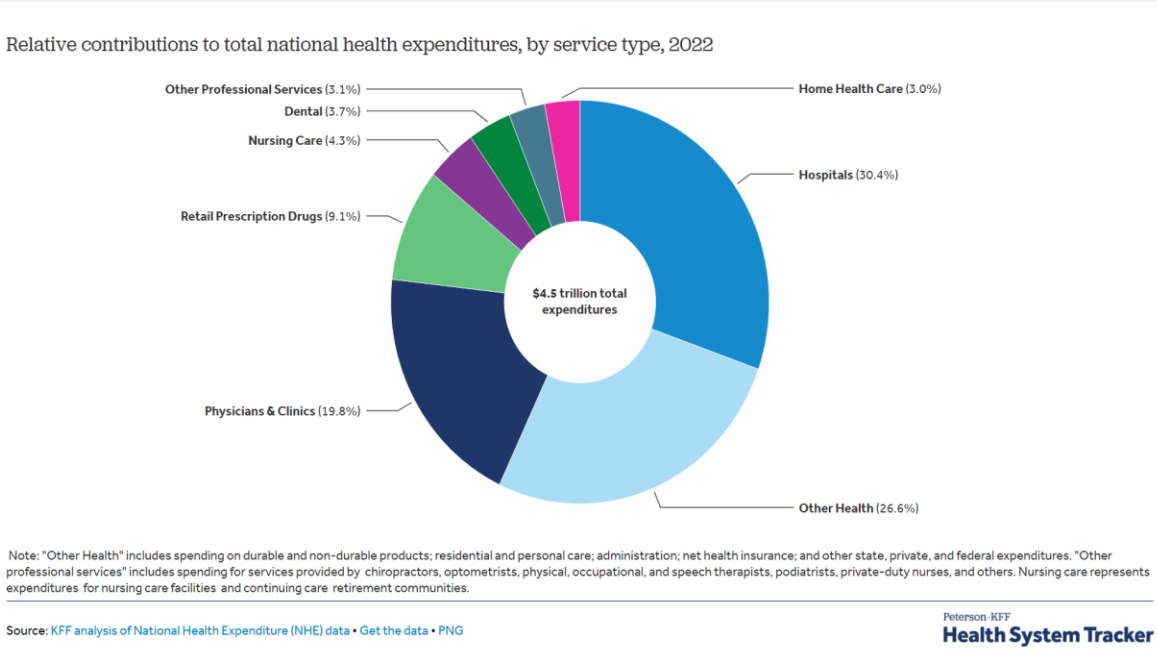


Note: A constant dollar is an inflation adjusted value used to compare dollar values from one period to another.

As a percentage of the country's total expenditures, the percentage in growth from year to year has slowed in recent decades, from a high of 12 percent in the 1970s to the current 9.6 percent for the 2020-2022 review period; however, health care spending still consistently exceeds growth in the country's gross domestic product (GDP).[8]

Health Insurance Expenditures

The rising prices of a few health care services accounted for approximately two-thirds of the growth in commercial health care spending, with prices for prescription drugs, provider services (physical examinations, screenings and procedures), and inpatient and outpatient care rising by 18.3 percent.[9]



[7] *Supra,* note 1.
[8] *Id.*
[9] *Id.*

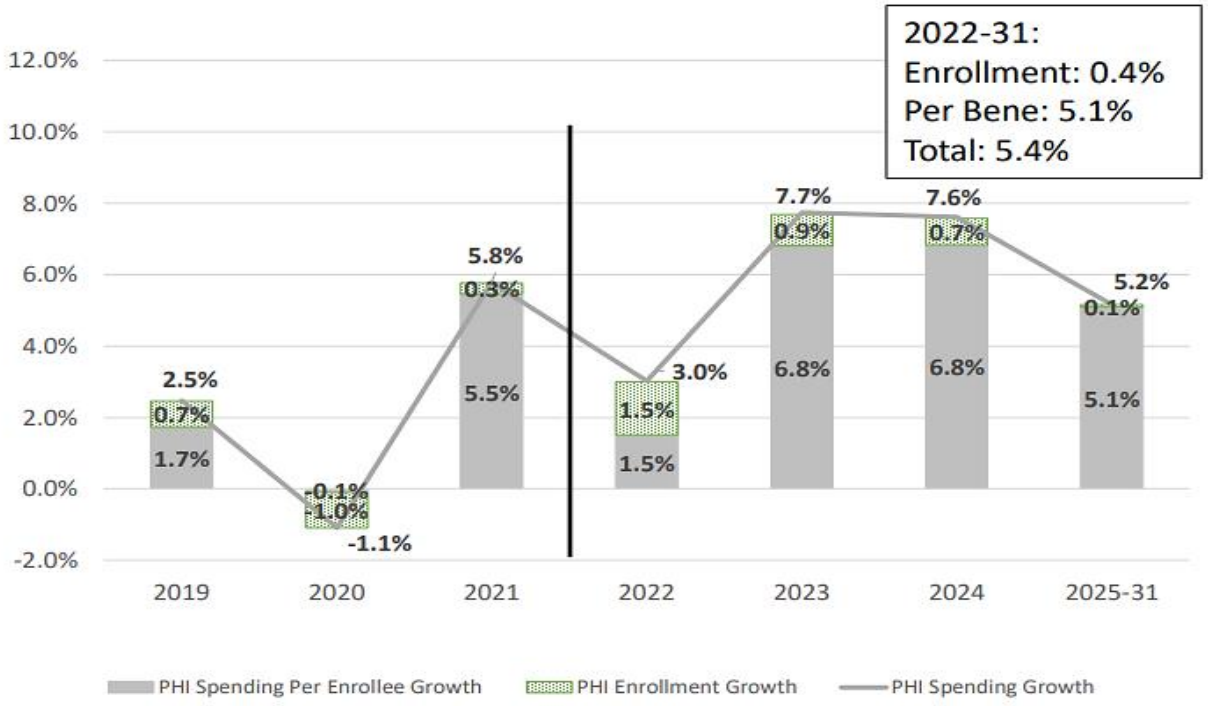
Private insurance expenditures have also been growing at a faster pace than either Medicaid or Medicare spending. In 1970, private health insurance expenditures represented 20.4 percent of total health spending; whereas, for 2022, the percentage had grown to 28.9 percent.[10] Additionally, per enrollee spending by private insurers increased by 61.6 percent from 2008 to 2022, a rate that was faster than the per enrollee spending for public programs such as Medicare and Medicaid. From 2021 to 2022, the rate for private insurers was 4.3 percent while Medicaid rose by 2.2 percent and Medicare by 3.8 percent.[11]

Per enrollee spending for those with private health insurance in 2023 to 2024 is expected to increase at a faster pace than in 2022 due to an increase in health care utilization and health care costs. This growth in the private health insurance market, according to a report by the Office of the Chief Actuary at the Centers for Medicare and Medicaid Services (CMS),[12] is tied to increased enrollment in the Marketplace[13] while additional subsidies were available under the American Rescue Plan Act of 2021 (ARP).[14] Beginning in 2021, the ARP legislation expanded the number of individuals eligible for certain premium tax credits and also provided additional eligible individuals with increased premium tax credits for the purchase of Marketplace coverage.

The CMS Actuary's report shows an average predicted growth rate in national health expenditures (NHE) of 5.4 percent which would outpace the expected average GDP growth rate for the same time period of 4.6 percent.[15]

The chart below illustrates the average annual growth in enrollment per beneficiary spending, and total spending, by the designated time period for private health insurance coverage.[16]

[10] *Id.*
[11] *Id.*
[12] Centers for Medicare and Medicaid Services, *National Health Expenditures Projections 2022-31: Growth to Stabilize Once Public Health Emergency Ends*, June 14, 2023, Slide 10, available at *https://www.cms.gov/files/document/release-presentation-slides-national*-health-*expenditure-projections-2022-31-growth-stabilize-once.pdf* (last visited February 18, 2024).
[13] The Marketplace refers to the federal marketplace, which may also be called the exchange, created by the Patient Protection and Affordable Care Act (PPACA). The purpose of the marketplace is to offer consumers the opportunity to compare a variety of health insurance plans with varying costs and benefits but which meet certain minimum requirements and to purchase such plans with premium tax credits and subsidies, if eligible.
[14] *American Rescue Plan of 2021*, Pub. Law 117-2 (March 11, 2021).
[15] *Supra,* note 12.
[16] *Id.*



NOTE: Average annual growth rates are from previous year shown.
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

The reductions shown above for the outlier years of 2025 through 2031 are tied to the expiration of the Marketplace subsidies. These subsidies exist in current law, and when those subsidies expire, the CMS Actuary's office projects an associated enrollment drop of 10 percent or two million beneficiaries in directly purchased health insurance coverage.[17]

Health Care Price Transparency

As consumers bear a greater share of health care costs, and more consumers participate in high deductible health plans (HDHP), consumers need clear, factual and easy to access information about the cost and quality of health care. Such information is essential for consumers if they are to make value-driven health care decisions. To promote consumer involvement and provider accountability, health care pricing and other data needs to be free, timely, reliable, and reflect individual health care needs and insurance coverage.

Price transparency often refers to the availability of provider-specific information on the cost for a specific health care service or set of services to consumers and other interested parties.[18] Price transparency can also be defined as the availability and provision of an estimate of a consumer's complete cost for a health care service or bundle of services that reflects any negotiated discounts; is inclusive of all other service or services to the consumer, including hospital, physician, and lab fees; and identifies a consumer's out-of-pocket cost.[19] Price transparency means the easy availability of information, including price disclosure matched with quality data, which enables patients and other care

[17] *Id.*
[18] Government Accounting Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, pg. 2, available at https://www.gao.gov/products/gao-11-791 (last visited January 22, 2024).
[19] *Id.*

purchasers to identify, compare, and choose providers that meet the consumer's desired level of quality and value.[20]

Employee Out of Pocket Costs

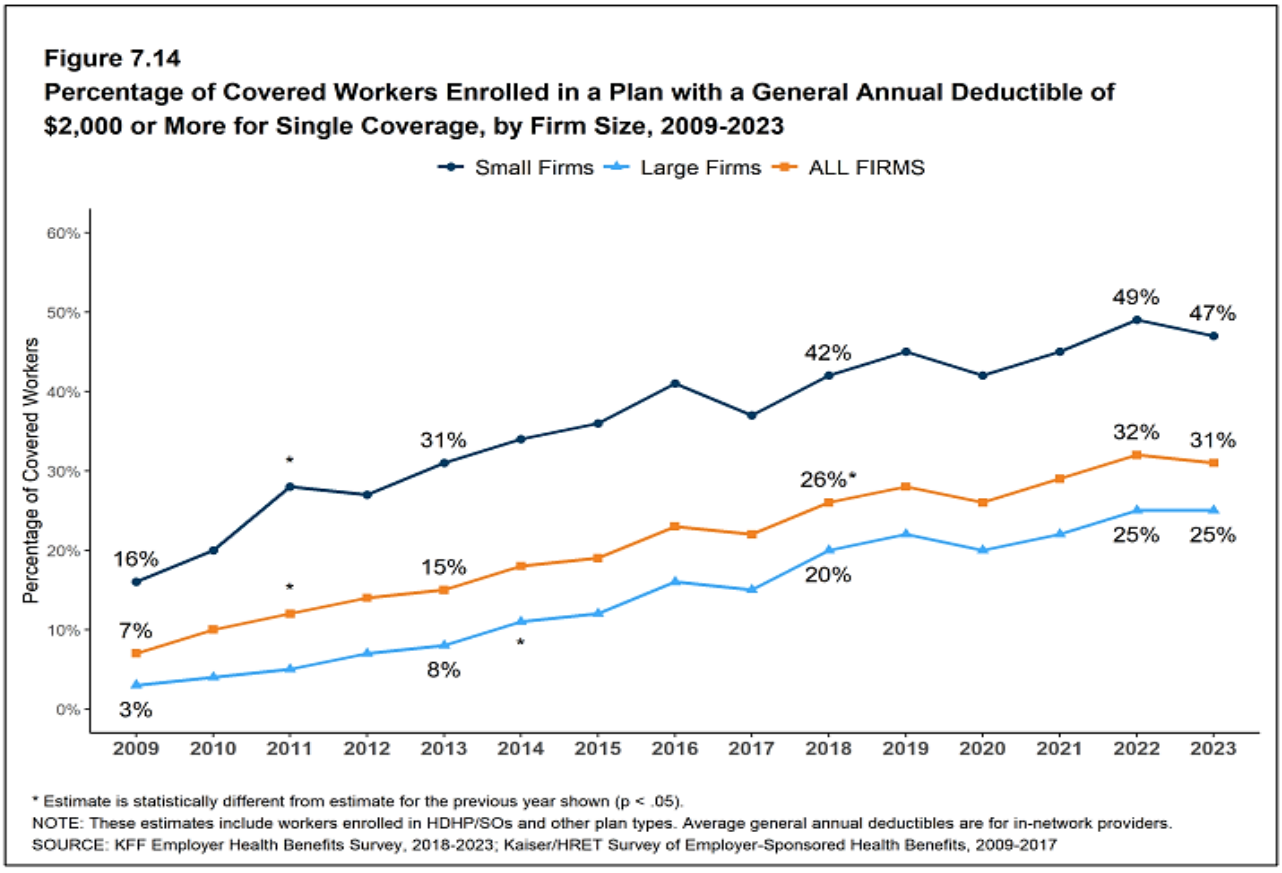
As health care costs continue to rise, most health insurance buyers are asking their consumers to take on a greater share of their costs, increasing both premiums and other out-of-pocket expenses, such as higher copayments or deductibles. According to the *2023 Kaiser Family Foundation Employer Health Benefits Survey*, 30 percent of Americans with private insurance were enrolled in a HDHP in 2023.[21] Additionally, employees in most firms, 77 percent, do not have a choice of health plans or benefit options, including 26 percent who are in firms where the only offer is a high deductible plan with savings option (HDHP/SO).

Most covered workers face additional out-of-pocket costs when they use health care services, such as co-payments or coinsurance for physician visits and hospitalizations. For 2023, 90 percent of covered workers had a general annual deductible[22] for single coverage that must be met before most services are paid for by their health plan.[23] Ten years ago, the percentage of covered workers with a general annual deductible was 78 percent and 85 percent five years ago.[24]

Among covered workers with a general annual deductible, the 2023 average deductible amount for single coverage across all plan types was $1,735 which is similar to the average amount for 2022 of $1,763.[25] Deductibles can differ greatly by a number of factors, including firm size, region, or whether a plan incorporates other cost sharing provisions. For 2023 when comparing costs by firm size, the average amount for single coverage was $2,434 in small firms and $1,478 in large firms.[26]

The 2023 plan deductible averages reflect moderate reductions from the average deductibles for small and large group plans in 2022 which were $2,543 and $1,493, respectively. Seventy-four percent of covered workers in small firms are in a plan with a deductible of at least $1,000 for single coverage compared to 58 percent in large firms;[27] a similar pattern exists for those in plans with a deductible of at least $2,000 (47 percent for small firms vs. 25 percent for large firms).

[20] Healthcare Financial Management Association, *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*, pg. 2, available at: https://www.hfma.org/wp-content/uploads/2022/10/Price20Transparency20Report.pdf (last visited February 18, 2024).
[21] The Henry J. Kaiser Family Foundation, *2023 Employer Health Benefits Survey,* October 18, 2023, p. 79, available at https://www.kff.org/report-section/ehbs-2023-section-4-types-of-plans-offered/ (last visited February 19, 2024).
[22] The term "general annual deductible" means a deductible which applies to both medical and pharmaceutical benefits and which must be met by the insured individual before most services are covered by the health plan. *See* The Henry J. Kaiser Family Foundation, *2023 Employer Health Benefits Survey, October 18, 2023, p.106,* available at: https://www.kff.org/report-section/ehbs-2023-section-4-types-of-plans-offered/ (last visited February 19, 2024).
[23] *Id.*
[24] *Id*., and FIG. 7.2, at p.108.
[25] *Id.*
[26] *Id.,* at 107-108.
[27] *Id.,* at 115 and FIG. 7.13.



The chart below shows the percent of workers enrolled in employer-sponsored insurance with an annual deductible of $1,000 or more for single coverage by employer size for 2009 through 2023.[28]

From 2013 to 2023, the average premium contribution required of covered workers with family coverage increased 19 percent and if broken down by just the last five years, the average worker contribution towards family health insurance coverage has increased by 22 percent compared to a 27 percent in workers' wages and 21 percent inflation.[29] Employer contributions to coverage vary widely based on the type of coverage and plan. For small plans, 30 percent of employers pay the entire premium for individual coverage of their workers whereas this is only the case with six percent of large firm employers. For family coverage, however, only small firm employees contribute more than half the premium costs for family coverage, compared to eight percent of covered workers in large firms.[30]

For workers in a HDHP, they may receive contributions from their employer into a savings account which may be used to reduce cost sharing amounts or to cover items not included in the employer's benefit package. In 2023, seven percent of covered workers with a HDHP with a health reimbursement arrangement (HRA)[31] and four percent of covered workers in a Health Savings Account (HSA) – qualified HDHP received an employer contribution to their accounts that was greater than or equal to their annual deductible.[32]

[28] *Id*., at 116 and FIG. 7.14.
[29] *Id*. at 7.
[30] *Id*. at 9.
[31] A high deductible health plan with a savings option (HDHP/SOs) are health plans which have a deductible of at least $1,000 for individual coverage and $2,000 for family coverage which are paired with a health reimbursement account (HRA), or a high deductible health plan that is considered by federal requirements to be a qualified HDHP. Funds in these savings accounts are pre-tax dollars which may be used to cover out-of-pocket medical expenses and other plan cost sharing.
[32] *Supra*, note 21, at 12.

An HRA is defined by the Internal Revenue Service (IRS) as an account-based group health plan provided by an employer to provide for the reimbursement of medical expenses under IRS Code section 213(d). The HRA is subject to maximum, fixed-dollar amounts for reimbursements within a specified period, usually a plan year.[33]

For those employees with an HDHP and an HRA, 12 percent of those workers received an employer contribution that if the amount had been applied to the worker's annual deductible, the remaining deductible would be less than $1,000.[34] HSA-qualified HDHPs are required by federal law to have an annual out of pocket maximum of no more than $7,500 for single coverage and $15,000 for family coverage. For HDHPs with an HRA option that are not grandfathered plans, the out of pocket maximum in 2023 was $9,100 for single coverage and $18,200 for family coverage. The average out of pocket maximum for 2023 was $5,456 for HDHP/HRAs and $4,415 for HSA-qualified HDHPs.[35]

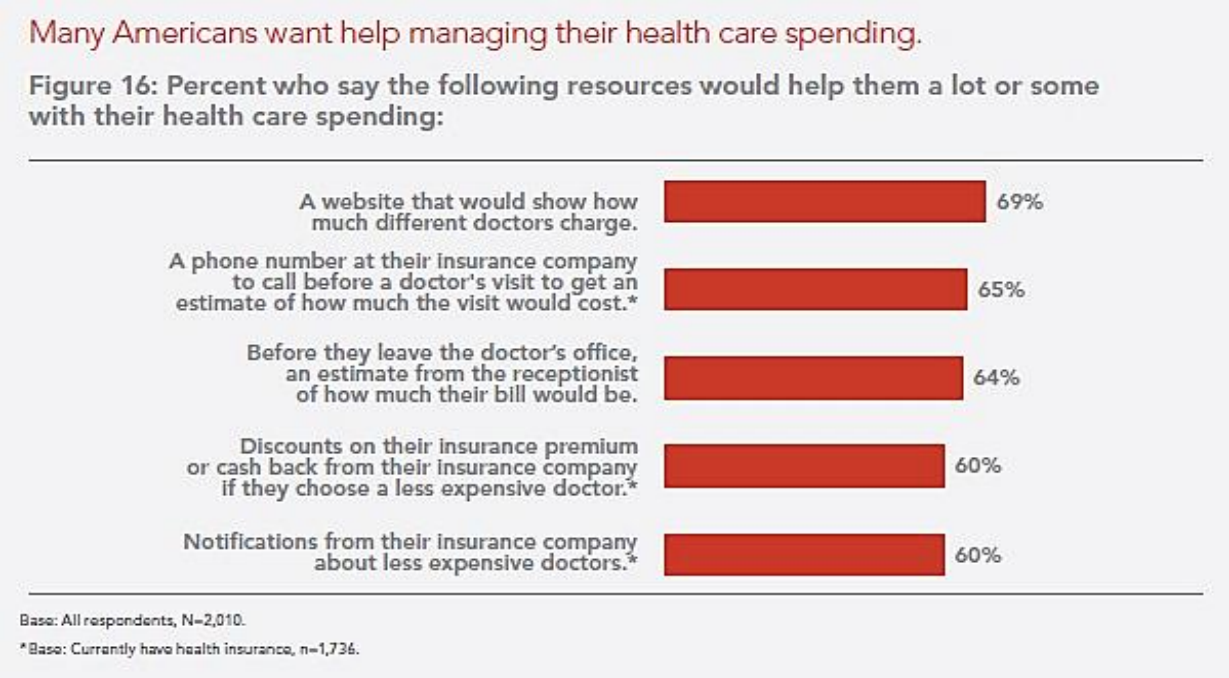
Such funding arrangements are more likely to be found in firms with more than 200 workers (57 percent) than smaller firms (29 percent).[36] Enrollment has increased over the past 10 years in HDHP/SOs growing from 10 percent of covered workers in 2013 to 29 percent in 2023.[37]

As the percentage of insured individuals taking on greater shares of their health care costs increases, the necessity for easy to access, accurate, and timely information on the availability, cost, and quality of health care services becomes more evident. If consumers are to make informed decisions about their health care and how to spend their health care funds, consumers need obtainable and readable data before and after the delivery of health care services.

National Price Transparency Studies

To explore how expanding price transparency efforts could produce significant cost savings for the healthcare system, the Gary and Mary West Health Policy Center funded an analysis, "Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending." As noted by the authors, American consumers have historically found it difficult to comparison shop for health care services as information about pricing and service delivery is buried in secrecy and shrouded in medical jargon once information is uncovered by the consumer.[38] As Americans bear more of the financial burden of their health care costs, research suggests that consumers want easier to access, easier to understand pricing tools, and quality health care data that will makes them better consumers.[39]

[33] *Health Reimbursement Arrangements and Other Account Based Group Health Plans*, Supplementary Information – Final Rule, 84 Fed.Reg.119, 28887 (June 20, 2019), available at https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf (last visited January 22, 2024).
[34] *Supra*, note 21, at 12.
[35] *Supra*, note 21, at 147.
[36] *Supra*, note 21, at 140.
[37] *Supra*, note 21, at 142.
[38] White, C., Ginsburg, P., et al., Gary and Mary West Health Policy Center, *Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending*, May 2014, p. 3, available at https://www.westhealth.org/wp-content/uploads/2015/05/Price-Transparency-Policy-Analysis-FINAL-5-2-14.pdf (last visited February 18, 2024).
[39] Public Agenda and Robert Wood Johnson Foundation, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015, page 34, available at https://www.publicagenda.org/reports/how-much-will-it-cost-how-americans-use-prices-in-health-care/ (last visited February 18, 2024).



One study in 2014, which included a national survey of more than 2,000 adults, found that 56 percent of Americans actively searched for price information before obtaining health care, including 21 percent who compared the price of health care services across multiple providers.[40] The study also reported that most Americans do not equate price with quality of care. Seventy-one percent did not believe higher price reflected higher level care quality and 63 percent did not believe that lower price was indicative of lower level care quality.[41]

Florida Price Transparency: Florida Patient's Bill of Rights and Responsibilities

In 1991, the Legislature enacted the Florida Patient's Bill of Rights and Responsibilities (Patient's Bill of Rights).[42] The statute established the right of patients to expect medical providers to observe standards of care in providing medical treatment and communicating with their patients.[43] The standards of care include, but are not limited to, the following aspects of medical treatment and patient communication:

- Individual dignity;
- Provision of information;
- Financial information and the disclosure of financial information;
- Access to health care;
- Experimental research; and
- Patient's knowledge of rights and responsibilities.

A patient has the right to request certain financial information from health care providers and facilities.[44] Specifically, upon request, a health care provider or health care facility must provide a person with a reasonable estimate of the cost of medical treatment prior to the provision of treatment.[45] Estimates must be written in language "comprehensible to an ordinary layperson."[46] The reasonable estimate does not preclude the health care provider or health care facility from exceeding the estimate or making additional charges as the patient's needs or medical condition warrant.[47] A patient has the right to

[40] *Id*., at 3.
[41] *Id.,* at 14.
[42] S. 1, Ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.
[43] S. 381.026(3), F.S.
[44] S. 381.026(4)(c), F.S.
[45] S. 381.026(4)(c)3., F.S.
[46] *Id.*
[47] *Id*.

receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[48]

Currently, under the Patient's Bill of Rights financial information and disclosure provisions:

- A request is necessary before a health care provider or health care facility must disclose to a Medicare-eligible patient whether the provider or facility accepts Medicare payment as full payment for medical services and treatment rendered in the provider's office or health care facility.
- A request is necessary before a health care provider or health care facility is required to furnish a person an estimate of charges for medical services before providing the services. The Florida Patient's Bill of Rights and Responsibilities does not require that the components making up the estimate be itemized or that the estimate be presented in a manner that is easily understood by an ordinary layperson.
- A licensed facility must place a notice in its reception area that financial information related to that facility is available on the website of the Agency for Health Care Administration (AHCA).
- The facility may indicate that the pricing information is based on a compilation of charges for the average patient and that an individual patient's charges may vary.
- A patient has the right to receive an itemized bill upon request.

Health care providers and health care facilities are required to make available to patients a summary of their rights. The applicable regulatory board or AHCA may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.[49]

The Patient's Bill of Rights also authorizes, but does not require, primary care providers[50] to publish a schedule of charges for the medical services offered to patients.[51] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[52] The law also requires the posting of the schedule in a conspicuous place in the reception area of the provider's office and at least 15 square feet in size.[53] A primary care provider who publishes and maintains a schedule of charges is exempt from licensure fees for a single renewal of a professional license and from the continuing education requirements for a single two-year period.[54]

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[55] This applies to any entity that holds itself out to the general public, in any manner, as a facility or clinic where immediate, but not emergent, care is provided, expressly including offsite facilities of hospitals or hospital-physician joint ventures; and licensed health care clinics that operate in three or more locations. The schedule requirements for urgent care centers are the same as those established for primary care providers.[56] The schedule must describe each medical service in language comprehensible to a layperson. This provision prevents a center from using medical or billing codes, Latin phrases, or technical medical jargon as the only description of each medical service. An urgent care center that fails to publish and post the schedule of charges is subject to a fine of not more than $1,000 per day (until the schedule is published and posted).[57]

[48] S. 381.026(4)(c)5., F.S.
[49] S. 381.0261, F.S.
[50] S. 381.026(2)(d), F.S.; defines primary care providers to include allopathic physicians, osteopathic physicians, and nurses who provide medical services that are commonly provided without referral from another health care provider, including family and general practice, general pediatrics, and general internal medicine.
[51] S. 381.026(4)(c)3., F.S.
[52] *Id.*
[53] *Id*.
[54] S. 381.026(4)(c)4., F.S.
[55] S. 395.107(1), F.S.
[56] S. 395.107(2), F.S.
[57] S. 395.107(6), F.S.

Under s. 395.301, F.S., a health care facility must comply, within 7 days of a written request, a good faith estimate of reasonably anticipated charges for the facility to treat the patient's condition. Upon request, the facility must also provide revisions to the estimate. The estimate may represent the average charges for that diagnosis related group[58] or the average charges for that procedure. The facility is required to place a notice in the reception area that this information is available. A facility that fails to provide the estimate as required may be fined $500 for each instance of the facility's failure to provide the requested information.

Also pursuant to s. 395.301, F.S., a licensed facility must notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. If requested, within seven days of discharge or release, the licensed facility must provide an itemized statement, in language comprehensible to an ordinary layperson, detailing the specific nature of charges or expenses incurred by the patient. This initial bill must contain a statement of specific services received and expenses incurred for the items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility. The patient or patient's representative may elect to receive this level of detail in subsequent billings for services.

Current law also directs these health care facilities to publish information on their websites detailing the cost of specific health care services and procedures, as well as information on financial assistance that may be available to prospective patients. The facility must disclose to the consumer that these averages and ranges of payments are estimates, and that actual charges will be based on the services actually provided.[59] Under s. 408.05, F.S., AHCA contracts with a vendor to collect and publish this cost information to consumers on an internet site.[60] Hospitals and other facilities post a link to this site - https://pricing.floridahealthfinder.gov/ - to comply with the price transparency requirements. The cost information is searchable, and based on descriptive bundles of commonly performed procedures and services. The information must, at a minimum, provide the estimated average payment received and the estimated range of payment from all non-governmental payers for the bundles available at the facility.[61]

The law also establishes the right of a patient to request a personalized estimate on the costs of care from health care practitioners who provide services in a licensed hospital facility or ambulatory surgical center.[62]

Regulation of Health Care Facilities and Providers

Oversight of Florida's health care facilities and health care providers is often a joint effort by the AHCA and the Department of Health (DOH), depending upon the regulatory issue. The AHCA regulates and monitors health care facilities under ch. 395, Part I, F.S., including those defined under s. 395.301, F.S. The definition of a health care facility includes, but is not limited to hospitals, ambulatory surgical centers, and urgent care facilities. As the regulatory entity for enforcement of, AHCA has the ability,

[58] Diagnosis related groups (DRGs) are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. DRGs allow facilities to categorize patients based on severity of illness, prognosis, treatment difficulty, need for intervention and resource intensity. For more information, see https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf (last visited January 22, 2024).
[59] S. 395.301, F.S.
[60] S. 408.05(3)(c), F.S.
[61] *Id.*
[62] S. 456.0575(2), F.S.

within statutory guidelines, to fine entities for failure to adhere to the law or take other administrative actions, as permitted.

AHCA 's Bureau of Facility Regulation (bureau) is responsible for the licensure of facilities, registration, and federal certification requirements for 27 different facilities and providers. The bureau implements statutory standards, targets, and guidelines, conducts surveillance, performs assessments and audits, conducts audits, and enforces sanctions and other regulatory actions when necessary.[63]

The DOH designates eligible facilities as trauma centers, either as a level I, level II, or a pediatric trauma center if the facility meets the statutory requirements outlined in ch. 395, Part II, F.S., and in ch. 64J—2, F.A.C. Hospitals must complete applications with the DOH for the appropriate trauma level being sought and certify as to the availability of certain types of providers, provide a description of the trauma team, and satisfy quality management protocols.[64]

The DOH also licenses and regulates health practitioners for the preservation of the health, safety, and welfare of the public. The DOH must investigate complaints and reports about health care practitioners which are licensed by the DOH and may take administrative actions against a practitioner to enforce state laws or regulations.[65]

Federal Price Transparency Laws and Regulations

Congress and federal regulatory agencies took steps in 2019 to improve the quantity and quality of health care cost information available to patients. Federal price transparency laws and regulations; however, does not cover all types of health care facilities. For example, federal transparency requirements excluded certain facilities leaving requirements and compliance to the States.

Hospital Facility Transparency: Shoppable Services

On November 15, 2019, the CMS finalized regulations[66] changing payment policies and rates for services furnished to Medicare beneficiaries in hospital outpatient departments. In doing so, CMS also established new requirements for hospitals to publish standard charges for a wide range of health care services offered by such facilities. Specifically, the regulations require hospitals to make public both a machine-readable file (MRF) of standard charges and a consumer-friendly presentation of prices for at least 300 shoppable health care services. The regulations became effective on January 1, 2021.[67]

The regulations define a shoppable service as one that can be scheduled in advance, effectively giving patients the opportunity to select the venue in which to receive the service. This is a more expansive designation of shoppable services than currently exists in Florida law. For each shoppable service, a hospital must disclose several pricing benchmarks to include:

- The gross charge;
- The payer-specific negotiated charge;

[63] Agency for Health Care Administration, State of Agency Organization and Operation (Revised Feb. 14. 2014), Division of Health Quality Assurance, Bureau of Health Facility Regulation, available at https://ahca.myflorida.com/content/download/4859/file/OrganizationAndOperationStatementRevised.pdf (last visited February 19. 2024).
[64] Florida Department of Health, *Trauma Center Designation, Application Process, available athttps://www.floridahealth.gov/licensing-and-regulation/trauma-system/trauma-center-designation.html* (last visited February 19, 2024).
[65] Florida Department of Health, Licensing and Regulation, Enforcement, available at https://www.floridahealth.gov/licensing-and-regulation/enforcement/index.html?utm_source=floridahealth.gov%26utm_medium=text-link%26utm_campaign=mqa%26utm_term=medical+quality+assurance+file+complaint%26utm_content=https://www.floridahealth.gov/licensing-and-regulation/ (Last visited February 19, 2024).
[66] Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and available at: Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 FR 65524 (November 27, 2019)(codified at 45 CFR Part 180).
[67] *Id.*

- A de-identified minimum negotiated charge;
- A de-identified maximum negotiated charge; and,
- The discounted cash price.

This information should provide a patient with both a reasonable point estimate of the charge for a shoppable service, and also a range in which the actual charge can be expected to fall.

Federal regulations and guidance also require that the facility's display be available in a prominent position on the facility website, free charge and without the requirement to register as a patient or account user, and accessible without the need for personal identifiable information.[68]

Compliance Reports

The penalty for facility noncompliance under the federal regulations is a maximum fine of $300 per day.[69] Very early indications suggested that there were varying levels of compliance with the new rules among hospital facilities and many facilities complaining about the high cost of implementation.[70] At least one patient advocacy group has consistently posted much lower compliance rates by hospitals in its semi-annual reports which highlight the status of each hospital.[71]

A 2021 review of more than 3,500 hospitals found that 55 percent of hospitals were not compliant with the rule and had not posted price information for commercial plans or had not posted any prices at all.[72] The first fines were not levied by federal CMS until almost 18 months after the rule's effective date. When levied against Northside-Atlanta, the total amount of those fines is less than 0.1 percent of Northside Hospital system's total gross revenues[73]. That assessment is still shown as under review on the CMS enforcement website.

A year ago, CMS reported an improving compliance rate as high as 70 percent by hospitals; however, CMS has also issued a very high volume of warning letters and corrective actions plans.[74] In April 2023, CMS reported the issuance of over 730 warning letters and 269 requests for corrective action plans.[75] More recently, a data transparency vendor reviewed the 2023 compliance rate by facilities and found at least 90 percent of facilities had submitted some of the listed mandated services via the required MRF requirement. The MRF contains a facility's cash, list, and negotiated rates for a significant number of the facility's services.[76] The same report also updated the number of warning letters in the past year to a cumulative of 1,000 letters and issuance of 14 civil penalties.[77]

CMS maintains a website with a list of facilities assessed civil monetary penalties for non-compliance, the non-compliance notices, and the status of any facilities which have requested a review of an

---

[68] Centers for Medicare and Medicaid Services, *Hospital Price Transparency Requirements – Quick Reference Checklists,* available at https://www.cms.gov/files/document/hospital-price-transparency-final-rule-quick-reference-checklists.pdf (last visited March 15, 2024).
[69]. 45 CFR §180.90. The maximum daily fine will be adjusted annually by the Office of Management and Budget.
[70] Dave Muoio, *Hospital, payer price transparency compliance improves, but new requirements are kicking in this year (January 4, 2024), Fierce Healthcare*, available at Hospital, payer price transparency improves across 2023: report finds (fiercehealthcare.com) (last visited February 18, 2024).
[71] *See Florida Fifth Semi-Annual Hospital Price Transparency Report,* http(s://www.patientrightsadvocate.org/s/FL-Florida-Fifth-Semi-Annual-Hospital-Price-Transparency-Compliance-Report.pdf *(Patientsrightsadvocate.org;)* (last visited February 18, 2024).
[72] John Xuefeng Jiang, et al., *Factors associated with compliance to the hospital price transparency final rule: A national landscape study*, Journal of General Internal Medicine (2021), available at https://link.springer.com/article/10.1007/s11606-021-07237-y (last visited on January 4, 2024).
[73] *Id*. at 4.
[74] American Bar Ass'n., *CMS States 70% of Hospitals Are Now Complying With Hospital Price Transparency Rules (April 23, 2023),* available at: *https://www.americanbar.org/groups/health_law/section-news/2023/february/cms-states-hospitals-are-now-complying-with-hospital-price-transparency-rules/* (last visited February 18, 2024).
[75] Centers for Medicare and Medicaid Services, *Hospital Transparency Enforcement Update (April 23, 2023),* available at https://www.cms.gov/newsroom/fact-sheets/hospital-price-transparncy-enforcement-update (last visited February 18, 2024).
[76] *Supra,* note 76.
[77] *Id.*

enforcement activity.[78] The Office of the Inspector General at HHS has announced its plans to review and audit HHS' monitoring and enforcement of the law and regulations. The Inspector General will review HHS' controls and randomly sample hospitals to determine if those controls are sufficient and issue a report later in 2024.[79]

On October 29, 2020, the federal Departments of HHS, Labor, and Treasury finalized regulations[80] imposing new transparency requirements on issuers of individual and group health insurance plans.

Health Plan and Health Insurers: Estimates

Central to the new regulations is the second half of the transparency requirement which requires the health plans and health insurers to provide an estimate of an insured's cost-sharing liability for covered items or services furnished by a particular provider. Under the final rule, health insurance plans must disclose cost-sharing estimates at the request of an enrollee and publicly release negotiated rates for in-network providers, historical out-of-network allowed amounts and billed charges, and drug pricing information. The rule's goal is to enable insured patients to estimate their out-of-pocket costs *before* receiving health care to encourage shopping and price competition amongst providers.[81]

Each health plan will be required to establish an online shopping tool that will allow insureds to see the negotiated rate between their provider and their plan, as well as a personalized estimate of their out-of-pocket cost for 500 of the most shoppable items and services. Beginning in 2024, health plans must provide personalized cost-sharing information to patients across the full range of covered health care services.[82] The federal rule also permits facilities to meet the cost estimator requirement through an Internet-based, online price estimator tool which meets the federal regulatory requirements.[83]

Similar to the minimum requirements for compliance with the shoppable services requirement, the checklist for compliance with the price estimate focus on the ease of use for the patient, include the ability of the patient to locate the information, if an online price estimator is provided by the plan, assurances that a patient does not need to create an account to access the information or use an estimator tool, and that use of the tool is free to the patient.[84]

Medical Loss Ratio

The federal regulations define the treatment of shared savings expenses under medical loss ratio (MLR) calculations required by the Patient Protection and Affordable Care Act (PPACA). The MLR refers to the percentage of insurance premium payments that are actually spent on medical claims by an insurer. In general, MLR requirements are intended to promote efficiency among insurers.[85] The PPACA established minimum MLR requirements for group and individual health insurance plans.[86] Under PPACA, large group plans must dedicate at least 85 percent of premium payments to medical claims, while small group and individual market plans must dedicate at least 80 percent of premium

[78] Centers for Medicare and Medicaid Services, *CMS Enforcement Actions,* available at : https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/enforcement-actions (last visited: February 18, 2024).
[79] Department of Health and Human Services, Office of the Inspector General, *Hospital Price Transparency, available at: https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000728.asp* (last visited February 18, 2024).
[80] Transparency in Coverage, 85 FR 73158 (November 12, 2020)(codified at 29 CFR Part 54, 29 CFR Part 2590, 45 CFR Part 147, and 45 CFR Part 158).
[81] Trump Administration Finalizes Transparency Rule for Health Insurers," Health Affairs Blog, November 1, 2020. Available at https://www.healthaffairs.org/do/10.1377/hblog20201101.662872/full/ (last visited January 22, 2024).
[82] 45 CFR §180.60(a)(1).
[83] 45 CFR §180.60(a)(2).
[84] *Supra,* note 68.
[85] "Explaining Health Care Reform: Medical Loss Ratio (MLR)", Henry J Kaiser Family Foundation, February 29, 2012. Available at https://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/ (last visited January 22, 2024).
[86] PPACA, s. 1001; 42 U.S.C. 300gg-18.

payments to medical claims.[87] Further, the law requires a health plan that does not meet these standards to provide annual rebates to individuals enrolled in the plan.[88]

The regulations finalized in October 2020 state that expenses by a health plan in direct support of a shared savings program may be counted as medical expenditures.[89] Thus, a health plan providing shared savings to members will receive an equivalent credit towards meeting the MLR standards established by PPACA.

The Federal *No Surprises Act*

On December 27, 2020, Congress enacted the *No Surprises Act* (Act) as part of the Consolidated Appropriations Act of 2021.[90] The Act included a wide-range of provisions aimed at protecting patients from surprise billing practices and ensuring that patients have access to accurate information about the costs of care. Most sections of the Act went into effect on January 1, 2022, and the Departments of Health and Human Services, Treasury, and Labor were tasked with issuing regulations and guidance to implement a number of the provisions.[91] Additional public notice requirements become effective July 1, 2024 resulting in further hospital charge information being posted for easily accessible viewing.

Estimates – Facilities

In the realm of price transparency, the Act establishes the concept of an "advanced explanation of benefits" that combines information on charges provided by a hospital facility with patient-specific cost information supplied by a health insurance plan. The process is triggered when a patient schedules a service at a hospital facility or requests cost information on a specific set of services. A hospital facility must share a "good faith estimate" of the total expected charges for scheduled items or services, including any expected ancillary services, with a health plan (if the patient is insured) or individual (if the patient is uninsured).[92]

Estimates – Health Plans

Once the "good faith estimate" has been shared with a patient's health plan, the plan must then develop a more detailed and "advanced explanation of benefits." This personalized cost estimate must include the following:

- An indication of whether the facility participates in the patient's health plan network. If the facility is non-participating, information on how the patient can receive services from a participating provider;
- The good-faith estimate prepared by the hospital facility based on billing/diagnostic codes;
- A good-faith estimate of the amount to be covered by the health plan;
- A good-faith estimate of the amount of the patient's out-of-pocket costs;
- A good-faith estimate of the accrued amounts already met by the patient towards any deductible or out-of-pocket maximum under the patient's health plan;
- A disclaimer indicating whether the services scheduled are subject to medical management techniques (i.e., medical necessity determinations, prior authorization, step therapy, etc.); and,
- A disclaimer that the information provided is only an estimate of costs and may be subject to change.[93]

The Act directed the Secretary of HHS to establish by January 1, 2022, a "patient-provider dispute resolution process" to resolve any disputes concerning bills received by uninsured individuals or

[87] Sections 627.6405 and 641.31097, F.S.
[88] *Id.*
[89] 45 CFR §158.221(b)(8).
[90] P.L. 116-260. The *No Surprises Act* is found in Division BB of the Act.
[91] *Id.*
[92] P.L. 116-260, Division BB, Section 112. (*The No Surprises Act)*
[93] P.L. 116-260, Division BB, Section 111 (*The No Surprise Act*).

individuals with insurance who received care not covered by insurance that substantially differ from a provider's good faith estimate provided prior to the service being rendered.[94] If one of the providers or facilities billed $400 more than the good faith estimate, the patient may dispute the bill through an independent third party.[95] To be considered, a patient must begin the dispute process within 120 days of receipt of the initial bill. The new requirements placed on hospitals and health plans by the Act are cumulatively intended to provide patients with increased certainty about the total and out-of-pocket costs associated with health care services. In turn, patients may be more equipped to seek out cost-effective care and avoid unforeseen costs that can lead to financial strain.

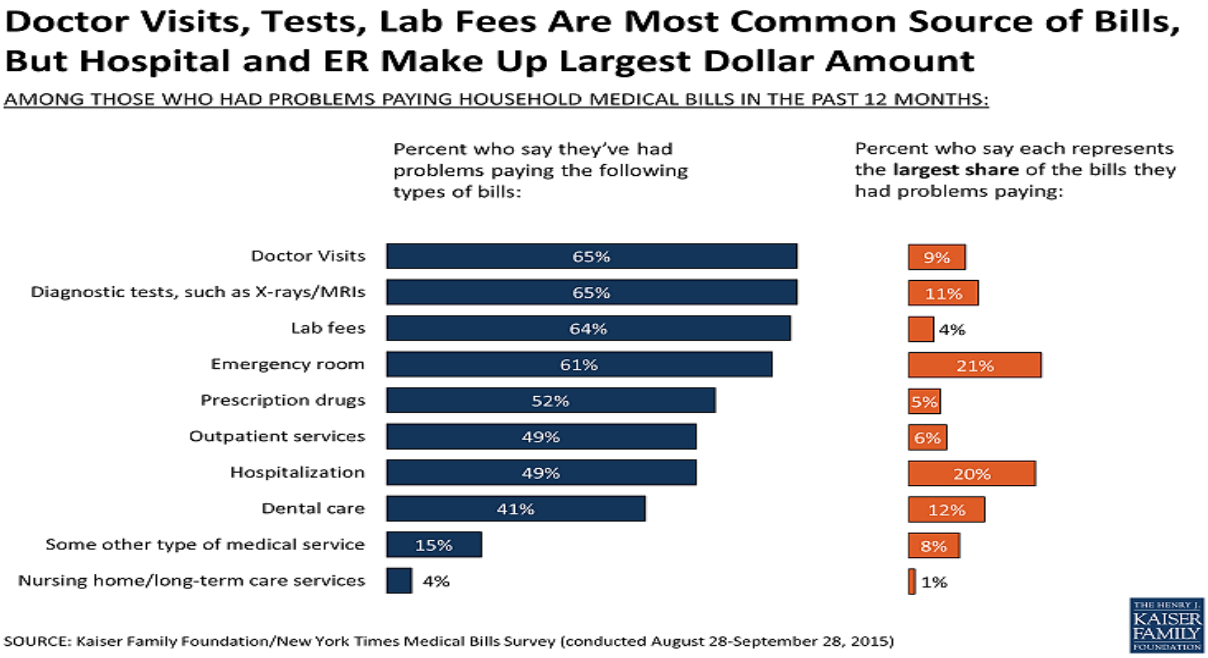
Medical Debt

Impact of Medical Debt

Medical costs can result in overwhelming debts to patients, and in some cases, bankruptcy. Nationwide, over 100 million have some form of medical debt.[96] A 2007 study suggested that illness and medical bills contributed to 62.1 percent of all personal bankruptcies filed in the United States during that year.[97] A more recent analysis, which considered only the impact of hospital charges, found that four percent of U.S. bankruptcies among non-elderly adults resulted from hospitalizations.[98] Four in ten U.S. adults have some form of health care debt,[99] including one in eight people who reported health care debts of at least $10,000 or more in a 2022 Kaiser Family Foundation poll.[100]

About half of adults – including three in ten who do not currently have health care debt – are vulnerable to falling in the debt, saying they would be unable to pay a $500 unexpected medical bill without borrowing money.[101] While about a third of adults with health care debt owe less than $1,000, even small amounts of debt can have significant financial consequences for some.[102] Though a third of those with current debt expect to pay it off within a year and about a quarter expect to pay it within one to two years, nearly one in five adults with health care debt think they will never be able to pay it off.[103]

[94] 45 CFR 149.510 (Independent Dispute Resolution Process).
[95] Centers for Medicare and Medicaid Services, *The No Surprises Act protects people from unexpected medical bills, https://www.cms.gov/medical-bill-rights* (last visited February 18, 2024).
[96] Kaiser Health News, *Diagnosis: Debt – 100 Million People in America Are Saddled with Health Care Debt*, June 16, 2022, available at https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/ (last visited January 22, 2024).
[97] David U. Himmelstein, et al. *"Medical Bankruptcy in the United States, 2007: Results of a National Study." American Journal of Medicine* 2009; 122: 741-6, available at https://pubmed.ncbi.nlm.nih.gov/19501347/ (last visited February 18, 2024) .
[98] Carlos Dobkin, et al. *"Myth and Measurement: The Case of Medical Bankruptcies." New England Journal of Medicine* 2018; 378:1076-1078, available at https://www.nejm.org/doi/full/10.1056/NEJMp1716604 (last visited February 19, 2024).
[99] Lopes, L., Kearney, A., et al, *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills*, June 16, 2022 (using results from the Kaiser Family Foundation Health Care Debt Survey), available at https://www.kff.org/health-costs/report/kff-health-care-debt-survey/ (last visited January 22, 2024).
[100] *Id.*
[101] *Id.*
[102] *Id.*
[103] *Id.*



Even when medical costs do not result in personal bankruptcy, the debts often weigh heavily on the financial health of patients and their families. According to the Kaiser Family Foundation, about a quarter of United States adults ages 18-64, say they or someone in their household have had problems paying or having an inability to pay medical bills in the past 12 months.[104] About three in ten survey respondents reported medical debt of $5,000 or more, with 13 percent of respondents indicating medical debt in excess of $10,000. Even patients with lower amounts of medical debt reported that the outstanding bills led to financial distress, in light of other financial commitments and/or limited income.[105]

Among those who reported problems paying medical bills, 66 percent said the bills were the result of a one-time or short-term medical expense such as a hospital stay or an accident, while 33 percent cited bills for treatment of chronic conditions that had accumulated over time. Respondents to the Kaiser survey reported a wide range of illnesses and injuries that led to an accumulation of medical debt. The largest share (36 percent) named a specific disease, symptom, or condition like heart disease or gastrointestinal problems, followed by issues related to chronic pain or injuries (16 percent), accidents and broken bones (15 percent), surgery (10 percent), dental issues (10 percent), and infections like pneumonia and flu (9 percent).[106]

Further polling results contained in the 2022 Kaiser report also showed that families who had experienced medical debt problems were also more likely to ask about the cost of a medical service or doctor's office visit beforehand than someone who had not had such difficulties (49 percent compared to 34 percent). Such families were also much more likely to shop around for services for the best price (34 percent compared to 17 percent) and to attempt to negotiate a lower rate before receiving a health care service (22 percent compared to six percent). Impacted families with medical debt also reported a higher rate of being asked to pay for health care services up front before services would be delivered.[107]

Medical Debt Collection Process

[104] The Henry J. Kaiser Family Foundation, *"The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey."* January 5, 2016, available at https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/ (last visited January 22, 2024).
[105] *Id.*
[106] *Id.*
[107] *Id.,* at 23.

Current law provides a court process for the collection of lawful debts, including medical debts. A creditor may sue a debtor and, if the creditor prevails, the creditor may receive a final judgment awarding monetary damages. If the debtor does not voluntarily pay the judgment, the creditor has several legal means to collect on the debt, including:

- Wage garnishment.
- Garnishment of money in a bank account.
- Directing the sheriff to seize assets, sell them, and give the proceeds to the creditor.

In order to protect debtors from being destitute, current state law provides that certain property is exempt from being taken by a creditor. The Florida Constitution provides that the debtor's homestead and $1,000 of personal property is exempt.[108] Statutory law provides numerous categories of exempt property, and federal law also provides certain exemptions applicable in all states.[109]

In addition to the protection from creditors contained in the Florida Constitution, ch. 222, F.S., protects other personal property from certain claims of creditors and legal process: garnishment of wages for a head of family;[110] proceeds from life insurance policies;[111] wages or unemployment compensation payments due certain deceased employees;[112] disability income benefits;[113] assets in qualified tuition programs; medical savings accounts; Coverdell education savings accounts; hurricane savings accounts;[114] $1,000 interest in a motor vehicle; professionally prescribed health aids; certain refunds or credits from financial institutions; and $4,000 interest in personal property, if the debtor does not claim or receive the benefits of a homestead exemption under the State Constitution.[115]

In 2018-2020, more than a quarter of the nation's largest hospitals and health systems pursued nearly 39,000 legal actions regarding consumer medical debt. More than two thirds of hospitals sue or take other legal action against patients with outstanding bills. Nearly 25 percent sell patient medical debt to collection agencies which pursue patients for years on unpaid bills. Further, one in five providers deny nonemergency care to people with outstanding medical debt.

Bankruptcy

Bankruptcy is a means by which the courts require that a person's assets are liquidated to pay the person's debts under court supervision. The United States Constitution gives Congress the right to uniformly govern bankruptcy law through federal bankruptcy courts.[116]

A debtor (the bankrupt person) is not required to give up all of his or her assets in bankruptcy. Under the Bankruptcy Code, the debtor may keep certain, designated property exempt from creditor claims.[117] In general, a debtor may choose the exempt property listing in state law or the exempt property of the Bankruptcy Code. However, federal law allows a state to opt-out of the federal law; Florida has elected to require debtors utilize only state law exemptions.[118]

Statute of Limitations

[108] Art. X, s. 4(a), Fla. Const.
[109] For example, the federal ERISA law provides that most retirement plans are exempt from creditor claims.
[110] S. 222.11, F.S.
[111] S. 222.13, F.S.
[112] S. 222.15, F.S.
[113] S. 222.18, F.S.
[114] S. 222.22, F.S.
[115] S. 222.25, F.S.
[116] Art. 1, s. 8, cl. 4, U.S. Const.
[117] 11 U.S.C. s. 522.
[118] 11 U.S.C. s. 522(b).

A statute of limitations bars a lawsuit's filing after a certain amount of time elapses following an injury.[119] This time period typically begins to run when a cause of action accrues (that is, on the date of the injury), but may also begin to run on the date the injury is discovered or on which it would have been discovered with reasonable efforts.[120] In other words, a statute of limitations bars the available civil remedy if a lawsuit is not timely filed after an injury.

Chapter 95, F.S., contains the bulk of Florida's statutes of limitations. Specifically, s. 95.11, F.S., details a variety of statutes of limitation for legal actions other than for recovery of real property. Some of the limitations require legal actions to be commenced as follows:

- WITHIN TWENTY YEARS.—An action on a judgment or decree of a court of record in this state.[121]
- WITHIN FIVE YEARS.—
    - An action on a judgment or decree of any court, not of record, of this state or any court of the United States, any other state or territory in the United States, or a foreign country.
    - A legal or equitable action on a contract, obligation, or liability founded on a written instrument, except for an action to enforce a claim against a payment bond, which shall be governed by the applicable provisions of s. 95.11(5)(e), s. 255.05(10), s. 337.18(1), or s. 713.23(1)(e), and except for an action for a deficiency judgment governed by s. 95.11(5)(h), F.S.
    - An action to foreclose a mortgage.
    - An action alleging a willful violation of s. 448.110, F.S.
    - Notwithstanding s. 95.11(b), F.S., an action for breach of a property insurance contract, with the period running from the date of loss.[122]
- WITHIN FOUR YEARS.—
    - An action relating to the determination of paternity, with the time running from the date the child reaches the age of majority.
    - An action founded on the design, planning, or construction of an improvement to real property, with the time running from the date of the issuance of certain certificates, or the date of construction abandonment, whichever is earliest, in general.
    - An action for injury to a person founded on the design, manufacture, distribution, or sale of personal property that is not permanently incorporated in an improvement to real property, including fixtures.
    - An action founded on a statutory liability.
    - An action for trespass on real property.
    - An action for taking, detaining, or injuring personal property.
    - An action to recover specific personal property.
    - A legal or equitable action founded on fraud.
    - A legal or equitable action on a contract, obligation, or liability not founded on a written instrument, including an action for the sale and delivery of goods, wares, and merchandise, and on store accounts.
    - An action to rescind a contract.
    - An action for money paid to any governmental authority by mistake or inadvertence.
    - An action for a statutory penalty or forfeiture.
    - An action for assault, battery, false arrest, malicious prosecution, malicious interference, false imprisonment, or any other intentional tort, except as provided in subsections (4), (5), and (7).
    - Any action not specifically provided for in these statutes.
    - An action alleging a violation, other than a willful violation, of s. 448.110. F.S.[123]
- WITHIN TWO YEARS.—

[119] Legal Information Institute, Statute of Limitations, https://www.law.cornell.edu/wex/statute_of_limitations (Last visited January 22, 2024).
[120] *Id.*
[121] S. 95.11(1), F.S.
[122] S. 95.11(2), F.S.
[123] S. 95.11(3), F.S.

- An action founded on negligence.
- An action for professional malpractice, other than medical malpractice, whether founded on contract or tort; provided that the period of limitations shall run from the time the cause of action is discovered or should have been discovered with the exercise of due diligence.
- An action for medical malpractice[124] with the period running from the time the incident giving rise to the action occurred or within two years from the time the incident is discovered, or should have been discovered, up to four years.
- An action for wrongful death.
- An action founded upon a violation of any provision of chapter 517, F.S. with the period running from the time the facts giving rise to the cause of action were discovered or should have been discovered with the exercise of due diligence, but not more than five years from the date such violation occurred.
- An action for libel or slander.[125]

- WITHIN ONE YEAR.—
  - An action for specific performance of a contract.
  - An action to enforce an equitable lien arising from the furnishing of labor, services, or material for the improvement of real property.
  - An action to enforce the Uniform Commercial Code - Letters of Credit, ch. 675, F.S.
  - An action against any guaranty association and its insured, with the period running from the date of the deadline for filing claims in the order of liquidation.
  - An action to enforce any claim, except certain claims, against a payment bond on which the principal is a contractor, subcontractor, or sub-subcontractor from the last furnishing of labor, services, or materials or from the last furnishing of labor, services, or materials by the contractor if the contractor is the principal on a bond on the same construction project, whichever is later.
  - Except for actions described in s. 95.11(8), F.S., , a petition for extraordinary writ, other than a petition challenging a criminal conviction, filed by or on behalf of a prisoner as defined in s. 57.085, F.S.
  - Except for actions described in s. 95.11(8), F.S., an action brought by or on behalf of a prisoner, as defined in s. 57.085, F.S., relating to the conditions of the prisoner's confinement.
  - An action to enforce a claim of a deficiency related to a note secured by a mortgage against a residential property that is a one-family to four-family dwelling unit which shall run from the day after the certificate is issued by the clerk of court or the day after the mortgagee accepts a deed in lieu of foreclosure.[126]

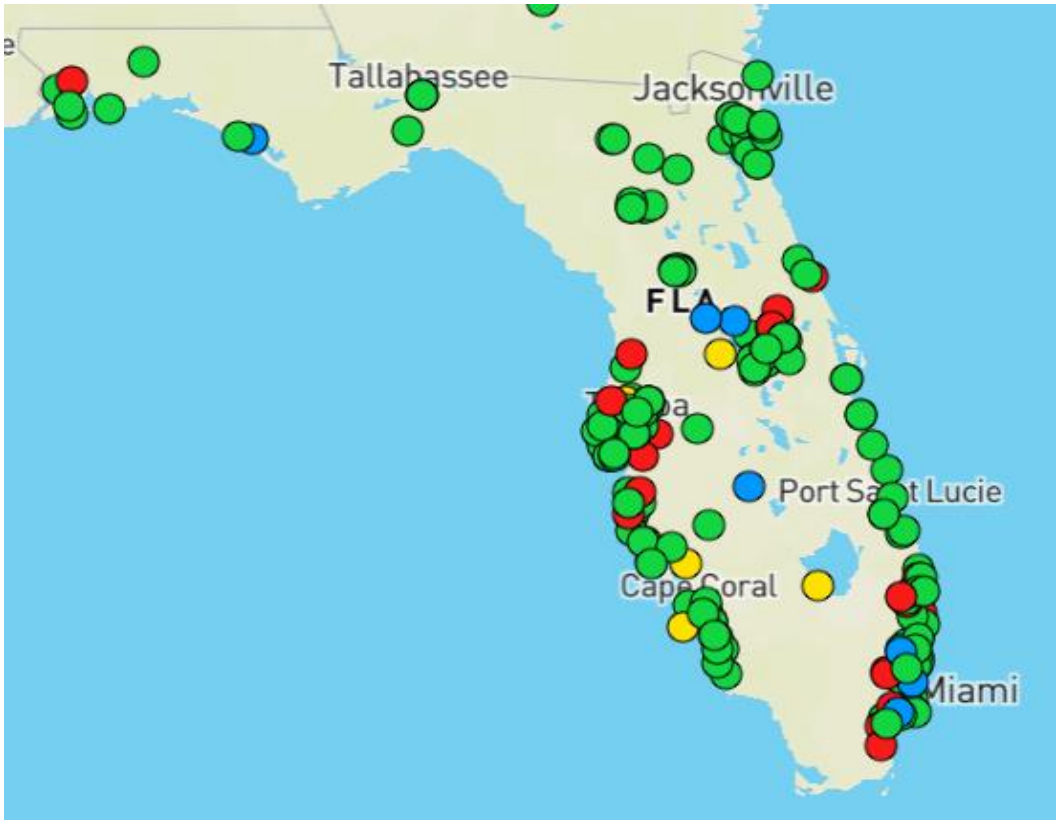
Direct Health Care Agreements

Codified in Florida law in 2028,[127] direct health care agreements are non-insurance contracts between health care providers and patients. Such agreements are not subject to the Florida Insurance Code and are not regulated by the Department of Financial Services or the Office of Insurance Regulation.

The direct provider arrangement eliminates third party payors and instead creates a contractual relationship between the health care provider and the patient usually with a small monthly fee (usually around $70 per individual) for access to the designated scope of benefits. Nationally, the Direct Primary Care Coalition reports over 1,600 associated practices.[128] On the map below, each green dot indicates

[124] An "action for medical malpractice" is defined as a claim in tort or in contract for damages because of the death, injury, or monetary loss to any person arising out of any medical, dental, or surgical diagnosis, treatment, or care by any provider of health care. See s. 95.11(4)(c), F.S.
[125] S. 95.11(4), F.S.
[126] S. 95.11(5), F.S.
[127] Ch. Law 2018-89, L.O.F.
[128] Direct Primary Care Coalition, *Direct Primary Care Mapper,* available at https://mapper.dpcfrontier.com/ (last visited January 22, 2024).

a pure direct primary care model, a red dot a hybrid model, and a blue dot an onsite model. A provider with a hybrid model may have a mix of both direct primary care patients as well as other patients.



The agreement between the parties must adhere to specific statutory requirements to be a valid agreement. To be valid, the agreement must:

- Be in writing.
- Be signed by the health care provider or an agent of the health care provider and the patient, the patient's legal representative, or the patient's employer.
- Allow a party to terminate the agreement by giving the other party at least 30 days' advance written notice. The agreement may provide for immediate termination due to a violation of the physician-patient relationship or a breach of the terms of the agreement.
- Describe the scope of health care services that are covered by the monthly fee.
- Specify the monthly fee and any fees for health care services not covered by the monthly fee.
- Specify the duration of the agreement and any automatic renewal provisions.
- Offer a refund to the patient, the patient's legal representative, or the patient's employer of monthly fees paid in advance if the health care provider ceases to offer health care services for any reason.
- Contain, in contrasting color and in at least 12-point type, the following statement on the signature page: "*This agreement is not health insurance and the health care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any health care services covered by the agreement. This agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provision of the Patient Protection and Affordable Care Act, 26 U.S.C. s. 5000A. This agreement is not workers' compensation insurance and does not replace an employer's obligations under chapter 440.*"[129]

[129] S. 624.67(4)(a)-(h), F.S.

Patients who seek services under these agreements may see health care providers for any services for which the provider is licensed and has the competency and training to provide.[130] Currently, direct health care arrangements are limited to those providers who are defined as a "health care provider", under s. 624.27, F.S., and licensed as one of the following:

- Chapter 458 (medical doctors);
- Chapter 459 (osteopathic doctors);
- Chapter 460 (chiropractic physicians);
- Chapter 461 (podiatrists);
- Chapter 464 (nursing, including advanced or specialized nursing practice, advanced practice registered nurse, licensed practice nurse, or registered nurse);
- Chapter 466 (dental or dental hygienist); or
- A health care group practice, who provides health care services to patients.[131]

Florida's Child Welfare System

Chapter 39, F.S., creates the dependency system, administered by the Department of Children and Families (DCF) and the state courts, charged with protecting child welfare, the four main purposes of which are to:[132]

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

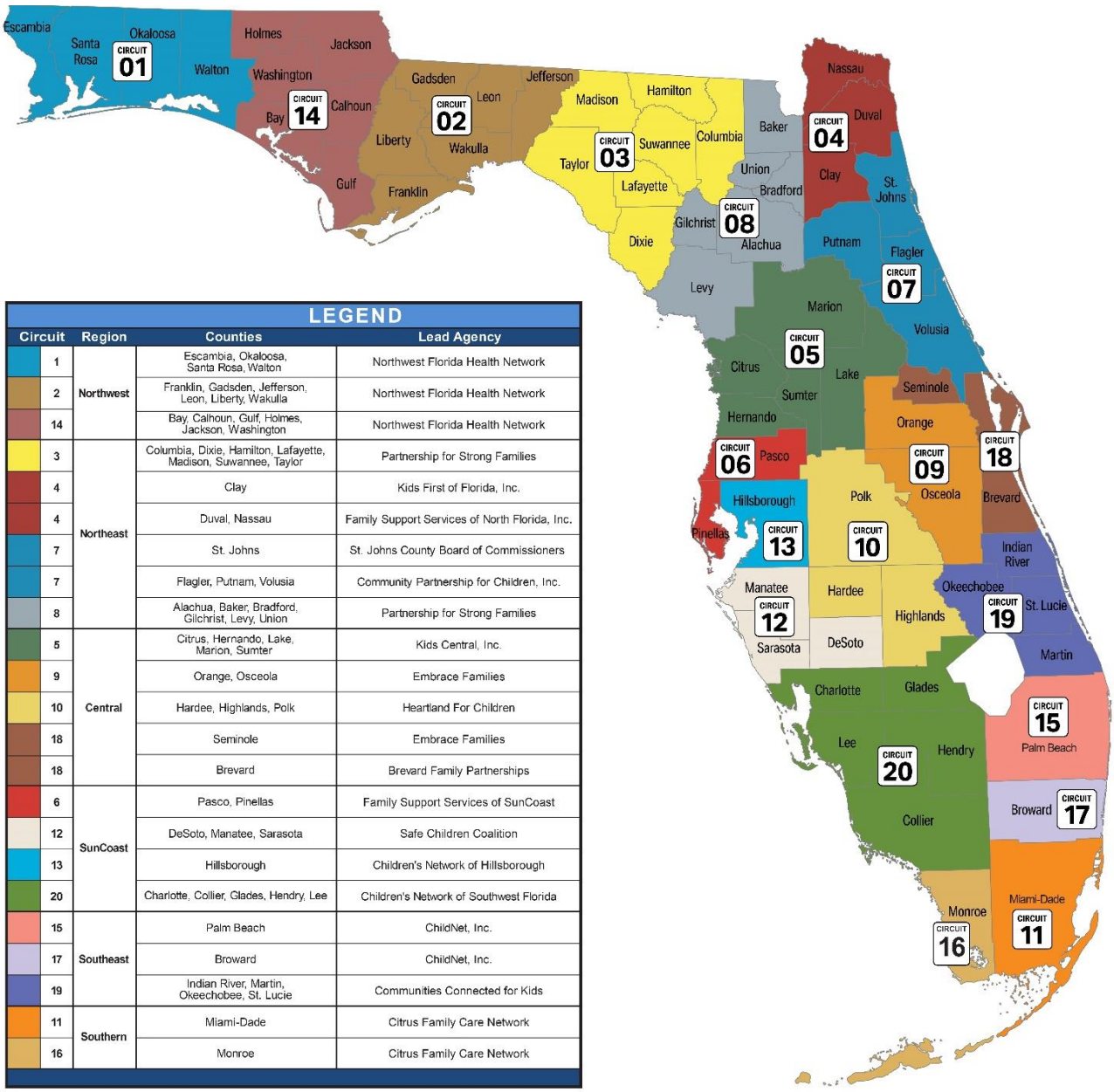
Florida's dependency system identifies children and families in need of services through reports to the central abuse hotline and child protective investigations. DCF works with those families to address the problems endangering children, if possible. DCF's practice model is based on the safety of the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

Community-Based Care Lead Agencies (CBCs)

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

At present, there are 18 CBCs that each cover specific geographic areas within the 20 Judicial Circuits in Florida. The geographic size of the CBCs varies widely. While a few serve only one county, ranging from St. Johns County to Broward County, several CBCs cover multiple counties, with one CBC (Partnership for Strong Families) encompassing 13 rural counties. The following map illustrates DCF Regions, Judicial Circuits, and CBC geographic areas.[133]

[130] S. 624.67(1)(c), F.S.
[131] S. 624.27(1)(b), F.S.
[132] S. 39.001(1)(a), F.S.
[133] Florida Department of Children and Families, *A Comprehensive, Multi-Year Review of the Revenues, Expenditures, and Financial Position of All Community-Based Care Lead Agencies with System of Care Analysis*, p. 2 (Dec. 1, 2023) https://www.myflfamilies.com/services/child-family/lmr (last visited Jan. 6, 2024).



LEGEND

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

DCF competitively contracts with CBCs as required by chapters 287 and 409, F.S., to provide child protection and child welfare services. These contracts generally cover case management, out-of-home services, and related services. The outsourced provision of child welfare services is intended to increase local community ownership of service delivery and design. Current law requires the DCF procurement team for each CBC contract to include individuals from that CBC's circuit community alliance.[134] Established by DCF, community alliances catalyze community participation and local governance of community-based child protection and child welfare services.[135] Each community

[134] S. 409.987(5), F.S.

[135] Ss. 20.19(5), F.S. Community alliances are composed of representatives from DCF, the county government, the school district, the county United Way, the county sheriff's office, the circuit court corresponding to the county, the county children's board (if one exists), and a faith-based organization involved in efforts to prevent child maltreatment, strengthen families, and promote adoption. Additional members may include state attorneys, public defenders, their designees, or individuals from funding organizations, community leaders or individuals who have knowledge of community-based service issues.

alliance may encompass more than one county when such arrangement is determined to provide for more effective representation.[136]

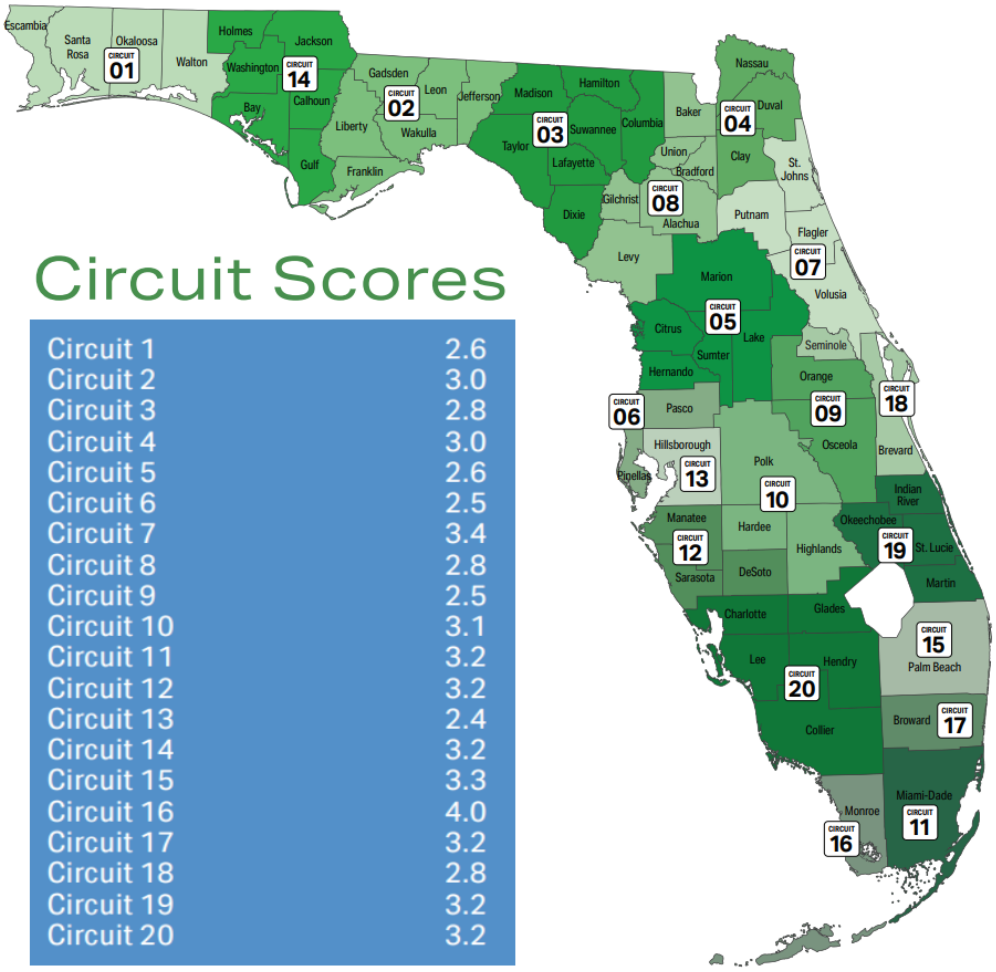
The CBCs, in turn, contract with a number of subcontractors for case management and direct care services to children and their families. DCF remains responsible for a number of child welfare functions, including operating the central abuse hotline, performing child protective investigations, and providing children's legal services. Ultimately, even with the community alliances, DCF is responsible for program oversight and the overall performance of the child welfare system. [137]

Performance of the Child Welfare System

DCF measures the performance of the child welfare system at the circuit level.[138] DCF identifies areas with the most significant systemic impact on improving permanency and well-being[139] and evaluates progress toward achieving permanency, safety, and well-being for children in the welfare system. The overall performance score of 0-5 for each of the 20 circuits aggregates individual circuit performance scores on permanency, safety, and well-being. A score over 3.50 indicates the circuit's performance exceeds established standards.[140] A score between 3.00-3.349 indicates the circuit's performance meets established standards.[141] A score of 2.00-2.99 indicated the circuit's performance does not meet established standards.[142]

For FY 2022-23, the overall median score was 3.0 out of a possible 5, and 60% of circuits earned a 3.0 or higher.[143] DCF gave 11 of 20 circuits a score of 3.0 or higher, indicating that the circuit's performance exceeded established standards. For the "well-being" category, every CBC except one was rated "below expectations or poor". The DCF map below indicates the overall performance scores by circuit.[144]

[136] S. 20.19(5)(a), F.S.
[137] S. 409.996, F.S.
[138] Florida Department of Children and Families, *Annual Accountability Report on the Health of Florida's Child Welfare System: Fiscal Year 2022-2023,* p. 6 (Dec. 1, 2023) https://www.myflfamilies.com/sites/default/files/2023-12/Annual%20Accountibility%20Report%20on%20the%20Health%20of%20Floridas%20Child%20Welfare%20System%20FY%202022-23.pdf (last visited Feb. 22, 2024).
[139] *Id*. at 3.
[140] *Id*. at 7.
[141] *Id*.
[142] *Id*.
[143] *Id*. at 2.
[144] *Id*. at 6.



Circuit Scores

Circuit 1	2.6
Circuit 2	3.0
Circuit 3	2.8
Circuit 4	3.0
Circuit 5	2.6
Circuit 6	2.5
Circuit 7	3.4
Circuit 8	2.8
Circuit 9	2.5
Circuit 10	3.1
Circuit 11	3.2
Circuit 12	3.2
Circuit 13	2.4
Circuit 14	3.2
Circuit 15	3.3
Circuit 16	4.0
Circuit 17	3.2
Circuit 18	2.8
Circuit 19	3.2
Circuit 20	3.2

Current law sets monthly reporting requirements for DCF regarding its case management services or the case management services provided by CBCs or their subcontractors. At a minimum, DCF must publish the following data points on its website by the 15th day of each month:[145]

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

Funding

The source of CBC revenues are predominately federal and state funds appropriated by the Florida Legislature. Nearly all federal funding for child welfare purposes comes pursuant to the federal Social Security Act,[146] particularly the Title IV-E Foster Care Program,[147] and the federal Child Abuse

[145] S. 409.988(1)(k), F.S.
[146] Relevant provisions of the Social Security Act include the Title IV-A Temporary Assistance for Needy Families (TANF) block grant, Title IV-B child welfare services, Title IV-B promoting safe and stable families, Title IV-E funds for foster care, Title IV-E funds for adoption assistance, independent living and education, training and voucher funds, and the Title XX Social Services Block Grant.
[147] The Title IV-E Foster Care Program helps states provide safe and stable out-of-home care for eligible children and youth until they achieve permanency through reunification, adoption, guardianship, or another permanent placement. Some states, like Florida, also distribute Title IV-E funds to extended foster care programs for eligible young adults up to age 21. In Federal Fiscal Year 2022, Congress appropriated $5.83 billion to fund the Title IV-E Foster Care Program. The Children's Bureau, *Title IV-E Foster Care*, U.S.

Prevention and Treatment Act (CAPTA). Each of these federal sources generally require state matching funds.[148] Historically, CBCs could use Title IV-E funds in a variety of state-specific, innovative ways because the federal government approved a waiver allowing Florida to experiment. However, the federal government terminated the Title IV-E waiver authority on September 30, 2019.[149] This led to significant change in the amounts and mix of federal and state funds over the last five years.

CBC appropriations from federal and state sources grew from $951.9 million in Fiscal Year (FY) 2018-19 to $1.3 billion for FY 2023-24.[150] The Legislature appropriates funds from both state and federal sources to CBCs through DCF.

Equity Allocation Model

State law specifies the calculation method of annual CBC funding distributions. The Legislature first established a CBC funding formula in law in 2011 and has changed it over time.[151] Before this statutory formula, known as the equity allocation model,[152] the allocation of new state or federal funds to lead agencies was based primarily on the number of children in care with direction to DCF through proviso language in the General Appropriations Act (GAA); at the time of the formula's enactment, the Legislature had begun considering additional factors such as those now in the formula.[153]

Under the current formula, the recurring core services funding for each CBC is based on the prior year recurring base of core services funds, and any new funds are allocated according to a statutory formula.[154] Generally, all funds allocated to a CBCs are considered "core service funds", except for:[155]

- Funds appropriated for independent living.
- Funds appropriated for maintenance adoption subsidies.
- Funds allocated by DCF for protective investigations training.
- Nonrecurring funds (e.g., risk pool appropriations, back of the bill authorizations designated in the GAA, Legislative Budget Commission actions, and prior year excess federal earnings).[156]
- Designated mental health wrap-around services.
- Funds for special projects for a designated CBC.
- Funds appropriated for the Guardianship Assistance Program under s. 39.6225, F.S.

Unless otherwise specified in the GAA, any new core service funds are allocated according to the equity allocation model on the following weighted basis:[157]

- 70% of new funding must be allocated among all CBCs; and
- 30% of new funding must be allocated among the CBCs that are funded below their equitable shares.

Department of Health & Human Services, (May 10, 2023) https://www.acf.hhs.gov/cb/grant-funding/title-iv-e-foster-care (last visited Mar. 22, 2024).

[148] In addition, a local match is required for the Title IV-B promoting safe and stable families fund.

[149] Florida Department of Children and Families, *A Comprehensive, Multi-Year Review of the Revenues, Expenditures, and Financial Position of All Community-Based Care Lead Agencies with System of Care Analysis*, p. 3 (Dec. 1, 2023) https://www.myflfamilies.com/services/child-family/lmr (last visited Jan. 6, 2024).

[150] *Supra*, FN 133 at 3.

[151] Ch. 2011-62, L.O.F.

[152] S. 409.991, F.S.

[153] Florida Senate Analysis of 2011 Senate Bill 2146, p. 3, 5 (April 1, 2011) https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?FileName=2011s2146.bc.DOCX&DocumentType=Analysis&BillNumber=2146&Session=2011 (last visited Jan. 26, 2024). This bill analysis anecdotally describes the historical context about how the state funded CBCs prior to the equity allocation model found in s. 409.991, F.S. The bill analysis advises that the Legislature created the equity allocation model in statute to ensure each CBC gets a fair share of new or recurring funds.

[154] S. 409.991(3),(4), F.S.

[155] S. 409.991(1), F.S.

[156] *Supra*, FN 133 at 4-5. At the time of DCF's annual report, the carry-forward balance for FY 2023-24 was not yet determined.

[157] S. 409.991(4), F.S.

A CBC's equitable share is determined by a formula that considers the proportions of the child population, the child abuse hotline workload, and the children in care relating to the CBC and its service area. Each of these 3 factors is weighted in this formula as follows: [158]

- Proportion of the child population: 5%.
- Proportion of the child abuse hotline workload: 35%.
- Proportion of the children in care: 60%.

A CBC which receives funding below what the formula indicates it should receive is below its equitable share. Once all CBCs funded below their equitable shares are identified, the dollar amount of the gaps in funding for all of those CBCs is totaled. A CBC receives a share of the 30% of new funding that is proportional to that CBC's share of the total amount of all CBCs' funding below the equitable share.

The table below indicates the core service funding allocation in the FY 2023-24 GAA.

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

Total state-appropriated funds available for CBCs for FY 2023-24 was $1.331 billion.[159]

In addition, some CBCs receive revenue from local sources such as local government, private businesses, and not-for-profit foundations.[160]

Risk Pool Funding

[158] S. 409.991(2), F.S.
[159] *Supra,* FN 133, at 5.
[160] *Supra*, FN 133 at 5.

Total new funding available to CBCs varies by year but is generally a small percentage of the total funding for CBC services. This means that a CBCs funding does not change significantly year to year. When extenuating circumstances result in increased expenditures for CBCs, the funding through the formula does not change significantly. Thus s. 409.990, F.S., establishes a risk pool for lead agencies. The risk pool is intended to mitigate the financial risk to eligible lead agencies.

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

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

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

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

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

The Legislature appropriates funding for the risk pool. The amount appropriated varies by year; for FY 23-24, the Legislature appropriated $3.0 million for the risk pool.[161] In FY 2022-23, two CBCs applied for risk pool funding, and one of the two (Embrace Families) was approved and awarded $3.1 million.[162]

CBC Subcontracting

CBCs must comply with state and federal laws and rules to provide contractual services.[163]

[161] *Supra,* FN 133 at 3.
[162] Department of Children and Families, *Risk Pool Peer Review Committee, Executive Summary Report, Fiscal Year 2022-23*, https://www.myflfamilies.com/sites/default/files/2023-05/Risk_Pool_Executive_Summary_FY22-23.pdf, p. 2.
[163] S. 409.988(1)(i), F.S.

Federal Requirements

Federal law classifies CBCs as subrecipients of federal funding directed to DCF.[164] Under federal law, a nonprofit organization that carries out a federal award as a subrecipient (i.e., a CBC) must ensure full and open competition in procuring goods and services.[165] When the value of the procurement for property or services under a federal award does not exceed a federal threshold of $250,000,[166] or a lower threshold established by a non-federal entity, formal procurement methods are not required.[167] When the value of the procurement for property or services under a federal financial assistance award exceeds of $250,000, or a lower threshold established by a non-federal entity, formal procurement methods are required.[168]

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

- The acquisition of services does not exceed an established micro-purchase threshold;
- The item is available only from a single source;
- There is public exigency or an emergency;
- The federal awarding agency or pass-through entity expressly authorizes a noncompetitive procurement in response to a written request from the non-federal entity[169]; or
- Competition is deemed inadequate after solicitation of a number of sources.[170]

At the time DCF directs federal funding to a CBC, DCF must put the CBC on notice of all federal requirements to ensure the federal award is used in accordance with federal statutes, regulations, and the terms and conditions of the federal award.[171] DCF must evaluate each CBC's risk of noncompliance with federal statutes, regulations, and terms and conditions of the subaward for purposes of determining the appropriate subrecipient monitoring protocols.[172] The federal government authorizes DCF to consider taking enforcement action against noncompliant subrecipients.[173]

The federal government delegates certain federal subaward enforcement responsibilities to DCF. If a CBC fails to comply with federal law or the terms and conditions of a federal award, DCF may impose additional conditions[174] on the subrecipient or contractor. If DCF determines that noncompliance cannot be remedied by imposing additional conditions, DCF may take one of more the following actions:[175]

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

---

[164] 2 C.F.R. § 200.331. The subrecipient classification means that the subrecipient (i.e., a CBC) determines a person's eligibility for federal assistance, has its performance measured in relation to whether the objectives of a federal program were met, has responsibility for programmatic decision-making, must adhere to applicable federal program requirements specified in the federal award, and uses federal funds to carry out a program for a public purpose authorized in statute. The subrecipient classification stands in contrast to the contractor classification, where a contractor merely provides goods or services within the normal course of business in a competitive marketplace for the benefit of the customer.

[165] 2 C.F.R. § 200.318-320.

[166] 48 C.F.R. § 2.101.

[167] 2 C.F.R. § 200.320(a).

[168] 2 C.F.R. § 200.320(b).

[169] e.g., a DCF waiver to bypass competitive procurement requirements that create inefficiencies or inhibit of the performance of the CBC's duties.

[170] 2 C.F.R. § 200.320(c)(1)-(5).

[171] 2 C.F.R. § 200.332(a)(2).

[172] 2 C.F.R. § 200.332(b).

[173] 2 C.F.R. § 200.332(h).

[174] Additional conditions include adjusting specific federal award conditions, requiring payments as reimbursements rather than advance payments, requiring more detailed financial reports, requiring additional project monitoring, requiring technical or management assistance, and establishing additional prior approvals. 2 C.F.R. 200.208.

[175] 2 C.F.R. § 200.339.

State Requirements

In Florida, Chapter 287, F.S., governs the procurement of commodities and contractual services. Generally, if a procurement request for commodities or contractual services exceeds $35,000, the competitive solicitation process is mandatory.[176] However, purchases of certain contractual services and commodities are exempt from this requirement, such as:

- Health services involving examination, diagnosis, treatment, prevention, medical consultation, or administration.
- Services provided to persons with mental or physical disabilities by nonprofits recognized as 501(c)(3)s by the IRS.
- Medicaid services delivered to Medicaid-eligible recipients.
- Family placement services.
- Prevention services related to mental health operated by nonprofits – including drug abuse prevention programs, child abuse prevention programs, and shelters for runaways.[177]

If an agency receives fewer than two responsive bids, proposals, or replies, the procuring agency may negotiate with the vendor on the best terms and conditions.[178] Also, an agency may award a non-competitive government contract if state or federal law prescribes with whom the agency must contract or if the rate of payment or the receipt of funds is established during the appropriations process.[179]

CBC procurements have additional limitations on beyond the general requirements in ch. 287, F.S. Specifically, CBCs cannot directly provide more than 35 percent of all child welfare services unless the CBC can demonstrate a need within the CBC's geographic service area to exceed this threshold. Current law requires community alliances[180] to review the CBC's justification for need and to recommend whether DCF should approve or deny the CBC's request for an exemption from the 35 percent threshold.[181] When CBCs outsource contractual services, the subcontracts must specify how the third-party vendor helps the CBC meet established performance standards under the child welfare results-oriented accountability system.[182]

Governance and Expenditures

Organization and Board Responsibilities

Each CBC must be organized as a Florida corporation or a governmental entity and be governed by a board of directors or a board committee composed of by board members.[183] The membership of the board of directors or board committee must be described in the bylaws or articles of incorporation of each lead agency.

For boards of directors, at least 75% of the membership must consist of Florida residents, and at least 51% of these must reside within the CBC service area. The board of directors must have the power to hire the CBC's executive director. For board committees, 100% of its membership must consist of persons residing within the CBC service area. The board committee must have the power to confirm the selection of an executive director.[184]

[176] Ss. 287.057(1), 287.017(2), F.S.
[177] S. 287.057(3)(e), F.S.
[178] S. 287.057(6), F.S.
[179] S. 287.057(11), F.S.
[180] Current law requires DCF to establish community alliances in each county to provide a focal point for community participation and governance of community-based services. s. 20.19(5), F.S.
[181] S. 409.988(1)(j). F.S.
[182] *Id*.
[183] e.g., St. Johns County Board of Commissioners is the CBC serving St. Johns County in Circuit 7.
[184] S. 409.987(4), F.S.

Regardless of organization, each governing body must approve its CBC budget, set the CBC's operational policy and procedures, and demonstrate financial responsibility through an organized plan for regular fiscal audits and the posting of a performance bond.[185]

Conflict of Interest Requirements

Section 409.987, F.S, addresses conflicts of interest in CBC board decisions. A CBC board member or officer must disclose to the board any activity that may reasonably be construed to be a conflict of interest before that activity may be initially considered and approved. This mandatory disclosure also applies to contract renewals.[186] Under current law, a conflict of interest transaction manifests when a CBC board member or officer, or their relatives within the third degree of consanguinity by blood or marriage:

- Enters into a contract or other transaction with the CBC for goods or services;
- Holds a direct or indirect interest in a corporation, limited liability corporation, partnership, limited liability partnership, or other business entity that conducts or proposes business with the CBC; or
- Knowingly obtains a direct or indirect personal, financial, professional, or other benefit as a result of the relationship of such board member or officer, or their relatives, with the CBC.[187]

A rebuttable presumption of a conflict of interest exists if the board acted on a proposed conflict of interest transaction without prior notice on the board's meeting agenda. The meeting agenda must clearly identify the existence of a potential conflict of interest for the proposed transaction. At the meeting, if an affirmative vote of two-thirds of all other non-interested board members present approve the proposed transaction, only then can the CBC board member or officer engage in the conflict of interest activity.[188] The interested CBC board member or officer must recuse himself or herself from the vote.[189] However, if the proposed transaction is not approved, the CBC board member or officer must decide whether to provide written notice of the board member's or officer's intent to not pursue the proposed transaction or to withdraw from CBC leadership.[190]

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

Executive Compensation

The portion of a CBC administrative employee's compensation package (i.e., base pay and any bonus and incentive payments) that comes from state-appropriated funds, including state-appropriated federal funds, cannot exceed 150% of the DCF Secretary's salary.[191] In practice, this partial cap on a CBC administrative employee's compensation package is currently a maximum of $350,449.71 of combined state and federal funds, of which only $213,000 can be federal funds. According to DCF, during recent audits of CBC spending on executive compensation, some CBCs stated that because they had multiple DCF contracts, they believed they could exceed this cap.[192]

Compliance Remedies

[185] S. 409.987(4), F.S.
[186] S. 409.987(7)(b), F.S.
[187] S. 409.987(7)(a), F.S.
[188] S. 409.987(7)(c), F.S.
[189] S. 409.987(e), F.S.
[190] S. 409.987(7)(d), F.S.
[191] S. 409.992(3), F.S. Additional federal requirements also apply.
[192] Florida Department of Children and Families, Agency Analysis of 2024 House Bill 1061, p. 6 (Jan. 1, 2024).

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

- Enhanced monitoring and reporting.
- Corrective action plans.
- Requirements to accept DCF's technical assistance and consultation.
- Financial penalties requiring a CBC to reallocate funds from administrative costs to direct care for children.
- Early termination of contracts.[193]

In the event that DCF determines health, safety, and welfare of the dependent children currently cared for or supervised by a CBC is in imminent danger, DCF may petition a court of competent jurisdiction for the appointment of a receiver to ensure the continued health, safety, and welfare of the dependent children.[194] According to current law, DCF can make at least two arguments in a receivership petition:

- DCF determines that conditions exist in the CBC which present an imminent danger to the health, safety, or welfare of dependent children under the CBC's care or supervision.
- The CBC cannot meet its current financial obligations to its employees, contractors, or foster parents. The issuance of bad checks or the existence of delinquent obligations for payment of salaries, utilities, or invoices for essential services or commodities constitute prima facie evidence that the CBC lacks the financial ability to meet its financial obligations.[195]

The court may appoint a receiver for up to 90 days. DCF may petition for additional 30-day extensions. Sixty days after the appointment of the receiver, and every 30 days until the receivership is terminated, DCF must submit to the court an assessment of the CBC's ability to ensure the health, safety, and welfare of the dependent children under its supervision.[196]

Forensic Audits

In December 2021, the DCF Inspector General (IG) identified 11 CBCs that routinely transferred funds to related parties. The IG expressed concern over this practice because funds transferred to related parties compromises DCF's ability to track further expenditures of state and federal dollars. Current law requires CBCs to abide by DCF's financial guidelines and allow for a regular independent audit of its financial activities;[197] thus DCF procured the services of two auditing firms with the expertise to perform a forensic audit of these CBCs. These auditing firms completed forensic examination reports for six CBCs and submitted them to DCF in August 2023.[198]

In response to the findings of the initial forensic examinations, the Department issued corrective action plans to address key findings which included:

- Non-compliant contract procurement for related and non-related entities.
- Receipt of Paycheck Protection Program Loans that were not properly reimbursed to the State.
- Board approval of deficit budgets.
- Allocated officer compensation in excess of mandatory caps.
- Non-compliance with Cost Allocation Plans.[199]

EFFECT OF THE BILL

[193] S. 409.996(d), F.S.
[194] S. 409.994, F.S.
[195] *Id.*
[196] S. 409.994(2)(d), F.S.
[197] S. 409.988(1)(c), F.S.
[198] The six CBCs were Northwest Florida Health Network, Embrace Families, Partnership for Strong Families, Children's Network of Southwest Florida, Kids First of Florida, and Brevard Family Partnership. The audit reports for the first six CBC's are at https://www.myflfamilies.com/community-based-care-lead-agencies-audit-findings (last visited Jan. 26, 2024). DCF plans for additional audits of the remaining CBCs.
[199] *Supra*, FN 192 at 3.

Health Care Price Transparency

The bill increases patient access to health care cost information, and offers a measure of protection from burdensome medical debt and unreasonable collections activity. The various provisions apply to hospitals, ambulatory surgical centers, health insurers, and HMOs. The bill brings provisions from recent federal law and regulation into the Florida Statutes; in doing so, the bill requires compliance by facilities and insurers as a condition of state licensure, better ensuring that these provisions will be fully adopted and adequately enforced in Florida.

Patient Estimates - Facilities

The bill requires hospitals and ASCs to provide patients cost-of-care information prior to receiving scheduled, nonemergency treatment. Under the bill, licensed facilities must provide a customized estimate of "reasonably anticipated charges" to a patient for treatment of the patient's specific condition. The bill makes these personalized estimates mandatory, rather than dependent on patient requests.

A facility must submit the estimate of charges to a patient's health insurer or plan at least three business days before a service is to be furnished, according to the following schedule:

- In the case of a service scheduled less than 10 business days in advance, no later than one business day after the service is scheduled.
- In the case of a service scheduled 10 or more business days in advance, no later than three business days after a service is scheduled.

The bill's good-faith estimate requirement mirrors the requirements of the federal No Surprises Act (Act).[200] The Act requires compliance by January 1, 2022; however, this bill's provisions relating to good faith estimates are not effective until the promulgation of a final federal rule on the topic. The bill requires AHCA to notify the Division of Law Revision when the federal government adopts a final rule, triggering the effect of these provisions.

Patient Estimates - Insurer Advanced Explanations of Benefits

The bill requires health plans to issue an advance explanation of benefits (AEOB) statement when a covered patient schedules a service in a hospital or ambulatory surgical center. This requirement builds on the facility charges estimate provision in the bill. Once a facility notifies a health plan that a patient has scheduled a medical service, the health plan must prepare a personalized estimate of costs for the patient in accordance with the federal No Surprises Act.

A health plan must provide an AEOB to the patient according to the following schedule:

- In the case of a service scheduled less than 10 business days in advance, no later than one business day after receiving the estimate of charges from the facility;
- In the case of a service scheduled 10 or more business days in advance, no later than three business days after receiving the estimate of charges from the facility.

The bill's AEOB requirement mirrors the requirements of the federal No Surprises Act (Act).[201] The Act requires compliance by January 1, 2022; however, this bill's provisions relating to AEOBs are not effective until the promulgation of a final federal rule on the topic. The bill requires AHCA to notify the Division of Law Revision when the federal government adopts a final rule, triggering the effect of these provisions.

Facilities - Shoppable Services

[200] The *No Surprises Act* was enacted as part of the Consolidated Appropriations Act of 2021; (Pub. Law 116-260).
[201] The *No Surprises Act* was enacted as part of the Consolidated Appropriations Act of 2021; (Pub. Law 116-260).

The bill requires each licensed hospital and ASCs to post a consumer-friendly list of standard charges for at least 300 shoppable health care services on a facility website. A facility that provides less than 300 distinct services will be required to post standard charges for each service it does provide.

The bill requires facilities to post pricing information for shoppable services in accordance with the definition of "standard charges" established in federal rule.[202] This information extends beyond the traditional concept of charges to include negotiated and actual prices paid for selected services. For each shoppable service, a hospital or ASC must disclose the following pricing benchmarks:

- The gross charge;
- The payer-specific negotiated charge;
- A de-identified minimum negotiated charge;
- A de-identified maximum negotiated charge; and,
- The discounted cash price.

This bill is intended to mirror the shoppable services requirement included in the hospital facility transparency regulations finalized by the CMS in 2019. The bill requires facilities to disclose the relevant cost information as a condition of state licensure, which should result in uniform compliance among facilities.

The bill delays application of the shoppable services requirements for ASCs until January 1, 2026. Hospital facilities must meet applicable federal deadlines.

Insurers - Shared Savings Programs

The bill establishes an accounting standard to remove a barrier to shared savings incentive programs. It specifies that insurer shared savings payments to patients may be counted as medical expenses for rate development and rate filing purposes.[203] This change aligns Florida law with the federal regulations that became final in 2020.[204]

Medical Debt

The bill offers a measure of consumer protection from burdensome medical debt and unreasonable collections activity.

Debt Exemptions

The bill establishes a new set of debt collection exemptions in Chapter 222, F.S. that apply explicitly to debt incurred as a result of medical services provided in hospitals, ASCs, or urgent care centers. Under current law, this type of medical debt is subject to the uniform exemptions that apply to all types of debt and are described above. The bill establishes a ceiling for the medical debt owed a hospital facility or ambulatory surgical center, as follows:

- $10,000 interest in a single motor vehicle (versus the current law exemption of $1,000);
- $10,000 interest in personal property, provided the a debtor does not claim the homestead exemption under s. 4, Art. X of the state constitution (versus the current law exemption of $4,000).

Debt Collection

[202] 45 CFR §180.20 – Definitions.
[203] Current law indicates that a shared savings incentive offered by a health plan is "not an administrative expense for rate development or rate filing purposes," but does not affirmatively categorize the expense. SS. 627.6387, 627.6648, and 641.31076, F.S.
[204] 45 CFR § 158.221 – Formula for calculating an issuer's medical loss ratio.

The bill requires each hospital and ASC to establish an internal grievance process allowing a patient to dispute any charges that appear on an itemized statement or bill. When a patient initiates a grievance, the facility must then provide an initial response to that patient within seven business days. The bill prohibits hospitals and ASCs from engaging in any extraordinary collection actions against a patient during an ongoing grievance process.

The bill also prohibits extraordinary collection actions against patients prior to determining whether that patient is eligible for financial assistance, before providing an itemized bill, prior to billing any applicable insurance coverage, for 30 days after notifying a patient in writing that a collections action will commence, and while the patient is negotiating in good faith the final amount of the bill or is complying with the terms of a payment plan with the facility. The bill prohibitions on extraordinary collection actions apply to any action that requires a legal or judicial process, including:

- Placing a lien on an individual's property;
- Foreclosing on an individual's real property;
- Attaching or seizing an individual's bank account or any other personal property;
- Commencing a civil action against an individual;
- Causing an individual's arrest; or,
- Garnishing an individual's wages.

Lastly, the bill creates a three-year statute of limitations for any legal action related to medical debt for services rendered by a facility licensed under chapter 395, F.S., such as hospitals, ambulatory surgical centers, and urgent care centers. The statute of limitations begins running on the date that the facility refers the debt to a third-party collection entity.

Florida's Child Welfare System

Community-Based Care Lead Agencies (CBCs)

The bill authorizes DCF to extend 5-year CBC lead agency contracts for a period of 1-5 years if the CBC lead agency meets performance expectations.

The bill requires newly procured contracts between DCF and CBC lead agencies to delineate the rights and obligations of both parties concerning the acquisition, transfer, or other disposition of real property during the contract term. At a minimum, the contract must:

- Require the CBC to follow all federal law on the acquisition, improvement, transfer, or other disposition or real property acquired and held by the CBC using state funds; and
- Require DCF to approve any sale, transfer, or disposition of real property acquired and held by the CBC using state funds, beginning July 1, 2024.

The bill requires the CBCs to comply with regular, independent auditing of their financial activities, including any requests for records associated with such financial audits within the timeframe established by DCF or its contracted vendors. The bill requires DCF to submit the results of a CBC's financial audit to the CBC's circuit community alliance.

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

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

Funding

Equity Allocation Model

The bill repeals s. 409.991, F.S., relating to allocation of funds for community-based care lead agencies. The bill directs DCF to work in collaboration with CBCs and child welfare providers to develop a new funding methodology. At a minimum, the methodology must:

- Be actuarily sound;
- Be reimbursement based;
- Be designed to incentivize efficient and effective CBC operations, prevention, family preservation, and child permanency;
- Consider variable costs for in-home and out-of-home care, prevention services, operational costs, and fixed costs; and
- Be scalable to account for regional cost-of-living differences.

The bill itemizes which variables are to be considered "operational and fixed costs" and reaffirms that "core services funding" refers to all funds allocated to a CBC with certain exceptions. Operational and fixed costs are administrative expenditures (including, but not limited to, information technology and human resources), lease payments, asset depreciation, utilities, and mandated activities such as training, quality improvement, and contract management. Core services funds do not include funding a CBC receives for independent living services, adoption subsidies, child protective investigation training, nonrecurring funds, mental health wrap-around services, special projects, and the Guardianship Assistance Program.

The bill includes three reporting requirements for DCF. First, from July 2024 through October 2024, DCF must submit monthly updates to the Governor and Legislature on the activities and progress in developing the new funding methodology.

Second, by December 1, 2024, DCF must submit the final report on the new methodology to the Governor and Legislature for consideration during the 2025 Session. The report must describe the proposed methodology, the data used to develop the methodology, and include proposed rates and allocations for each CBC that may not exceed the total amount of funding provided in the General Appropriations Act (GAA) for Fiscal Year 2024-25. The report must also include risk mitigation recommendations for when a CBC's proposed allocation negatively impacts operations or result in a reduction of services to children.

Third, beginning October 31, 2025, DCF must submit an annual report including recommended adjustments to the proposed methodology that incorporate fluctuations to the underlying criteria used to calculate the allocations.

The bill subjects the new funding methodology to the state government planning and budgeting requirements of Chapter 216. The bill authorizes DCF to report on the proposed rates and total allocations for each CBC that reflect any additional core service funding requested by DCF in legislative budget requests.

Beginning FY 2025-26, the bill requires the Legislature to allocate funding to the CBCs through the GAA with due consideration given to the funding methodology developed by DCF, in collaboration with the CBCs and child welfare providers.

The bill prohibits DCF from changing the allocation of funds to a CBC as provided in the GAA without legislative approval, except for additional risk pool funding.

CBC Subcontracting

State Requirements

The bill requires CBCs to competitively procure all contracts, consistent with the simplified acquisition threshold as specified the Code of Federal Regulations; the simplified acquisition threshold is currently $250,000. When a CBC subcontracts, the bill requires subcontracts in excess of $250,000 to comply with the federal competitive procurement process.

If a CBC desires to exceed the current 35 percent cap on providing child welfare services, the bill requires the CBC to demonstrate a need within its circuit where there is a lack of qualified providers available to perform the necessary services. DCF may approve a CBC's waiver request if the CBC submits a detailed report to the circuit's community alliance of all efforts to recruit a qualified provider to perform the necessary services within the CBC's circuit. If a CBC requests a waiver renewal and DCF decides the CBC failed to make a good faith effort to recruit a qualified provider, the bill authorizes DCF to deny the renewal request and initiate reprocurement of the CBC contract for the circuit. The bill also limits the initial waiver period and any renewals to two-year increments.

The bill prohibits a CBC from providing more than 40 percent of all child welfare services unless DCF approves an exemption. If DCF approves an exemption, DCF must notify the Auditor General. Once notified, the Auditor General must conduct an operational audit of the CBC to examine the CBC's procurement of and financial arrangements for providing child welfare services. The Auditor General's audit of the CBC must, at a minimum:

- Examine the costs incurred and any payments made by the CBC to itself for services directly provided by the CBC compared to any procurement solicitations by the CBC;
- Assess the adequacy of the CBC's effects to obtain services from subcontractors; and
- Assess the resulting cost and cost-effectiveness of the services provided directly by the CBC.

The bill requires the contract between DCF and a CBC to specify the administrative functions for which the CBC will subcontract.

Governance and Expenditures

Organization and Board Responsibilities

The bill requires board members to act in a fiduciary capacity[205] to prevent conflicts of interest, to promote accountability and transparency for the system of care, and to protect state and federal funding from misuse. The bill requires at least 75 percent of the membership of the board of directors or the board committee be composed of Florida residents. The bill requires CBCs to ensure that board members participate in annual training related to their responsibilities. The bill requires DCF to identify the minimum training criteria in the department's contracts with the CBCs.

Conflict of Interest Requirements

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

The bill defines related party as "any entity of which a director or an officer of the entity is also directly or indirectly related to, or has a direct or indirect financial or other material interest in, the lead agency. The term also includes any subsidiary firm, parent entity, associate firm, or joint venture."

[205] Fiduciary representation is a legally cognizable relationship of trust where the fiduciary must advance the interests of a principal for the primary and direct benefit of the principal's designated beneficiary. DCF partners with CBCs through contracts to provide child protection and child welfare services to children in the child welfare system. Therefore, CBCs individually act in a fiduciary capacity under DCF's direction to maximize DCF's financial resources for the primary and direct benefit of chidren in the child welfare system.

The bill requires the board to disclose any known or actual conflicts of interest. The bill prohibits a CBC from contracting or being a party to a transaction with a related party when the CBC does not properly disclose the conflict to DCF. The bill prohibits a CBC from delegating management functions by contract to a related party. The bill defines management functions as the planning, directing, organizing, coordinating, and carrying out oversight duties of the CBC, or, in the alternative, the contracting for officer or director level staffing to perform such activities. If a CBC complies with these disclosure and delegation requirements, the bill authorizes a CBC to contract or be a party to a transaction with a related party as long as the fee, rate, or price paid by the lead agency for the commodities or services do not exceed the fair market value of those commodities or services.

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

The bill requires the contract between DCF and a CBC to contain specific contractual penalty provisions as an enforcement measure against a CBC's improper subcontracts and transactions with related parties. The table below itemizes the specific contractual penalties required by the bill.

Penalties: Each Known and Potential Conflict of Interest Not Disclosed		
Pre-Execution and/or Renewal	**Contracts Executed**	
Per Occurrence	First Offense	Each Subsequent Offense
$5,000	$20,000	$30,000
	Removal of board member who failed to disclose known conflict	

The contractual penalties apply to all methods of procurement. In addition to the contractual penalties, the bill requires the CBCs to re-procure transactions that involved a conflict of interest that was not disclosed to DCF and requires DCF to recoup from a CBC the expenses related to the improperly executed contract. As a prerequisite to the contract with DCF, the bill requires that a CBC post a fidelity bond to cover any costs associated with reprocurement and assessed penalties.

Notwithstanding these related party requirements and enforcement mechanisms, the bill allows any CBC that holds more than one contract with DCF to request an exemption from DCF for specific related party requirements.

Executive Compensation

The bill applies the partial cap on a CBC administrative employee's compensation package to all contracts that a CBC executes with DCF, measured in the aggregate. This makes the cap (currently a maximum of $350,449.71 of combined state and federal funds, of which only $213,000 can be federal funds) applicable to each employee, regardless of how many contracts a CBC executes with DCF.

Compliance Remedies

The bill requires contracts between DCF and CBCs to include a provision that requires a CBC to pay financial penalties and sanctions for failure to comply with contractual terms, for noncompliance with applicable local, state, or federal procurement law, and for inadequate performance. To this end, the bill eliminates the current system of tiered interventions and graduated penalties, providing DCF more flexibility in addressing CBC performance deficiencies. To this end, as a matter of contract, DCF may immediately address CBC performance deficiencies with financial penalties. The bill requires any financial penalties assessed by DCF to revert to the state treasury upon DCF enforcement.

The bill establishes a deadline of January 1, 2025, by which DCF must ensure that each CBC contract executed includes a list of financial penalties for failure to comply with contractual requirements.

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

Future of Child Protection Contracting and Funding Working Group

The bill establishes the Future of Child Protection Contracting and Funding Working Group (working group). The DCF-led working group must study, evaluate, and offer recommendations relating to contractual and funding matters in the privatized child welfare system to the Governor and Legislature in a report due by October 15, 2025.

At a minimum, the report must:

- Examine the current contracting methods for the provision of all foster care and related services.
- Consider the unique regional needs of children and families at-risk of abuse and neglect.
- Identify current barriers to implementing federally approved Title IV-E prevention services.
- Recommend changes to existing laws, rules, and policies necessary to implement those recommendations.

The bill requires the DCF Secretary, or a designee, to chair the working group and to invite the secretaries of AHCA and the Department of Management Services, or their designees, to participate as members. The DCF Secretary must appoint the following individuals as members of the workgroup:

- A CBC employee with executive-level experience.
- A current contractor for lead agency child protection services.
- Two representatives of a direct provider of child protection or child welfare services.
- A member of the Family Law Section of the Florida Bar or a member of the court exercising jurisdiction over family law matters.
- A representative of a for-profit managed care entity.
- A representative from the Florida Institute for Child Welfare.
- Any additional members as the department deems appropriate.

The bill requires the working group to terminate immediately after DCF submits the report.

DCF Reporting Requirements

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

Effective Dates

Subject to the Governor's veto powers, the effective date of the bill is July 1, 2024; except for the provisions related to good faith estimates and advanced explanations of benefits which are effective and contingent upon certain federal action.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The CBC funding formula provisions have no fiscal impact in Fiscal Year 2024-2025, as the only requirements during this fiscal year are for DCF reporting. For FY 2025-26, the bill specifies that the sum of the proposed allocations for each CBC may not exceed the total amount appropriated to CBCs for FY 2024-25; however, to the extent that the proposed methodology suggests an amount to each CBC that is different that its FY 2024-25 allocation, there may be either a positive or negative fiscal impact to individual lead agencies.

   The bill does not require the Legislature to adopt the proposed methodology for FY 2025-26, but requires due consideration of such when developing the General Appropriations Act for FY 2025-26. Furthermore, while the bill specifies that each annual update may not exceed the total provided

to CBCs in the prior fiscal year, it does not preclude DCF from making a request for additional CBC funding through the Legislative Budget Request process.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may increase costs for facilities licensed under ch. 395, F.S., by requiring them to issue cost estimates for all non-emergency patients, but only if the facilities are out of compliance with the current federal requirement to provide these estimates.

The bill may have a negative, but indeterminate, fiscal impact on health insurers and HMOs, due to the costs of producing advanced explanations of benefits for insureds and subscribers, triggered by the estimates provided by facilities, but only if these health plans are out of compliance with the current federal requirement to provide these to subscribers.

Facilities may forego revenues due to the bill's limits on the use of extraordinary collection activities; however, some facilities may already be providing similar due process for patients, such that the bill will have little impact on them. Similarly, the bill's increased dollar limit on personal property exemptions under ch. 222, F.S., may reduce revenues for medical service providers or their collection agents.

The elimination of the CBC equity allocation model and the substitution of an actuarially sound, reimbursement-based funding methodology may redistribute funding among the CBCs beginning FY 2025-26. The specific impact to each lead agency is indeterminate.

D. FISCAL COMMENTS:

None.