By Senator Simon

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A bill to be entitled

An act relating to medical placement for high-acuity children; amending s. 39.01, F.S.; providing definitions; amending s. 39.01375, F.S.; requiring that specific needs of a high-acuity child be considered when determining a child's best interest; amending s. 39.302, F.S.; conforming a cross-reference; amending s. 39.303, F.S.; revising the role of and services provided by a Child Protection Team; requiring that reports involving a high-acuity child be referred to a Child Protection Team; requiring certain agencies and departments to avoid duplicating the provision of certain services; authorizing a Child Protection Team to prioritize the placement of a high-acuity child and to require certain services for a high-acuity child; revising membership of the Children's Medical Services task force; amending s. 39.4021, F.S.; providing for the placement of a high-acuity child; amending s. 39.4022, F.S.; revising the definition of the term "multidisciplinary team"; revising the goals of multidisciplinary teams; revising the participants in a multidisciplinary team; requiring that a multidisciplinary team staffing be held for placement decisions for a high-acuity child; providing the process for instances when the multidisciplinary team cannot reach a consensus on a plan for the placement of a high-acuity child; amending s. 39.407, F.S.; requiring a licensed health care professional to perform a medical screening for

certain conditions on a child who is removed from the home and maintained in an out-of-home placement; requiring a judge to order the placement of a high-acuity child in a medical placement after he or she is evaluated even if there are other placement options available; authorizing the placement of a high-acuity child in a setting that best meets the needs of the high-acuity child; revising definitions; requiring that a specified examination and suitability assessment be conducted on a high-acuity child; requiring a high-acuity child's guardian ad litem to notify the court within a specified timeframe if a suitable placement is not identified after an evaluation and suitability assessment within a specified timeframe; requiring the court to set an emergency evidentiary hearing within a specified timeframe to determine a suitable placement; authorizing the court to prioritize certain placements; creating s. 39.4078, F.S.; providing a short title; providing legislative findings and intent; providing definitions; providing applicability; providing for medical placements; providing requirements for a medical placement; requiring a comprehensive clinical assessment of a high-acuity child by a qualified licensed professional under certain circumstances; providing requirements for such clinical assessment and admission to a medical placement; requiring the court to hold an emergency evidentiary hearing under certain

circumstances; requiring the Department of Children and Families to petition the court within a specified timeframe after a multidisciplinary team staffing; requiring the court to conduct an evidentiary hearing and provide specified written findings; requiring that certain consent and authorization be obtained and documented; requiring the court to maintain certain services and contacts for a high-acuity child; requiring the court to conduct certain periodic reviews during the duration of a medical placement; requiring the department to file a certain report at a specified time before each review hearing; authorizing the court to immediately order that a high-acuity child be moved to a less or more restrictive licensed placement under certain circumstances; authorizing the department to implement certain emergency procedures; requiring a transition plan; requiring that a high-acuity child's case plan be updated within a specified timeframe; prohibiting a medical placement from exceeding a specified number of days except under certain circumstances; providing that a high-acuity child maintains certain rights; requiring the department to collect certain data; requiring the department to submit to the Legislature a specified annual report; providing construction; authorizing the department and the Department of Health to adopt rules; amending s. 39.523, F.S.; revising legislative findings and intent; requiring that a comprehensive placement assessment for a high-acuity child be used

to determine the medical necessity of such child; requiring that certain procedures be followed for high-acuity children; requiring appropriate agencies and departments to prioritize the placement of a high-acuity child; amending s. 39.6012, F.S.; requiring that a high-acuity child's case plan include a specific description of the child's needs; requiring that certain tasks and descriptions be included in the high-acuity child's case plan; amending s. 39.6013, F.S.; requiring that a high-acuity child's case plan reflect certain goals, services, and requirements; amending s. 391.025, F.S.; providing that the Children's Medical Services program includes the Medical Placement for High-acuity Children Act; amending s. 391.029, F.S.; providing that a high-acuity child is eligible for the Children's Medical Services program and the Children's Medical Services Safety Net program; amending s. 393.065, F.S.; requiring that a high-acuity child be placed in category 1 for priority purposes of Medicaid waiver services; conforming a cross-reference; amending s. 394.495, F.S.; providing that certain services include placement of a high-acuity child in a medical bed in a medical placement; revising the list of who a community action treatment team serves to include a high-acuity child; revising the list of who certain mobile response teams serve to include a high-acuity child; conforming a cross-reference; amending s. 409.145, F.S.; revising the goals of a system of care;

defining the term "high-acuity child"; requiring that the medical necessity of a high-acuity child take priority over the reasonable and prudent parent standard; amending s. 409.166, F.S.; revising the definition of the term "difficult-to-place child"; amending s. 409.906, F.S.; authorizing the Agency for Health Care Administration to pay for a medical bed in a medical placement and certain services for a high-acuity child; amending s. 409.986, F.S.; revising goals of the Department of Children and Families; defining the term "high-acuity child"; amending ss. 934.255, 960.065, and 984.03, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Present subsections (38) through (49), (50), and (51) through (91) of section 39.01, Florida Statutes, are redesignated as subsections (39) through (50), (52), and (54) through (94), respectively, new subsections (38), (51), and (53) are added to that section, and subsection (10) and present subsection (39) of that section are amended, to read:

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

(10) "Caregiver" means the parent, legal custodian, permanent guardian, adult household member, or other person responsible for a child's welfare as defined in subsection (60) ~~(57)~~.

(38) "High-acuity child" means a child age birth to 18 who

presents with intensive and complex medical, developmental, behavioral health, or disability needs across multiple areas of functioning and who requires immediate clinical assessment and specialized care, services, and medical placement. The term includes a child who is reasonably presumed to meet the criteria for high acuity.

(40)~~(39)~~ "Institutional child abuse or neglect" means situations of known or suspected child abuse or neglect in which the person allegedly perpetrating the child abuse or neglect is an employee of a public or private school, public or private day care center, residential home, institution, facility, or agency or any other person at such institution responsible for the child's welfare as defined in subsection (60) ~~(57)~~.

(51) "Medical bed" means a licensed placement that meets the criteria of a medical placement and is approved by the applicable licensing authority, such as the Department of Health, the Agency for Persons with Disabilities, the Agency for Health Care Administration, or the department.

(53) "Medical placement" means a residential setting that provides clinical oversight, licensed nursing care, and therapeutic supports 24 hours a day, 7 days a week to adequately address the immediate needs of a high-acuity child being placed who requires intensive, specialized medical care consistent with the standards of the Affordable Care Act and the Centers for Medicare and Medicaid Services guidelines for pediatric medical necessity.

Section 2. Present subsection (15) of section 39.01375, Florida Statutes, is redesignated as subsection (16), and a new subsection (15) is added to that section, to read:

39.01375 Best interest determination for placement.—The department, community-based care lead agency, or court shall consider all of the following factors when determining whether a proposed placement under this chapter is in the child's best interest:

(15) The intensive and complex medical, developmental, behavioral health, or disability needs of a high-acuity child and the need for medical placement under s. 39.4078 to address the high-acuity child's needs.

Section 3. Subsection (1) of section 39.302, Florida Statutes, is amended to read:

39.302 Protective investigations of institutional child abuse, abandonment, or neglect.—

(1) The department shall conduct a child protective investigation of each report of institutional child abuse, abandonment, or neglect. Upon receipt of a report that alleges that an employee or agent of the department, or any other entity or person covered by s. 39.01(40) or (60) ~~s. 39.01(39) or (57)~~, acting in an official capacity, has committed an act of child abuse, abandonment, or neglect, the department shall initiate a child protective investigation within the timeframe established under s. 39.101(2) and notify the appropriate state attorney, law enforcement agency, and licensing agency, which shall immediately conduct a joint investigation, unless independent investigations are more feasible. When conducting investigations or having face-to-face interviews with the child, investigation visits shall be unannounced unless it is determined by the department or its agent that unannounced visits threaten the safety of the child. If a facility is exempt from licensing, the

department shall inform the owner or operator of the facility of the report. Each agency conducting a joint investigation is entitled to full access to the information gathered by the department in the course of the investigation. A protective investigation must include an interview with the child's parent or legal guardian. The department shall make a full written report to the state attorney within 3 business days after making the oral report. A criminal investigation shall be coordinated, whenever possible, with the child protective investigation of the department. Any interested person who has information regarding the offenses described in this subsection may forward a statement to the state attorney as to whether prosecution is warranted and appropriate. Within 15 days after the completion of the investigation, the state attorney shall report the findings to the department and shall include in the report a determination of whether or not prosecution is justified and appropriate in view of the circumstances of the specific case.

Section 4. Subsections (3) and (7) and paragraph (a) of subsection (9) of section 39.303, Florida Statutes, are amended, and paragraph (j) is added to subsection (4) of that section, to read:

39.303 Child Protection Teams and sexual abuse treatment programs; services; eligible cases.—

(3) The Department of Health shall use and convene the Child Protection Teams to supplement the assessment and protective supervision activities of the family safety and preservation program of the Department of Children and Families. This section does not remove or reduce the duty and responsibility of any person to report pursuant to this chapter

all suspected or actual cases of child abuse, abandonment, or neglect or sexual abuse of a child. The role of the Child Protection Teams is to support activities of the program and to provide services, including services necessary and appropriate to address the needs of a high-acuity child, deemed by the Child Protection Teams to be necessary and appropriate to abused, abandoned, and neglected children upon referral. The specialized diagnostic assessment, evaluation, coordination, consultation, and other supportive services that a Child Protection Team must be capable of providing include, but are not limited to, the following:

(a) Medical diagnosis and evaluation services, including provision or interpretation of X rays and laboratory tests, and related services, as needed, and documentation of related findings.

(b) Telephone consultation services in emergencies and in other situations.

(c) Medical evaluation related to abuse, abandonment, or neglect, as defined by policy or rule of the Department of Health.

(d) Such psychological and psychiatric diagnosis and evaluation services for the child or the child's parent or parents, legal custodian or custodians, or other caregivers, or any other individual involved in a child abuse, abandonment, or neglect case, as the team may determine to be needed.

(e) Expert medical, psychological, and related professional testimony in court cases.

(f) Case staffings to develop treatment plans for children whose cases have been referred to the team. A Child Protection

Team may provide consultation with respect to a child who is alleged or is shown to be abused, abandoned, or neglected, which consultation shall be provided at the request of a representative of the family safety and preservation program or at the request of any other professional involved with a child or the child's parent or parents, legal custodian or custodians, or other caregivers. In every such Child Protection Team case staffing, consultation, or staff activity involving a child, a family safety and preservation program representative shall attend and participate.

(g) Case service coordination and assistance, including the location of services available from other public and private agencies in the community.

(h) Such training services for program and other employees of the Department of Children and Families, employees of the Department of Health, and other medical professionals as is deemed appropriate to enable them to develop and maintain their professional skills and abilities in handling child abuse, abandonment, and neglect cases. The training service must include training in the recognition of and appropriate responses to head trauma and brain injury in a child under 6 years of age as required by ss. 402.402(2) and 409.988.

(i) Educational and community awareness campaigns on child abuse, abandonment, and neglect in an effort to enable citizens more successfully to prevent, identify, and treat child abuse, abandonment, and neglect in the community.

(j) Child Protection Team assessments that include, as appropriate, medical evaluations, medical consultations, family psychosocial interviews, specialized clinical interviews, or

forensic interviews.

(k) Identification of a child who meets the criteria for a high-acuity child and the basis for the determination of the Child Protection Team.

A Child Protection Team that is evaluating a report of medical neglect and assessing the health care needs of a medically complex child shall consult with a physician who has experience in treating children with the same condition.

(4) The child abuse, abandonment, and neglect reports that must be referred by the department to Child Protection Teams of the Department of Health for an assessment and other appropriate available support services as set forth in subsection (3) must include cases involving:

(j) A report involving a high-acuity child or a child believed to meet the criteria of a high-acuity child.

(7)(a) In all instances in which a Child Protection Team is providing certain services to abused, abandoned, or neglected children, other offices and units of the Department of Health, ~~and offices and units of~~ the Department of Children and Families, the Agency for Persons with Disabilities, and the Agency for Health Care Administration must ~~shall~~ avoid duplicating the provision of those services.

(b) A Child Protection Team may:

1. Prioritize the placement of a high-acuity child into a specialized and appropriate placement in accordance with s. 39.4078, including, but not limited to, a medical bed or group home in a facility licensed or maintained by the department, the Agency for Persons with Disabilities, the Department of Health,

or the Agency for Health Care Administration, even if such placement is outside of the normal services of the Child Protection Team.

2. Require the provision of services to the high-acuity child by an entity deemed appropriate and necessary by the Child Protection Team for the stabilization, treatment, or safety of the high-acuity child, even if such services are outside of the normal services of the Child Protection Team.

(9)(a) Children's Medical Services shall convene a task force to develop a standardized protocol for forensic interviewing of children suspected of having been abused. The Department of Health shall provide staff to the task force as necessary. The task force shall include:

1. A representative from the Florida Prosecuting Attorneys Association.

2. A representative from the Florida Psychological Association.

3. The Statewide Medical Director for Child Protection.

4. A representative from the Florida Public Defender Association.

5. The executive director of the Statewide Guardian ad Litem Office.

6. A representative from a community-based care lead agency.

7. A representative from Children's Medical Services.

8. A representative from the Florida Sheriffs Association.

9. A representative from the Florida Chapter of the American Academy of Pediatrics.

10. A representative from the Florida Network of Children's

Advocacy Centers.

11. Other representatives designated by Children's Medical Services.

12. An expert or a direct care provider who has experience in serving high-acuity children.

Section 5. Paragraph (a) of subsection (2) of section 39.4021, Florida Statutes, is amended, and subsection (3) is added to that section, to read:

39.4021 Priority placement for out-of-home placements.—

(2) PLACEMENT PRIORITY.—

(a) Except as provided in subsection (3), when a child cannot safely remain at home with a parent, out-of-home placement options must be considered in the following order:

1. Nonoffending parent.

2. Relative caregiver.

3. Adoptive parent of the child's sibling, when the department or community-based care lead agency is aware of such sibling.

4. Fictive kin with a close existing relationship to the child.

5. Nonrelative caregiver that does not have an existing relationship with the child.

6. Licensed foster care.

7. Group or congregate care.

(3) MEDICAL PLACEMENT FOR A HIGH-ACUITY CHILD.—In cases in which a child is identified or assessed as a high-acuity child, the department or any contractor or subcontractor of the department must follow the procedures and requirements in s. 39.4078 and place the high-acuity child in a medical placement

if he or she meets the eligibility criteria in order to ensure the high-acuity child's complex medical, behavioral, and developmental needs are addressed in an appropriate medical setting.

Section 6. Paragraph (c) of subsection (2), paragraph (b) of subsection (3), paragraph (a) of subsection (4), paragraph (a) of subsection (5), and paragraph (d) of subsection (6) of section 39.4022, Florida Statutes, are amended to read:

39.4022 Multidisciplinary teams; staffings; assessments; report.—

(2) DEFINITIONS.—For purposes of this section, the term:

(c) "Multidisciplinary team" means an integrated group of individuals which meets to collaboratively develop and attempt to reach a consensus decision on the most suitable out-of-home placement or the appropriateness of a medical placement under s. 39.4078, educational placement, or other specified important life decision that is in the best interest of the child.

(3) CREATION AND GOALS.—

(b) The multidisciplinary teams must adhere to all of the following goals:

1. Secure a child's safety in the least restrictive and intrusive placement that can meet his or her needs.~~;~~

2. Minimize the trauma associated with separation from the child's family and help the child to maintain meaningful connections with family members and others who are important to him or her.~~;~~

3. Provide input into the proposed placement decision made by the community-based care lead agency and the proposed services to be provided in order to support the child.~~;~~

4. Provide input into the decision to preserve or maintain the placement, including necessary placement preservation strategies.~~;~~

5. Contribute to an ongoing assessment of the child and the family's strengths and needs.~~;~~

6. Ensure that plans are monitored for progress and that such plans are revised or updated as the child's or family's circumstances change.~~; and~~

7. Ensure that the child and family always remain the primary focus of each multidisciplinary team meeting.

8. Ensure that if the child meets the classification of a high-acuity child, the multidisciplinary team considers such classification when determining the appropriate placement for the child. The multidisciplinary team must prioritize the placement of a high-acuity child in appropriate specialized placements within the department, the Agency for Persons with Disabilities, the Department of Health, or the Agency for Health Care Administration.

(4) PARTICIPANTS.—

(a) Collaboration among diverse individuals who are part of the child's network is necessary to make the most informed decisions possible for the child. A diverse team is preferable to ensure that the necessary combination of technical skills, cultural knowledge, community resources, and personal relationships is developed and maintained for the child and family. The participants necessary to achieve an appropriately diverse team for a child may vary by child and may include extended family, friends, neighbors, coaches, clergy, coworkers, or others the family identifies as potential sources of support.

1. Each multidisciplinary team staffing must invite all of the following members:

a. The child, unless he or she is not of an age or capacity to participate in the team, and the child's guardian ad litem.~~;~~

b. The child's family members and other individuals identified by the family as being important to the child, provided that a parent who has a no contact order or injunction, is alleged to have sexually abused the child, or is subject to a termination of parental rights may not participate.~~;~~

c. The current caregiver, provided the caregiver is not a parent who meets the criteria of one of the exceptions under sub-subparagraph b.~~;~~

d. A representative from the department other than the Children's Legal Services attorney, when the department is directly involved in the goal identified by the staffing.~~;~~

e. A representative from the community-based care lead agency, when the lead agency is directly involved in the goal identified by the staffing.~~;~~

f. The case manager for the child, or his or her case manager supervisor.~~; and~~

g. A representative from the Department of Juvenile Justice, if the child is dually involved with both the department and the Department of Juvenile Justice. The representative must have the authority to make a same-day placement of a high-acuity child in an appropriate medical placement in the Department of Juvenile Justice if necessary.

h. A representative from the Agency for Persons with Disabilities who has the authority to make a same-day placement of a high-acuity child in an appropriate medical placement in

the agency if such child meets the eligibility criteria under s. 393.065 and is in a preenrollment category.

2. The multidisciplinary team must make reasonable efforts to have all mandatory invitees attend. However, the multidisciplinary team staffing may not be delayed if the invitees in subparagraph 1. fail to attend after being provided reasonable opportunities.

(5) SCOPE OF MULTIDISCIPLINARY TEAM.—

(a) A multidisciplinary team staffing must be held when an important decision is required to be made about a child's life, including all of the following:

1. Initial placement decisions for a child who is placed in out-of-home care. A multidisciplinary team staffing required under this subparagraph may occur before the initial placement or, if a staffing is not possible before the initial placement, must occur as soon as possible after initial removal and placement to evaluate the appropriateness of the initial placement and to ensure that any adjustments to the placement, if necessary, are promptly handled.

2. Changes in physical custody after the child is placed in out-of-home care by a court and, if necessary, determination of an appropriate mandatory transition plan in accordance with s. 39.4023.

3. Changes in a child's educational placement and, if necessary, determination of an appropriate mandatory transition plan in accordance with s. 39.4023.

4. Initial placement decisions or a change in placement for a high-acuity child in a medical placement under s. 39.4078, as appropriate, to stabilize such child.

5.~~4.~~ Placement decisions for a child as required by subparagraph 1., subparagraph 2., ~~or~~ subparagraph 3., or subparagraph 4. which involve sibling groups that require placement in accordance with s. 39.4024.

6.~~5.~~ Any other important decisions in the child's life which are so complex that the department or appropriate community-based care lead agency determines convening a multidisciplinary team staffing is necessary to ensure the best interest of the child is maintained.

(6) ASSESSMENTS.—

(d)1. If the participants of a multidisciplinary team staffing reach a unanimous consensus decision, it becomes the official position of the community-based care lead agency regarding the decision under subsection (5) for which the team convened. Such decision is binding upon all department and lead agency participants, who are obligated to support it.

2.a. If the participants of a multidisciplinary team staffing cannot reach a unanimous consensus decision on a plan to address the identified goal of a child who has not been classified as a high-acuity child, the trained professional acting as the facilitator shall notify the court and the department within 48 hours after the conclusion of the staffing. The department shall then determine how to address the identified goal of the staffing by what is in the child's best interest.

b. If the participants of a multidisciplinary team staffing cannot reach a unanimous consensus decision on a plan to address the appropriate initial placement or change in placement of a high-acuity child, the trained professional acting as the

facilitator must notify the court and the department within 48 hours after the conclusion of the staffing. The court must set an emergency evidentiary hearing within 10 days after such notification to address the appropriate initial placement or change in placement of the high-acuity child and determine if the high-acuity child should be placed in a medical placement in accordance with s. 39.4078. The court may require the representative from a community-based care lead agency or the department who was required to attend the multidisciplinary team staffing to attend the evidentiary hearing.

Section 7. Subsection (1), paragraph (b) of subsection (4), and subsection (6) of section 39.407, Florida Statutes, are amended to read:

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

(1) When any child is removed from the home and maintained in an out-of-home placement, the department is authorized to have a medical screening performed on the child without authorization from the court and without consent from a parent or legal custodian. ~~Such medical screening shall be performed by~~ A licensed health care professional must perform such medical screening and ~~shall be to~~ examine the child, in part, for injury;~~,~~ illness; mental, disability, or behavioral health conditions;~~,~~ and communicable diseases and to determine the need for immunization. The department shall by rule establish the invasiveness of the medical procedures authorized to be performed under this subsection. ~~In no case does~~ This subsection does not:

(a) Authorize the department to consent to medical treatment for such children; or

(b) Limit the procedures for a medical placement of a high-acuity child established under s. 39.4078.

(4)

(b) The judge may also order such child to be evaluated by a psychiatrist or a psychologist or, if a developmental disability is suspected or alleged, by the developmental disability diagnostic and evaluation team of the department. If it is necessary to place a child in a residential facility for such evaluation, the criteria and procedure established in s. 394.463(2) or chapter 393 must ~~shall~~ be used, whichever is applicable. If, after the evaluation is conducted under this paragraph, the psychiatrist, psychologist, or developmental disability diagnostic and evaluation team determines that the child meets the criteria to be classified as a high-acuity child under s. 39.4078, the judge must immediately order the high-acuity child to be placed in a medical placement to address the basis for the child's high-acuity needs, even if there are other placement options available under s. 39.4021.

(6) Children in the legal custody of the department may be placed by the department, without prior approval of the court, in a residential treatment center licensed under s. 394.875 or a hospital licensed under chapter 395 for residential mental health treatment only pursuant to this section or may be placed by the court in accordance with an order of involuntary examination or involuntary placement entered pursuant to s. 394.463 or s. 394.467. A high-acuity child may be placed in a residential treatment program or medical placement, as

appropriate, which best meets the needs of the high-acuity child based on the high-acuity child's complex medical, developmental, behavioral health, or disability needs. All children placed ~~in a residential treatment program~~ under this subsection must have a guardian ad litem appointed.

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

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

2. "Residential treatment" or "residential treatment program" means a placement for observation, diagnosis, or treatment of an emotional disturbance in a residential treatment center licensed under s. 394.875 or a hospital licensed under chapter 395. The term includes a medical placement under s. 39.4078 for a high-acuity child who presents with needs that are not suitable for treatment in a standard foster care or therapeutic group home environment due to the complexity of the needs or the potential for harm to others in the same care setting.

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

a. The child requires residential treatment.

b. The child is in need of a residential treatment program

and is expected to benefit from mental or behavioral health treatment, or a combination of treatment.

c. An appropriate, less restrictive alternative to residential treatment is unavailable.

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

(b) If ~~Whenever~~ the department believes that a child in its legal custody is emotionally disturbed or is classified or likely to be classified as a high-acuity child under s. 39.4078 and may need residential treatment, an examination and suitability assessment must be conducted by a qualified evaluator appointed by the department. This suitability assessment must be completed before the placement of the child in a residential treatment program.

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

2. The qualified evaluator for placement in a therapeutic group home must be a psychiatrist licensed under chapter 458 or chapter 459, a psychologist licensed under chapter 490, or a mental health counselor licensed under chapter 491 who has at

least 2 years of experience in the diagnosis and treatment of serious emotional, medical, developmental, or behavioral disturbances ~~disturbance~~ in children, including high-acuity children, and adolescents and who has no actual or perceived conflict of interest with any residential treatment center or program.

(c)1. Consistent with the requirements of this section, the child shall be assessed for suitability for residential treatment by a qualified evaluator who has conducted an examination and assessment of the child and has made written findings that:

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

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

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

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

3. If the written findings of the evaluation and

suitability assessment state that the child meets the criteria of a high-acuity child and there is not a suitable residential treatment program or medical placement for the high-acuity child identified within 5 business days after the written findings are provided to the department and guardian ad litem, the high-acuity child's guardian ad litem must notify the court within 24 hours after the expiration of the 5-day time period that there is a failure to identify a suitable placement. Within 5 business days after receiving such notification, the court must set an emergency evidentiary hearing to determine the most suitable placement for the high-acuity child in accordance with s. 39.4078. The court may prioritize the placement of a high-acuity child who is being placed or currently residing in foster care to a specialized and appropriate placement, including, but not limited to, a medical bed or group home in a facility licensed or maintained by the department, the Agency for Persons with Disabilities, the Department of Health, or the Agency for Health Care Administration.

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

(e) Within 10 days after the admission of a child to a residential treatment program, the director of the residential treatment program or the director's designee must ensure that an individualized plan of treatment has been prepared by the

program and has been explained to the child, to the department, and to the guardian ad litem, and submitted to the department. The child must be involved in the preparation of the plan to the maximum feasible extent consistent with his or her ability to understand and participate, and the guardian ad litem and the child's foster parents must be involved to the maximum extent consistent with the child's treatment needs. The plan must include a preliminary plan for residential treatment and aftercare upon completion of residential treatment. The plan must include specific behavioral and emotional goals against which the success of the residential treatment may be measured. A copy of the plan must be provided to the child, to the guardian ad litem, and to the department.

(f) Within 30 days after admission, the residential treatment program must review the appropriateness and suitability of the child's placement in the program. The residential treatment program must determine whether the child is receiving benefit toward the treatment goals and whether the child could be treated in a less restrictive treatment program. The residential treatment program shall prepare a written report of its findings and submit the report to the guardian ad litem and to the department. The department must submit the report to the court. The report must include a discharge plan for the child. The residential treatment program must continue to evaluate the child's treatment progress every 30 days thereafter and must include its findings in a written report submitted to the department. The department may not reimburse a facility until the facility has submitted every written report that is due.

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

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

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

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

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

Section 8. Section 39.4078, Florida Statutes, is created to read:

<u>39.4078 Medical Placement for High-acuity Children Act.—</u>

<u>(1) SHORT TITLE.—This section may be cited as the "Medical Placement for High-acuity Children Act."</u>

<u>(2) LEGISLATIVE FINDINGS AND INTENT.—</u>

(a) The Legislature finds that high-acuity children, particularly those with disabilities, who are entering or currently involved in the child protection system in this state require prompt and specialized medical health assessments, as well as appropriate medical placements.

(b) It is the intent of the Legislature to establish a time-limited, court-supervised process for the medical placement of high-acuity children which:

1. Ensures the high-acuity child receives medically necessary treatment and stabilization in the least restrictive setting that can safely meet the child's needs.

2. Coordinates judicial oversight with clinical assessment, case planning, and transition planning.

3. Promotes a prompt transfer to a less restrictive setting as acute symptoms resolve, while preserving the high-acuity child's rights to education, visitation, and normalcy.

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

(a) "Community-based care lead agency" has the same meaning as in s. 409.986(3).

(b) "Multidisciplinary team" has the same meaning as in s. 39.4022(2).

(4) APPLICABILITY.—This section applies to the assessment, eligibility, placement, case plan tasks, transfers to more or less restrictive settings, and discharge of high-acuity children in medical placements. This section operates in accordance with ss. 39.4022, 39.407, 39.523, and 39.6013; however, if this section conflicts with another section of law, this section prevails to the extent necessary to address the needs of a high-acuity child.

(5) MEDICAL PLACEMENT.—A medical placement may include all of the following, as clinically appropriate and subject to applicable licensure under chapter 394, chapter 395, chapter 400, or chapter 409:

(a) Acute care beds for short-term intensive medical or psychiatric treatment.

(b) Subacute beds for continued clinical support after acute care.

(c) Therapeutic medical foster care providing in-home medical services directed by a licensed health care professional.

(d) Specialized residential treatment programs for children with significant co-occurring medical and behavioral health conditions.

(e) Placements that meet the requirements of the pilot program of treatment foster care under s. 409.996(27).

(f) Other licensed settings capable of delivering equivalent medically necessary services to a high-acuity child in the least restrictive environment.

(6) REQUIREMENTS OF A MEDICAL PLACEMENT.—A medical placement must do all of the following:

(a) Stabilize the high-acuity child's acute symptoms and address any immediate safety risks.

(b) Initiate or continue evidence-based treatment and medication management, consistent with s. 39.407.

(c) Maintain the high-acuity child's educational services and reasonable family and sibling contact.

(d) Develop clear, time-limited clinical and functional goals that determine when the high-acuity child is ready for a

less restrictive setting.

(e) Create a plan for placement and services that address the range of needs of the high-acuity child from his or her admission to a medical bed until he or she transitions to a less restrictive setting and eventually reaches permanency.

(f) Ensure that high-acuity children in the custody of the department under this chapter are given priority for placements in the most appropriate facilities licensed or maintained by the Agency for Persons with Disabilities, the Agency for Health Care Administration, the Department of Health, or the department, as applicable.

(7) ASSESSMENT AND ADMISSION.—

(a) Before admission to a medical placement, or within 24 hours after an emergency admission, a Child Protection Team must collaborate with the department or community-based care lead agency to obtain a comprehensive clinical assessment conducted by a qualified licensed professional which identifies a high-acuity child's needs, recommended level of care, and anticipated length of stay.

(b) In accordance with s. 39.4022, a multidisciplinary team staffing must occur within 72 hours after a child is classified as a high-acuity child, and the staffing must include all necessary participants who can appropriately address the basis for classifying the child as a high-acuity child.

(c) The multidisciplinary team staffing must recommend the least restrictive medical bed placement that is capable of meeting the needs of the high-acuity child and identify measurable goals and criteria for less restrictive placement. The recommendations of the multidisciplinary team staffing must

be filed with a court pursuant to subsection (8).

(d) If the multidisciplinary team staffing cannot reach a consensus on the placement of a high-acuity child, a designated person present at the staffing must notify the court and, within 10 days after such notification, the court must hold an emergency evidentiary hearing in accordance with s. 39.4022(6)(d)2.b.

(8) COURT APPROVAL AND WRITTEN FINDINGS.—

(a) Within 72 hours after a multidisciplinary team staffing at which a consensus is reached to place a high-acuity child in a medical placement, the department shall petition the court for approval of such placement. The petition must include a copy of the comprehensive clinical assessment and recommendations of the multidisciplinary team staffing.

(b) The court shall conduct an evidentiary hearing and provide written findings on all of the following:

1. The medical, behavioral, or complex conditions of the child which are the basis for classifying the child as a high-acuity child.

2. Whether the medical bed suggested by the multidisciplinary team staffing is the least restrictive setting available for the high-acuity child.

3. Clearly defined goals and criteria for the high-acuity child to enter a less restrictive placement.

4. The appropriate timeframe in which the case plan must be updated to address the written findings of the court.

(c) Consent and authorization for medical, psychiatric, and behavioral health services must be obtained and documented in accordance with s. 39.407.

(d) The court must ensure that a high-acuity child's educational services, including any individualized education program services if applicable, continue without interruption and that reasonable family and sibling contact occurs unless such contact is against clinical judgment and court order.

(9) PERIODIC REVIEWS.—Within 30 days after the court provides its written findings under subsection (8), and every 30 days thereafter for as long as the high-acuity child remains in a medical placement, the court must review the high-acuity child's progress through acute presentation of complex behaviors. Each review must include updated clinical reports, the progress of the high-acuity child toward defined goals that address the stabilization and treatment of any identified high-acuity behaviors, educational progress, family and sibling contact, and a recommendation regarding whether the high-acuity child is ready for a less restrictive setting. Within 5 days before each review hearing, the department must file with the court an updated report that includes a recommendation for maintaining the medical placement or, if appropriate, transferring the high-acuity child to a less restrictive setting. The multidisciplinary team staffing shall reconvene before each review unless such requirement is waived by the court.

(10) PLACEMENT PROCEDURES.—

(a) Upon motion of any party or on the court's own motion, and based on competent substantial evidence of the high-acuity child's clinical status, the court may immediately order the high-acuity child to be moved to a less or more restrictive licensed placement as indicated by the presence or resolution of

acute symptoms without having to wait for a regularly scheduled review.

(b) The department may implement emergency procedures for moving a high-acuity child to a more restrictive setting for the safety of the high-acuity child or based on medical necessity. The department shall notify the court and all parties within 24 hours after implementation of emergency procedures. The court shall set the matter for a hearing within 3 days after being notified of the implementation of emergency procedures.

(c) The transition between placements of a high-acuity child must comply with s. 39.523 and include a written transition plan that addresses medication continuity, treatment hand-offs, education, and family and sibling contact of the high-acuity child.

(11) CASE PLAN.—A high-acuity child's case plan must be updated within 7 days after court approval under subsection (8) and after each review under subsection (9) to reflect placement goals and transition planning.

(12) DURATION OF A MEDICAL PLACEMENT.—

(a) A medical placement may not exceed 90 consecutive days without express written consent by the court, supported by clear and convincing evidence that the medical placement remains medically necessary and is the least restrictive setting available to safely meet the needs of the high-acuity child.

(b) This section does not authorize the placement of a high-acuity child in a setting prohibited by federal or state law or rule.

(13) RIGHTS OF HIGH-ACUITY CHILDREN.—Unless otherwise ordered by the court, a high-acuity child who is in a medical

placement retains all rights under this chapter, including, but not limited to, access to an attorney ad litem and a guardian ad litem, reasonable visitation with family and siblings, individualized education program services, and participation in case plan development based on the age and capacity of the high-acuity child.

(14) ANNUAL REPORT.—

(a) The department shall collect data relating to the Medical Placement for High-acuity Children Act, including admissions, placement types, lengths of stay, goals achieved, outcomes of less restrictive settings, recidivism, education continuity, family and sibling contact, and time to permanency. Community-based care lead agencies and providers must furnish to the department any data required to comply with this subsection.

(b) By January 31, 2027, and annually thereafter, the department shall submit to the President of the Senate and the Speaker of the House of Representatives a report relating to utilization, outcomes, and service gaps of and recommendations regarding the Medical Placement for High-acuity Children Act.

(15) CONSTRUCTION.—This section may not be construed to limit the requirements of medical consent under s. 39.407 or the court's authority under s. 39.522.

(16) RULEMAKING.—The department and the Department of Health may adopt rules to implement this section.

Section 9. Paragraphs (c) and (d) of subsection (1) and subsection (2) of section 39.523, Florida Statutes, are amended, and paragraph (e) is added to subsection (1) of that section, to read:

39.523 Placement in out-of-home care.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(c) The Legislature also finds that the timely identification of and therapeutic response to acute presentation of symptoms indicative of trauma or high-acuity complex needs can reduce adverse outcomes for a child, aid in the identification of services to enhance initial placement stability and of supports to caregivers, and reduce placement disruption.

(d) It is the intent of the Legislature that whenever a child is unable to safely remain at home with a parent, the most appropriate available out-of-home placement must ~~shall~~ be chosen after an assessment of the child's needs and the availability of caregivers qualified to meet the child's needs, including certain group or treatment settings that are appropriate for addressing the needs of a high-acuity child.

(e) It is the intent of the Legislature that this section applies to transitions between all out-of-home placements, including, but not limited to, medical placements under s. 39.4078.

(2) ASSESSMENT AND PLACEMENT.—When any child is removed from a home and placed in out-of-home care, a comprehensive placement assessment process shall be completed in accordance with s. 39.4022 or s. 39.4078, as applicable, to determine the level of care needed by the child and match the child with the most appropriate placement.

(a) In accordance with rules adopted by the department, the department, ~~or~~ community-based care lead agency, or Child Protection Team, if the child being evaluated has been identified as a high-acuity child under s. 39.4078, must:

1. Coordinate a multidisciplinary team staffing as established in s. 39.4022 with the necessary participants for the stated purpose of the staffing.

2. Conduct a trauma screening as soon as practicable after the child's removal from his or her home but no later than 21 days after the shelter hearing. If indicated as appropriate or necessary by the screening, the department or community-based care lead agency must, at a minimum:

a. Promptly refer the child to appropriate trauma assessment, which must be completed within 30 days, and if appropriate, services and intervention as needed. To the extent possible, the trauma screening, the assessment, and the services and intervention must be integrated into the child's overall behavioral health treatment planning and services.

b. In accordance with s. 409.1415(2)(b)3.f., provide information and support, which may include, but need not be limited to, consultation, coaching, training, and referrals to services, to the caregiver of the child to help the caregiver respond to and care for the child in a trauma-informed and therapeutic manner.

(b) The comprehensive placement assessment process may also include the use of an assessment instrument or tool that is best suited for the individual child and is able to identify a high-acuity child.

(c) The most appropriate available out-of-home placement shall be chosen after consideration by all members of the multidisciplinary team of all of the information and data gathered, including the results and recommendations of any evaluations conducted and considering the most appropriate

placement of each child under ss. 39.4021 and 39.4022.

(d) Placement decisions for each child in out-of-home placement shall be reviewed as often as necessary to ensure permanency for that child and address special issues related to this population of children.

(e) The department, a community-based care lead agency, or a case management organization must document all placement assessments and placement decisions in the Florida Safe Families Network.

(f) If it is determined during the comprehensive placement assessment process that:

1. Residential treatment as defined in s. 39.407 would be suitable for the child, the procedures in that section must be followed.

2. A child is classified as a high-acuity child, the procedures in s. 39.4078 must be followed.

(g) The appropriate agencies and departments shall prioritize the placement of a high-acuity child who is taken into or currently in out-of-home care under this chapter into a specialized and appropriate placement, including, but not limited to, a medical bed or group home placement in a facility licensed or maintained by the department, the Department of Health, the Agency for Persons with Disabilities, or the Agency for Health Care Administration.

Section 10. Subsection (2) and paragraph (a) of subsection (3) of section 39.6012, Florida Statutes, are amended to read:

39.6012 Case plan tasks; services.—

(2) The case plan must include all available information that is relevant to the child's care including, at a minimum:

(a) A description of the identified needs of the child while in care, including the needs of a child who has been evaluated and meets the criteria of a high-acuity child. The description of such needs must be specific enough for the parent or caregiver to sufficiently understand how to properly address any high-acuity medical conditions and the provision of care for such conditions to ensure the safe placement and care of the high-acuity child in compliance with s. 39.4078.

(b) A description of the plan for ensuring that the child receives safe and proper care and that services are provided to the child in order to address the child's needs. To the extent available and accessible, all of the following health, mental health, and education information and records of the child must be attached to the case plan and updated throughout the judicial review process:

1. The names and addresses of the child's health, mental health, and educational providers.~~;~~

2. The child's grade level performance.~~;~~

3. The child's school record or, if the child is under the age of school entry, any records from a child care program, early education program, or preschool program.~~;~~

4. Documentation of compliance or noncompliance with the attendance requirements under s. 39.604, if the child is enrolled in a child care program, early education program, or preschool program.~~;~~

5. Assurances that the child's placement takes into account proximity to the school in which the child is enrolled at the time of placement.~~;~~

6. The child's immunizations.~~;~~

7. The child's known medical history, including any known health problems.~~;~~

8. The child's medications, if any.~~; and~~

9. Any other relevant health, mental health, and education information concerning the child.

10. Any other tasks that the Child Protection Team deems appropriate for a case plan prepared in accordance with s. 39.4078 for a high-acuity child which are specific to addressing the child's high-acuity needs and appropriate transition plans to more restrictive and less restrictive settings, regardless of whether the high-acuity designation is based on the child's mental health, behavioral health, disability, or involvement with the juvenile justice system.

(3) In addition to any other requirement, if the child is in an out-of-home placement, the case plan must include:

(a) A description of the type of placement in which the child is to be living, including if such placement is a medical bed in a medical placement for a high-acuity child.

Section 11. Subsections (1) and (2) of section 39.6013, Florida Statutes, are amended to read:

39.6013 Case plan amendments.—

(1) After the case plan has been developed under s. 39.6011, the tasks and services agreed upon in the plan may not be changed or altered in any way except as provided in this section. If a high-acuity child is placed in a medical placement, the case plan must reflect the goals, services, and transition requirements identified in s. 39.4078.

(2) The case plan may be amended at any time in order to change the goal of the plan, employ the use of concurrent

planning, add or remove tasks the parent must complete to substantially comply with the plan, provide appropriate services for the child, and update the child's health, mental health, and education records as required by s. 39.4078 or s. 39.6012.

Section 12. Paragraph (k) is added to subsection (1) of section 391.025, Florida Statutes, to read:

391.025 Applicability and scope.—

(1) The Children's Medical Services program consists of the following components:

(k) The Medical Placement for High-acuity Children Act established under s. 39.4078.

Section 13. Subsection (1) of section 391.029, Florida Statutes, is amended, and paragraph (d) is added to subsection (2) and paragraph (d) is added to subsection (3) of that section, to read:

391.029 Program eligibility.—

(1) Eligibility for the Children's Medical Services program is based on the diagnosis of one or more chronic and serious medical conditions or meeting the criteria for a high-acuity child as defined in s. 39.01 and the family's need for specialized services.

(2) The following individuals are eligible to receive services through the program:

(d) Children or youth with complex behavioral or mental health needs from birth to 18 years of age who meet the criteria of a high-acuity child as defined in s. 39.01 or who are placed in a medical bed in a medical placement under s. 39.4078.

(3) Subject to the availability of funds, the following individuals may receive services through the Children's Medical

Services Safety Net program:

(d) Children or youth with complex behavioral or mental health needs from birth to 18 years of age who meet the criteria of a high-acuity child as defined in s. 39.01 or who are placed in a medical bed in a medical placement under s. 39.4078.

Section 14. Subsection (5) of section 393.065, Florida Statutes, is amended to read:

393.065 Application and eligibility determination.—

(5) Except as provided in subsections (6) and (7), if a client seeking enrollment in the developmental disabilities home and community-based services Medicaid waiver program meets the level of care requirement for an intermediate care facility for individuals with intellectual disabilities pursuant to 42 C.F.R. ss. 435.217(b)(1) and 440.150, the agency must assign the client to an appropriate preenrollment category pursuant to this subsection and must provide priority to clients waiting for waiver services in the following order:

(a) Category 1, which includes clients deemed to be in crisis as described in rule and clients who meet the criteria of a high-acuity child as defined in s. 39.01, must be given first priority in moving from the preenrollment categories to the waiver.

(b) Category 2, which includes clients in the preenrollment categories who are:

1. From the child welfare system with an open case in the Department of Children and Families' statewide automated child welfare information system and who are either:

a. Transitioning out of the child welfare system into permanency; or

b. At least 18 years but not yet 22 years of age and who need both waiver services and extended foster care services; or

2. At least 18 years but not yet 22 years of age and who withdrew consent pursuant to s. 39.6251(5)(c) to remain in the extended foster care system.

For individuals who are at least 18 years but not yet 22 years of age and who are eligible under sub-subparagraph 1.b., the agency must provide waiver services, including residential habilitation, and must actively participate in transition planning activities, including, but not limited to, individualized service coordination, case management support, and ensuring continuity of care pursuant to s. 39.6035. The community-based care lead agency must fund room and board at the rate established in s. 409.145(3) and provide case management and related services as defined in s. 409.986(3)(f) ~~s. 409.986(3)(e)~~. Individuals may receive both waiver services and services under s. 39.6251. Services may not duplicate services available through the Medicaid state plan.

(c) Category 3, which includes, but is not required to be limited to, clients:

1. Whose caregiver has a documented condition that is expected to render the caregiver unable to provide care within the next 12 months and for whom a caregiver is required but no alternate caregiver is available;

2. At substantial risk of incarceration or court commitment without supports;

3. Whose documented behaviors or physical needs place them or their caregiver at risk of serious harm and other supports

are not currently available to alleviate the situation; or

4. Who are identified as ready for discharge within the next year from a state mental health hospital or skilled nursing facility and who require a caregiver but for whom no caregiver is available or whose caregiver is unable to provide the care needed.

(d) Category 4, which includes, but is not required to be limited to, clients whose caregivers are 60 years of age or older and for whom a caregiver is required but no alternate caregiver is available.

(e) Category 5, which includes, but is not required to be limited to, clients who are expected to graduate within the next 12 months from secondary school and need support to obtain a meaningful day activity, maintain competitive employment, or pursue an accredited program of postsecondary education to which they have been accepted.

(f) Category 6, which includes clients 21 years of age or older who do not meet the criteria for category 1, category 2, category 3, category 4, or category 5.

(g) Category 7, which includes clients younger than 21 years of age who do not meet the criteria for category 1, category 2, category 3, or category 4.

Within preenrollment categories 3, 4, 5, 6, and 7, the agency shall prioritize clients in the order of the date that the client is determined eligible for waiver services. A client within any preenrollment category who meets the criteria of a high-acuity child as defined in s. 39.01 whose high-acuity designation is related to a disability that otherwise makes the

child eligible for services under this chapter must be placed in category 1 for priority placement in an appropriate medical bed in a medical placement in accordance with s. 39.4078 if the child is taken into or is currently in the custody of the Department of Children and Families under chapter 39.

Section 15. Paragraph (p) of subsection (4), paragraph (a) of subsection (6), and paragraph (a) of subsection (7) of section 394.495, Florida Statutes, are amended, and paragraph (r) is added to subsection (4) of that section, to read:

394.495 Child and adolescent mental health system of care; programs and services.—

(4) The array of services may include, but is not limited to:

(p) Trauma-informed services for children who have suffered sexual exploitation as defined in s. 39.01(83)(g) ~~s. 39.01(80)(g)~~.

(r) Placement in a medical bed in a medical placement under s. 39.4078.

(6) The department shall contract for community action treatment teams throughout the state with the managing entities. A community action treatment team shall:

(a) Provide community-based behavioral health and support services to children from 11 to 13 years of age, adolescents, and young adults from 18 to 21 years of age with serious behavioral health conditions who are at risk of out-of-home placement as demonstrated by:

1. Repeated failures at less intensive levels of care;

2. Two or more behavioral health hospitalizations;

3. Involvement with the Department of Juvenile Justice;

4. A history of multiple episodes involving law enforcement; ~~or~~

5. A record of poor academic performance or suspensions; or

6. A designation as a high-acuity child as defined in s. 39.01 or placement in a medical bed in a medical placement under s. 39.4078.

Children younger than 11 years of age who otherwise meet the criteria in this paragraph may be candidates for such services if they demonstrate two or more of the characteristics listed in subparagraphs 1.-5.

(7)(a) The department shall contract with managing entities for mobile response teams throughout the state to provide immediate, onsite behavioral health crisis services to children, adolescents, and young adults ages 18 to 25, inclusive, who:

1. Have an emotional disturbance;

2. Are experiencing an acute mental or emotional crisis;

3. Are experiencing escalating emotional or behavioral reactions and symptoms that impact their ability to function typically within the family, living situation, or community environment; ~~or~~

4. Are served by the child welfare system and are experiencing or are at high risk of placement instability; or

5. Have been evaluated and meet the criteria of a high-acuity child as defined in s. 39.01 or who are placed in a medical bed in a medical placement under s. 39.4078.

Section 16. Paragraphs (a) and (b) of subsection (2) of section 409.145, Florida Statutes, are amended, and paragraph (h) is added to subsection (1) of that section, to read:

409.145 Care of children; "reasonable and prudent parent" standard.—The child welfare system of the department shall operate as a coordinated community-based system of care which empowers all caregivers for children in foster care to provide quality parenting, including approving or disapproving a child's participation in activities based on the caregiver's assessment using the "reasonable and prudent parent" standard.

(1) SYSTEM OF CARE.—The department shall develop, implement, and administer a coordinated community-based system of care for children who are found to be dependent and their families. This system of care must be directed toward the following goals:

(h) Ensure that a child who has been designated as a high-acuity child after an assessment for such purpose has the most appropriate medical placement and necessary services, including transitions to more restrictive and less restrictive settings, to address the acute or chronic expression of the medical conditions that are the reason for the high-acuity designation.

(2) REASONABLE AND PRUDENT PARENT STANDARD.—

(a) *Definitions.*—As used in this subsection, the term:

1. "Age-appropriate" means an activity or item that is generally accepted as suitable for a child of the same chronological age or level of maturity. Age appropriateness is based on the development of cognitive, emotional, physical, and behavioral capacity which is typical for an age or age group.

2. "Caregiver" means a person with whom the child is placed in out-of-home care, or a designated official for a group care facility licensed by the department under s. 409.175.

3. "High-acuity child" has the same meaning as in s. 39.01.

4.~~3.~~ "Reasonable and prudent parent" standard means the standard of care used by a caregiver in determining whether to allow a child in his or her care to participate in extracurricular, enrichment, and social activities. This standard is characterized by careful and thoughtful parental decisionmaking that is intended to maintain a child's health, safety, and best interest while encouraging the child's emotional and developmental growth.

(b) *Application of standard of care.*—

1. Every child who comes into out-of-home care pursuant to this chapter is entitled to participate in age-appropriate extracurricular, enrichment, and social activities.

2. Each caregiver shall use the reasonable and prudent parent standard in determining whether to give permission for a child living in out-of-home care to participate in extracurricular, enrichment, or social activities. When using the reasonable and prudent parent standard, the caregiver must consider:

a. The child's age, maturity, and developmental level to maintain the overall health and safety of the child.

b. The potential risk factors and the appropriateness of the extracurricular, enrichment, or social activity.

c. The best interest of the child, based on information known by the caregiver.

d. The importance of encouraging the child's emotional and developmental growth.

e. The importance of providing the child with the most family-like living experience possible.

f. The behavioral history of the child and the child's

ability to safely participate in the proposed activity.

For a high-acuity child, the medical necessity of such child and the need for medical placement or transitions to more restrictive and less restrictive settings take priority over the reasonable and prudent parent standard until such time as the court determines that the acute or chronic expression of the medical conditions that are the reason for the high-acuity designation have been stabilized.

Section 17. Paragraph (d) of subsection (2) of section 409.166, Florida Statutes, is amended to read:

409.166 Children within the child welfare system; adoption assistance program.—

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

(d) "Difficult-to-place child" means:

1. A child whose permanent custody has been awarded to the department or to a licensed child-placing agency;

2. A child who has established significant emotional ties with his or her foster parents or is not likely to be adopted because he or she is:

a. Eight years of age or older;

b. Developmentally disabled;

c. Physically or emotionally handicapped;

d. A member of a racial group that is disproportionately represented among children described in subparagraph 1.; ~~or~~

e. A member of a sibling group of any age, provided two or more members of a sibling group remain together for purposes of adoption; or

f. A high-acuity child as defined in s. 39.01; and

3. Except when the child is being adopted by the child's foster parents or relative caregivers, a child for whom a reasonable but unsuccessful effort has been made to place the child without providing a maintenance subsidy.

Section 18. Subsection (30) is added to section 409.906, Florida Statutes, to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(30) HIGH-ACUITY CHILD SERVICES.—The agency may pay for a

medical bed in a medical placement and any transitions to more restrictive and less restrictive settings that are required to appropriately serve a high-acuity child as defined in s. 39.01 to ensure that a child designated as a high-acuity child has the most appropriate placement and services necessary to address the acute or chronic expression of the medical conditions that are the reason for the high-acuity designation. The agency may seek federal approval if necessary to implement this subsection.

Section 19. Present paragraph (e) of subsection (3) of section 409.986, Florida Statutes, is redesignated as paragraph (f), and paragraph (j) is added to subsection (2) and a new paragraph (e) is added to subsection (3) of that section, to read:

409.986 Legislative findings and intent; child protection and child welfare outcomes; definitions.—

(2) CHILD PROTECTION AND CHILD WELFARE OUTCOMES.—It is the goal of the department to protect the best interest of children by achieving the following outcomes in conjunction with the community-based care lead agency, community-based subcontractors, and the community alliance:

(j) If applicable, the needs of a high-acuity child are stabilized and the child is provided the most appropriate services and placements.

(3) DEFINITIONS.—As used in this part, except as otherwise provided, the term:

(e) "High-acuity child" has the same meaning as in s. 39.01.

Section 20. Paragraph (c) of subsection (1) of section 934.255, Florida Statutes, is amended to read:

934.255 Subpoenas in investigations of sexual offenses.—

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

(c) "Sexual abuse of a child" means a criminal offense based on any conduct described in s. 39.01(83) ~~s. 39.01(80)~~.

Section 21. Subsection (5) of section 960.065, Florida Statutes, is amended to read:

960.065 Eligibility for awards.—

(5) A person is not ineligible for an award pursuant to paragraph (2)(a), paragraph (2)(b), or paragraph (2)(c) if that person is a victim of sexual exploitation of a child as defined in s. 39.01(83)(g) ~~s. 39.01(80)(g)~~.

Section 22. Subsection (24) of section 984.03, Florida Statutes, is amended to read:

984.03 Definitions.—When used in this chapter, the term:

(24) "Neglect" has the same meaning as in s. 39.01 ~~s. 39.01(53)~~.

Section 23. This act shall take effect July 1, 2026.